STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555028	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palos Verdes Health Care Center	26303 Western Ave. Lomita, CA 90717

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** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from verbal abuse. The facility failed to:1.Separate Resident 1 and Resident 2 immediately when Licensed Vocational Nurse (LVN) 1 was notified by Certified Nursing Assistant (CNA) 1 about the alleged verbal abuse and altercation between Resident 1 and Resident 2 on 3/28/2026 at 5:30 a.m.2.Follow the facility's policy and procedures (P&P) titled, Resident to Resident Altercation, which indicated the staff will separate the residents if two residents are involved in an altercation and identify what happened.These failures had the potential to put Resident 1 at risk for further verbal abuse, unnecessary anxiety and fear from Resident 2.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or reduced control on one side of the body) following cerebral infarction (stroke-blood flow to a part of the brain is interrupted by a blockage or burst vessel) and major depressive disorder (mental health condition characterized by persistent feeling of sadness).During a review of Resident 1's History and Physical (H&P) dated 10/16/2025, 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 1/16/2026, the MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues) with eating, and substantial / maximal assistance (helper does more than half the effort) with transferring to and from a bed to chair or wheelchair. The MDS indicated Resident 1 had the ability to understand others and express his ideas and wants.During a review of Resident 1's Progress Notes dated 3/28/2026 timed at 5:21 a.m., the Progress Notes indicated Resident 1 stated Resident 2 was antagonizing him and was calling him names like, Faggot, and Cry Baby. The Progress Notes indicated the author of the Progress Notes was LVN 1.During the review of Resident 1's Progress Notes dated 3/28/2027 at 7:27 a.m., the Progress Notes indicated LVN 1 reported to Registered Nurse Supervisor (RNS) 1 that Resident 1 and Resident 2 should have a room change due to alleged nameˆcalling directed at Resident 1. The notes also indicated RNS 1 will speak with both Resident 1 and Resident 2.During a review of Resident 1's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember] behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 3/28/2026 timed at 10:09 a.m., the COC indicated around 9:30 a.m. to 10:00 a.m. RNS 1 interviewed Resident 1 and Resident 2. The COC indicated Resident 2 allegedly threatened Resident 1 by saying, I will kill you. The COC indicated the Administrator, Director of Nursing, physician and family were notified.During a review of Resident 1's Care Plan titled, Resident 1 reports anger, irritation, or dislike towards Resident 2's yelling, insults, name calling and verbal threats, initiated on 3/30/2026. The Care Plan interventions included maintaining a safe environment for all patients and separating patient.During a review of Resident 2's admission Record, the admission (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), diabetes mellitus, pleural effusion(abnormal buildup of excess fluid between the thin membranes lining the lungs and the chest cavity), and dependence on renal dialysis(patient must use a machine or a specialized treatment to filter their blood regularly because their kidneys stopped working well).During a review of Resident 2's H&P dated 3/26/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had the ability to express ideas and wants and understand others. The MDS indicated Resident 2 required supervision with eating and substantial /maximal assistance with transferring to and from the bed to chair or wheelchair.During a review of Resident 2's COC dated 3/28/2026 and timed at 10:20 a.m., the COC indicated around 9:30 a.m. to 10:00 a.m. Resident 1 stated Resident 2 was allegedly threatening him by saying, I will kill you. The COC indicated Resident 2 stated he did not say anything and Resident 1 started to scream. The COC indicated Resident 2 told Resident 1 to be quiet in a language other than English.During a review of Resident 2's Care Plan titled, The Resident has the potential to be verbally aggressive, alleged threatening words, I will kill you, to Resident 1 initiated 3/28/2026, the Care Plan indicated to intervene before agitation escalates by guiding away from sources of distress.During a review of Resident 2's Progress Notes dated 3/29/2026 at 12:52 p.m., the Progress Notes indicated Resident 2 left the facility against medical advice (AMA-patient leaving a facility before the physician recommends discharge).During a telephone interview on 4/1/2026 at 11:07 a.m., with