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	07/03/2025

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 0600 Level of Harm - 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. (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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm), for one of two sampled residents (Resident 3) when Resident 4 physically attacked Resident 3.This deficient practice resulted in Resident 3 sustaining welts (raised, red, or skin-colored bumps that appear on the skin) to his left arm, after Resident 4 hit him with a clothes hanger.Findings: During a review of Resident 3's admission Record (face sheet), the face sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of worry or fear, often about potential future problems), and dementia (a progressive state of decline in mental abilities) with other behavioral disturbance. During a review of Resident 3's Care Plan titled, the resident has been physically aggressive by throwing his food tray at nursing staff, dated 3/19/2024 indicated interventions including anticipate resident's needs, monitor/document observed behavior and attempted interventions in behavior log. The interventions also indicated that when the residents become agitated, staff will intervene before agitation escalates. During a review of Resident 3's History and Physical (H&P) dated 5/23/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make medical decisions. During a review of Resident 3's Minimum Data Set (MDS - a comprehensive quarterly resident assessment) dated 6/4/2025, the MDS indicated Resident 3 had the ability to make self-understood and the ability to understand others. During a review of Resident 3's Change of Condition Evaluation (COC) dated 6/25/2025, the COC indicated Resident 3 exhibited behavioral changes when he pulled on another resident's call light, curtain, and yanked his bed. The COC indicated Resident 3 had a left arm open scratch, with a sad and frightened facial expression. The COC indicated Resident 3 showed facial grimacing when his left arm was touched during assessment. During a review of Resident 3's Skin Check (an assessment of the residents' skin), dated 6/25/2025, the skin check indicated Resident 3 had three welts measuring 8.0 cm, and 0.4 cm (centimeter-a unit of measurement), in length on the left outer forearm after Resident 3 was hit with a hanger by Resident 4. The assessment indicated one of the welts included a scratch. During a review of Resident 3's Order Summary Report dated 6/25/2025, the order summary report indicated cleanse the left arm open scratch and apply Bacitracin ointment (a topical antibiotic used to prevent and treat minor skin infections from cuts, scrapes, and burns) for 14 days, one time a day until finished. During a review of Resident 4's admission Record, the admission record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyarthritis (swelling or tenderness in five or more joints causing pain or stiffness that gets worse with age), cardiomegaly (an enlarged heart), left leg above knee amputation (surgical removal of the leg when it is severely damaged). During a review of Resident 4's H&P dated 10/28/2024, the H&P indicated Resident 4 had the capacity to understand and make medical decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had the ability to make self-understood and the ability to understand others. During a review of Resident 4's Change of Condition Evaluation (COC) dated 6/25/2025, the COC indicated Resident 4 alleged hitting another resident (Resident 3) with a hanger. The COC indicated staff will monitor Resident 4 for 72 hours. During a concurrent observation and interview on 6/27/2025 at 4:08 pm in Resident 3's room, Resident 3 was observed lying in bed with a small, dry, scab (a crusty protective covering) on the left arm. Resident 3 stated he was lying in his bed a few days ago, when Resident 4 hit him with a hanger. Resident 3 stated Resident 4 accused him of throwing dirty towels under his bed. Resident 3 stated he sustained a bruise and had pain in his left arm after Resident 4 hit him with a hanger. Resident 3 stated it made him feel scared and afraid. During an interview on 6/27/2025 at 4:23 pm in Resident 4's room, Resident 4 stated a few days ago, he hit Resident 3 because Resident 3 was pulling and pushing his (Resident 4's) bed, pulling on the privacy curtains, and call light. Resident 4 stated Resident 3 had done this several times before and had thrown dirty towels under his bed, but he did not report it to staff. During an interview on 7/2/2025 at 1:40 pm, with LVN (Licensed Vocational Nurse) 1, the LVN stated no resident should be abused. During a review of the facility's Policy & Procedure (P&P) titled, Abuse Prevention and Prohibition Program revised 8/1/2023, indicated Each resident has the right to be free from abuse, neglect, or misappropriation of resident property. The P&P indicated welts and bruises are signs and symptoms of physical abuse. The P&P indicated The Administrator is the Abuse

