STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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 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** 49131 Based on interview and record review, the facility failed to implement the abuse prevention program policy and procedure by not reporting an allegation of abuse for one of four sampled residents (Resident 1) to the California Department of Public Health ([CDPH]- state agency), after Family Member (FM) 1 stated Certified Nurse Assistant (CNA) 1 raised her arm to hit Resident 1. This deficient practice had the potential for under-reporting abuse incidents, delay in investigation of an abuse allegation, and placed Resident 1 and other residents at risk for further 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 hemiplegia (paralysis on one side of the body), and hemiparesis (weakness or inability to move one side of the body) following intracranial hemorrhage (brain bleed), and syncope (fainting or passing out). During a review of Resident 1 ' s Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 6/21/2024, indicated Resident 1 was cognitively intact (ability to reason, understand, remember, judge, and learn). During a review of Resident 1 ' s Situation, Background, Assessment, and Recommendation form ([SBAR]- a communication tool used by licensed staff after a resident has a change in condition), dated 8/17/24 at 12:02 AM, signed by Licensed Vocational Nurse (LVN) 2, the SBAR indicated FM 1 spoke with LVN 2 and told LVN 2 that CNA 1 raised their hand in a motion like they were going to hit Resident 1 but stopped before actually doing so. During a phone interview on 8/28/24 at 10:30 AM with LVN 2, LVN 2 stated she spoke with FM 1 and was informed that CNA 1 made a motion like CNA 1 was going to hit Resident 1. LVN 2 stated she reported the incident to Registered Nurse (RN) 2. LVN 2 stated CNA 1 provided a written statement regarding the events that night and LVN 2 stated RN 2 sent CNA 1 home for the rest of the shift. LVN 2 stated because there was no actual physical contact they did not need to complete and fax the Report of Suspected Dependent Adult/Elder Abuse (SOC 341) to notify the state agency. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 11:33 AM with the Administrator (ADM), the ADM stated all allegations of abuse must be reported to the state agency. The ADM stated all staff are trained to report any allegations of abuse to the appropriate agencies and the staff did not report the abuse allegation on the evening of 8/17/2024. During a review of the policy and procedure, Abuse Prevention and Prohibition Program, dated 8/1/2023, indicated the facility will report allegations of abuse immediately but no later than 2 hours after forming the suspicion of abuse.