LVN 1, LVN 1 stated Resident 1 and Resident 2 were arguing during her shift on 3/28/2026 at around 6:00 a.m. LVN 1 stated CNA 1 informed her during the 5:30 a.m. medication pass that Resident 1 and Resident 2 were arguing. LVN 1 stated she went to speak with both residents and learned from Resident 1 that Resident 2 had been calling him names (faggot and cry baby). LVN 1 stated she informed RNS 1, who arrived around 7:15 a.m. on 3/28/2026, to request a room change for both residents because they were arguing. LVN 1 stated she did not separate the residents immediately because she believed only the Social Service Director (SSD) or RNS 1 could authorize room changes. LVN 1 stated staff should report allegations of abuse to the abuse coordinator or the Director of Nursing (DON) immediately and separate the residents. LVN 1 stated keeping both residents in the same room after an alleged residentˆtoˆresident altercation could escalate the verbal conflict and lead to potential harm.During a telephone interview on 4/1/2026 at 11:48 a.m., with CNA 1, CNA 1 stated he answered Resident 1's call light on 3/28/2026 at around 4:30 a.m. CNA 1 stated Resident 1 complained that Resident 2 was cursing at him and speaking to him rudely. CNA 1 stated he reported the incident to LVN 1 around 5:00 a.m. on 3/28/2026. CNA 1 stated staff should separate residents involved in an altercation immediately for their safety. CNA 1 stated Resident 1 and Resident 2 were not separated immediately. CNA 1 stated the incident involved verbal abuse between the two residents. CNA 1 stated if residents were not separated immediately after an alleged residentˆtoˆresident altercation, they may be at risk of injury or further abuse.During interviews on 4/1/2026 at 9:00 a.m. and again at 2:29 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the alleged resident altercation occurred during the 11:00 p.m. to 7:00 a.m. shift on 3/27/2026. RNS 1 stated that around 7:15 a.m. to 7:30 a.m. on 3/28/2026, LVN 1 informed her Resident 1 and Resident 2 were having misunderstandings and that one of them should receive a room change. RNS 1 stated she did not report the incident immediately because she believed it was a misunderstanding rather than abuse. She stated she did not talk to both residents right away for the same reason. RNS 1 stated at 8:00 a.m. on 3/28/2026, Resident 2 was asleep, and she chose not to interview Resident 1 because she was concerned Resident 2 might wake up and become aggressive. RNS 1 stated Resident 2 had a strong personality, spoke loudly, could become rude, and was not sociable. RNS 1 stated she was aware the alleged abuse occurred at 5:30 a.m. on 3/28/2026. RNS 1 also stated that staff should report allegations of abuse immediately so the facility can investigate promptly, and Resident 1 and Resident 2 should have been separated immediately. She stated failing to separate the residents (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could escalate the situation and lead to injury. RNS 1 stated that not reporting an allegation of abuse immediately could place Resident 1 in danger and at risk of emotional distress.During a concurrent observation and interview on 4/1/2026 at 12:15 p.m. in Resident 1's room, Resident 1 sat on his bed. Resident 1 stated he never engaged in conversation with Resident 2. Resident 1 stated Resident 2 called him chicken, chavala (a Spanish word for woman), not a man, and screamed at him. He stated Resident 2 told him he would go to his bed and kick his behind when he was alone in the room. Resident 1 stated he could no longer ignore the behavior and reported it to CNA 1 early in the morning on 3/28/2026 at approximately 5:00 a.m. Resident 1 also stated he told the SSD that he felt depressed about what happened to him on 3/28/2026.During a review of facility's policy and procedure (P&P) titled, Resident-to-Resident Altercation, revised 12/1016, the P&P indicated All altercations including resident-to-resident abuse will be investigated and reported to the nursing supervisor, Director of Nursing, and to the Administrator. The P&P indicated the staff will separate the residents, will implement measures to calm the situation, and identify what might led to the aggressive conduct on the part of one or more individuals.During a review of facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, revised 4/2021, the P&P indicated allegations of abuse, neglect, exploitation, misappropriation of resident property is suspected should be reported immediately to the administrator and to other officials according to state law. The P&P indicated immediately is defined as within two hours of an allegation involving abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of verbal abuse in a timely manner for one of two sampled residents (Resident 1). The facility failed to:1. Report allegation of verbal abuse in a timely manner. Resident 1 reported the verbal abuse to Certified Nursing Assistant (CNA) 1 on 3/28/2026 at 5:00 a.m. CNA 1 reported it to Licensed Vocational Nurse (LVN)1 on 3/28/2026 at around 5:30 a.m. LVN 1 then reported the the allegation to Registered Nurse Supervisor (RNS)1 on 3/28/2026 at 7:15 a.m. SOC 341 (Report of Suspected Dependent Adult -Elder Abuse-California form used by mandatory reporters to officially report suspected abuse, neglect, or financial exploitation of elders 65 years and above) indicated it was faxed on 3/28/2026 at 2:20 p.m.to California Department of Public Health (CDPH).2.Follow the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, which indicated allegations of abuse should be reported immediately (immediately is defined as within two hours of an allegation involving abuse per P&P).These failures had the potential to delay the State agency's investigation and placed Resident 1 at risk for further occurrences of abuse.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or reduced control on one side of the body) following cerebral infarction (stroke-blood flow to a part of the brain is interrupted by a blockage or burst vessel) and major depressive disorder (mental health condition characterized by persistent feeling of sadness).During a review of Resident 1's History and Physical (H&P) dated 10/16/2025, 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 1/16/2026, the MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues) with eating, and substantial / maximal assistance (helper does more than half the effort) with transferring to and from a bed to chair or wheelchair. The MDS indicated Resident 1 had the ability to understand others and express his ideas and wants.During a review of Resident 1's Progress Notes dated 3/28/2026 timed at 5:21 a.m., the Progress Notes indicated Resident 1 stated Resident 2 was antagonizing him and was calling him names like, Faggot, and Cry Baby. The Progress Notes indicated the author of the Progress Notes was LVN 1.During the review of Resident 1's Progress Notes dated 3/28/2027 at 7:27 a.m., the Progress Notes indicated LVN 1 reported to Registered Nurse Supervisor (RNS) 1 that Resident 1 and Resident 2 should have a room change due to alleged nameˆcalling directed at Resident 1. The notes also indicated RNS 1 will speak with both Resident 1 and Resident 2.During a review of Resident 1's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember] behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 3/28/2026 timed at 10:09 a.m., the COC indicated around 9:30 a.m. to 10:00 a.m. RNS 1 interviewed Resident 1 and Resident 2. The COC indicated Resident 2 allegedly threatened Resident 1 by saying, I will kill you. The COC indicated the Administrator, Director of Nursing, physician and family were notified.During a review of Resident 1's Care Plan titled, Resident 1 reports anger, irritation, or dislike towards Resident 2's yelling, insults, name calling and verbal threats, initiated on 3/30/2026. The Care Plan interventions included maintaining a safe environment for all patients and separating patient.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), diabetes mellitus, pleural effusion(abnormal buildup of excess fluid between the thin membranes lining the lungs and the chest cavity), and dependence on renal (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis(patient must use a machine or a specialized treatment to filter their blood regularly because their kidneys stopped working well).During a review of Resident 2's H&P dated 3/26/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had the ability to express ideas and wants and understand others. The MDS indicated Resident 2 required supervision with eating and substantial /maximal assistance with transferring to and from the bed to chair or wheelchair.During a review of Resident 2's COC dated 3/28/2026 and timed at 10:20 a.m., the COC indicated around 9:30 a.m. to 10:00 a.m. Resident 1 stated Resident 2 was allegedly threatening him by saying, I will kill you. The COC indicated Resident 2 stated he did not say anything and Resident 1 started to scream. The COC indicated Resident 2 told Resident 1 to be quiet in a language other than English.During a review of Resident 2's Care Plan titled, The Resident has the potential to be verbally aggressive, alleged threatening words, I will kill you, to Resident 1 initiated 3/28/2026, the Care Plan indicated to intervene before agitation escalates by guiding away from sources of distress.During a review of Resident 2's Progress Notes dated 3/29/2026 at 12:52 p.m., the Progress Notes indicated Resident 2 left the facility against medical advice (AMA-patient leaving a facility