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the licensed nursing staff failed to develop a baseline care plan addressing identified mood/behavior concerns for one of five sampled residents (Resident 2).This deficient practice had the potential for delayed provision of necessary care and services.Findings:During a review of Resident 1's admission Record (face sheet), the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety (a feeling of worry or fear, often about potential future problems), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and depression (a mood disorder characterized by persistent feelings of sadness, loss of interest in activities, and a range of other symptoms that can significantly impair daily functioning.)During a review of Resident 1's History and Physical (H&P) dated 4/1/2025, the H&P indicated Resident 1 did not have capacity to understand and make medical decisions.During a review of Resident 1's Minimum Data Set (MDS - a comprehensive quarterly resident assessment) dated 4/19/2025, the MDS indicated Resident 1 was dependent on a helper to do all of the effort for eating, bathing, and dressing upper and lower body. During a review of Resident 1's Behavior Care Plan dated 4/21/2025, Resident 1 had a behavior problem of taking clothes off and playing with his penis out in the open. The care plan indicated interventions to administer medications as ordered, anticipate the resident's needs, discuss the resident's behavior, intervene as necessary to protect the rights and safety of others, and minimize the potential of Resident 1 exposing himself by offering tasks which divert attention such as inviting/escorting to activities.During a review of Resident 2's admission Record, the admission record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified mood (affective) disorder (a group of mental illnesses characterized by significant disturbances in a person's emotional state [mood]), anxiety, and difficulty walking.During a review of Resident 2's Minimum Data Set (MDS - a comprehensive quarterly resident assessment) dated 4/30/2025, the MDS indicated Resident 2 was independent (completes the activity by themselves with no assistance from a helper) with personal hygiene.During a review of Resident 2's H&P dated 6/20/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Medication Administration Record (MAR) dated 6/1/2025 - 6/30/2025, the MAR indicated an order to monitor Resident 2 for episodes of verbal aggressiveness towards staff every shift. The MAR indicated Resident 2 had 24 episodes of verbal aggression between 6/5/2025 and 6/12/2025.During an observation and interview on 6/27/2025 at 3:35 pm Resident 1 was observed lying in bed, uncovered, wearing a hospital gown and adult diaper, knees bent, moving his legs up and down. Resident 1 stated Resident 2 poured water on him because he was acting up. I was laying in my bed. I do not remember what I did, but I know I was acting up. Resident 1 stated he felt cold because the water had ice in it.During an observation and interview on 6/27/2025 at 3:47 pm with Resident 2, Resident 2 was observed lying in bed wearing a hospital gown, emptying a colostomy (a surgical procedure that brings one of the large intestine out through the abdominal wall to allow waste to leave the body.) Resident 2 tossed the bag of waste on the floor. Resident 2 stated Resident 1 kept taking his clothes off and playing with himself. Every time you come in the room, he is naked. All you see is nuts and dick. My daughter came in and saw him like that, so I threw water on him. I got tired of that shit. He had to go.During an interview on 7/2/2025 at 8:44 am, with RN 1, RN 1 stated Resident 1's care plan interventions are not working. We talk to him, and he does not listen. There should be more specific interventions, but I do not know what else we can do. RN 1 stated Resident 2 should have a care plan for his behavioral diagnoses with interventions when he has aggressive behavior. RN 1 stated any licensed nurse could implement care plans. During a concurrent interview and record review on 7/2/2025 at 4:01 pm with the Director of Nursing (DON), Resident 2's care plan was reviewed. The DON stated there were no care plans for his behavior diagnoses of mood disorder and anxiety. The DON stated Resident 2 should have care plans to list interventions needed for his behavior to protect staff and other residents.During an interview on 7/3/2025 at 3:27 pm with the Administrator (ADM), the ADM stated It was Resident 1's right to pleasure himself. We try to give Resident 1 privacy but Resident 2 does not like the privacy curtain closed.A review of the facility's Policy and Procedures (P&P) titled Care Planning revised 10/22/2024, the P&P indicated The Comprehensive Care Plan must be implemented within seven days after completion of the Comprehensive admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment. The P&P also indicated A

