STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longwood Manor Conv.Hospital	4853 W. Washington Bl. Los Angeles, CA 90016

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) were free from verbal abuse by Certified Nursing Assistant (CNA) 1. This deficient practice had the potential for Resident 1 to feel upset and that his needs were not being met. Findings: a. During a review of Resident 1's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included partial amputation of the right foot (involves surgically removing part of the foot), functional quadriplegia (inability to move due a physical disability), and diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical (H&P), dated 7/19/2024, the H&P indicated, Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 2/1/2025, the MDS indicated Resident 1's cognition (ability to learn, reason, remember, understand, and make decisions) was normally intact. The MDS indicated Resident 1's verbal behavioral symptoms directed toward others were not exhibited. The MDS indicated Resident 1 required supervision for dressing and personal hygiene. During a review of Resident 1's Progress Note, dated 2/19/2025, the Progress Notes indicated Resident 1 had a verbal disagreement with Certified Nursing Assistant (CNA) 1 regarding the placement of his roommate's (Resident 2) wheelchair. The Progress Note indicated Resident 1 expressed loudly that the wheelchair obstructs his passage on the way out of the room. The Progress note indicated CNA 1 loudly expressed the necessity of moving it to feed Resident 2. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Change of Condition (COC) dated 2/19/2025, the COC indicated Resident 1 had a verbal disagreement with his caregiver regarding the placement of Resident 2's wheelchair. The COC indicated Resident 1 expressed that the wheelchair obstructs his passage to get out of the room. The COC indicated the disagreement escalated and CNA 1's voice started to get louder and louder and began yelling at the resident. During a review of CNA 1's Performance Correction Notice, dated 2/21/2025, the Performance Correction Notice indicated CNA 1 stated I am also a human being. I don't allow anyone to disrespect me in regards to the incident with Resident 1. The Performance Correction Notice indicated on 2/19/2025, CNA 1 was verbally aggressive and disrespectful towards Resident 1. The Performance Correction Notice indicated the incident was a direct violation of Resident Rights and the company's code of conduct was unacceptable and grounds for immediate termination. During an interview on 2/26/2025 at 11:25 a.m. with Resident 1, Resident 1 stated on 2/19/2025, Resident 2's wheelchair was blocking the bathroom door and he was not able to exit the bathroom door. Resident 1 stated as he was trying to exit out of the bathroom, CNA 1 began raising her voice at Resident 2 that she would leave the wheelchair at the bathroom door. Resident 1 stated when CNA 1 raised her voice he felt a bit upset. During an interview on 2/26/2025 at 12:33 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 2/19/2025 around 8:00 a.m., he heard CNA 1 yelling at Resident 1 about the placement of Resident 2's wheelchair. LVN 1 stated CNA 1 should have explained to the resident why she needed to move the wheelchair without yelling. LVN 1 stated it was verbal abuse when the staff yelled at the residents. LVN 1 stated when the staff yells at the residents it could make them feel guarded and unsafe. During an interview on 2/26/2025 at 1:56 p.m. with Registered Nurse (RN) 1, RN 1 stated on 2/19/2025, CNA 1 yelled at Resident 1, You're not the only one in this room! RN 1 stated CNA 1 was being verbally abusive and should have gone to tell the charge nurse their was an issue. During an interview on 2/26/2025 at 2:23 p.m. with the Assistant Director of Nursing (ADON), the ADON stated CNA 1 had yelled at Resident 1, You're not the only one in here! The ADON stated CNA 1 should have listened to the needs of the resident by moving the wheelchair out of his way. The ADON stated CNA 1 yelling at Resident 1 could affect him psychosocially (the emotional and social aspects of a patient's health). During an interview on 3/12/2025 at 3:00 p.m. with the Administrator (ADM), the ADM stated the staff had reported on 2/19/2025 around 8:30 a.m. they witnessed CNA 1 in Resident 1's room screaming and yelling at Resident 1. The ADM stated CNA 1 used the F word, while screaming at Resident 1. The ADM stated CNA 1 was suspended on 2/19/2025 and later was terminated on 2/21/2025 because of her conduct. The ADM stated the residents should not be yelled and cursed at any time and the primary goal of the facility was for the residents to feel safe. b. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included paraplegia (loss of movement and/or sensation, to some degree, of the legs), heart failure (a condition where the heart doesn't pump blood well), and DM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's H&P, dated 1/6/2025, the H&P indicated, Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was normally intact. During an interview on 2/26/2025 at 12:26 p.m. with Resident 2, Resident 2 stated on 2/19/2025, CNA 1 was upset about his (Resident 2) wheelchair being in her way. Resident 2 stated CNA 1 moved the wheelchair in front of the bathroom door. Resident 2 stated he tried to explain to CNA 1 that Resident 1 was in the bathroom. Resident 2 stated CNA 1 was loud and yelling at Resident 1 about how the wheelchair was going to stay in front of the bathroom door. During a review of the facility's policy and procedure (P&P), Abuse & Mistreatment of Residents, date unknown, the P&P indicated to uphold a resident's right to be free from verbal abuse. The P&P indicated verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents with the hearing distance, regardless of their age, ability to comprehend, or disability.