before the physician recommends discharge).During an interview on 4/1/2026 at 10:54 a.m., CNA 2 stated that he learned about the incident between Resident 1 and Resident 2 at 7:15 a.m. on 3/28/2026, when LVN 1 informed him that the two residents had been fighting. CNA 2 stated staff must report any allegation of abuse immediately and that he would report such allegations to his charge nurse. CNA 2 stated everyone in the facility is a mandated reporter of abuse and that the interaction between Resident 1 and Resident 2 constituted verbal abuse.During a telephone interview on 4/1/2026 at 11:07 a.m., with LVN 1, LVN 1 stated Resident 1 and Resident 2 were arguing during her shift on 3/28/2026 at around 6:00 a.m. LVN 1 stated CNA 1 informed her during the 5:30 a.m. medication pass that Resident 1 and Resident 2 were arguing. LVN 1 stated she went to speak with both residents and learned from Resident 1 that Resident 2 had been calling him names (faggot and cry baby). LVN 1 stated she informed RNS 1, who arrived around 7:15 a.m. on 3/28/2026, to request a room change for both residents because they were arguing. LVN 1 stated she did not separate the residents immediately because she believed only the Social Service Director (SSD) or RNS 1 could authorize room changes. LVN 1 stated staff should report allegations of abuse to the abuse coordinator or the Director of Nursing (DON) immediately and separate the residents.During a telephone interview on 4/1/2026 at 11:48 a.m., with CNA 1, CNA 1 stated he answered Resident 1's call light on 3/28/2026 at around 4:30 a.m. CNA 1 stated Resident 1 complained that Resident 2 was cursing at him and speaking to him rudely. CNA 1 stated he reported the incident to LVN 1 around 5:00 a.m. on 3/28/2026. CNA 1 stated any allegations of abuse should be reported immediately to avoid further occurrence of abuse. CNA 1 stated staff should separate residents involved in an altercation immediately for their safety. CNA 1 stated Resident 1 and Resident 2 were not separated immediately. CNA 1 stated the incident involved verbal abuse between the two residents. CNA 1 stated if residents were not separated immediately after an alleged residentˆtoˆresident altercation, they may be at risk of injury or further abuse.During a concurrent observation and interview on 4/1/2026 at 12:15 p.m. in Resident 1's room, Resident 1 sat on his bed. Resident 1 stated he never engaged in conversation with Resident 2. Resident 1 stated Resident 2 called him chicken, chavala (a Spanish word for woman), not a man, and screamed at him. He stated Resident 2 told him he would go to his bed and kick his behind when he was alone in the room. Resident 1 stated he could no longer ignore the behavior and reported it to CNA 1 early in the morning on 3/28/2026 at approximately 5:00 a.m. Resident 1 also stated he told the SSD that he felt depressed about the incident on 3/28/2026 and about having to move rooms when it was not his fault.During interviews on 4/1/2026 at 9:00 a.m. and again at 2:29 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the alleged resident altercation occurred during the 11:00 p.m. to 7:00 a.m. shift on 3/27/2026. RNS 1 stated that around 7:15 a.m. to 7:30 a.m. on 3/28/2026, LVN 1 informed her Resident 1 and Resident 2 were having misunderstandings and that one of them should (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive a room change. RNS 1 stated she did not report the incident immediately because she believed it was a misunderstanding rather than abuse. She stated she did not talk to both residents right away for the same reason. RNS 1 stated at 8:00 a.m. on 3/28/2026, Resident 2 was asleep, and she chose not to interview Resident 1 because she was concerned Resident 2 might wake up and become aggressive. RNS 1 stated Resident 2 had a strong personality, spoke loudly, could become rude, and was not sociable. RNS 1 stated she was aware the alleged abuse occurred at 5:30 a.m. on 3/28/2026. RNS 1 also stated that staff should report allegations of abuse immediately so the facility can investigate promptly, and Resident 1 and Resident 2 should have been separated immediately. She stated failing to separate the residents could escalate the situation and lead to injury. RNS 1 stated that not reporting an allegation of abuse immediately could place Resident 1 in danger and at risk of emotional distress.During a review of facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, revised 4/2021, the P&P indicated allegations of abuse, neglect, exploitation, misappropriation of resident property is suspected should be reported immediately to the administrator and to other officials according to state law. The P&P indicated immediately is defined as within two hours of an allegation involving abuse.Cross Reference F600.