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 received staff training after a resident (Resident 5) accused CNA 1 of abuse during personal hygiene care.This deficient practice had the potential for CNA 1 to cause harm to residents if not properly trained regarding abuse. Findings:During a review of Resident 5's admission Record (face sheet), the admission record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including muscle weakness, schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of worry or fear, often about potential future problems), dementia (a progressive state of decline in mental abilities) with psychotic disturbance (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality.) During a review of Resident 5's History and Physical (H&P), dated 3/11/2025, the H&P indicated Resident 5 had the capacity to understand and make medical decisions. During a review of Resident 5's Verbally Aggressive Care Plan dated 3/11/2025, the care plan indicated Resident 5 had the potential to be verbally aggressive toward staff, related to anxiety disorder. A review of Resident 5's Refusing Care Care plan dated 3/11/2025, the care plan indicated Resident 5 had episodes of refusing care, refusing to take meds at times, refusal to be repositioned and refusing care as ordered.During a review of Resident 5's Minimum Data Set (MDS, a comprehensive quarterly resident assessment) dated 4/26/2025, the MDS indicated Resident 5 had the ability to make self understood and the ability to understand others. The MDS indicated Resident 5 was dependent (helper does all of the effort) for toileting hygiene and lower body dressing.During a concurrent observation and interview on 6/27/2025 at 3:51 pm in the activities room with resident 5, Resident 5 was sitting in a wheelchair watching television. When asked about the allegation he made regarding CNA 1 grabbing his arm during care, Resident 5 stated he told CNA 1 to leave him alone and go get someone else to clean him then CNA 1 grabbed his arm. Resident 5 did not remember which arm was grabbed. Observation of both arms showed skin was intact without bruising or swelling. Resident 5 denied pain in both arms.During a concurrent record review and interview on 7/2/2025 at 10:55 am with the Director of Staff Development (DSD), Certified Nursing Assistant (CNA) 1's most recent abuse training titled Abuse (Reporting abuse, Mandated Reporter) dated 8/24/2024, was reviewed. The DSD stated CNA 1 was suspended 6/18/2025 pending investigation of Resident 5's allegation of abuse. The DSD stated that when CNA 1 returned to work 6/23/2025, CNA 1 should have received staff training regarding abuse. The DSD stated staff training is important to remind staff what abuse is and how to prevent it. The DSD stated Staff need to know how to prevent abuse, what protocols to follow if abuse happens including reporting abuse. The DSD stated scheduling CNA 1 for training was difficult due to her schedule on night shift (11:00 pm - 7:00 am).During an interview on 7/2/2025 at 2:30 pm with CNA 1, CNA 1 stated she was providing hygiene care to Resident 5 Resident 5 demanded CNA 1 get his pants immediately and yelled I do not want you to be my nurse, leave me alone! CNA 1 stated Resident 5 then cursed at her and she left the room. CNA 1 stated she did not report the incident to a supervisor because this behavior happens often. CNA 1 stated she had not received abuse training since the incident.During a concurrent record review and interview on 7/2/2025 at 4:06 pm with the Director of Nursing (DON), Resident 5's Refusing Care - Care Plan dated 3/11/2025 was reviewed. The care plan indicated Resident 5 had episodes of refusing care, refusing to take meds at times, refusal to be repositioned, and refusing care as offered. The care plan indicated a goal that Resident 5 would have no complications related to refusing medications/care and will have fewer episodes through the review date. The care plan interventions included: Implement behavior management techniques such as reality orientation, explaining care/procedures before carrying out, provide reality orientation during care, provide resident with adequate time to express needs or concerns, notify MD if any recurrence of behavior problem noted, administer medications as ordered. The DON stated, The care plan should include interventions specific to the resident having the right to refuse care and if the resident says stop, you should stop. The DON stated, The CNA's want to make sure the residents are clean before they finish their shift. The DON also stated, CNA 1 should have immediately been retrained regarding abuse upon returning from suspension. The DON stated it is important to retrain staff regarding policies and procedures periodically and after incidents with residents.A review of the facility Policy and Procedure (P&P), titled, Staff Development Program dated 10/24/2022, the P&P indicated the primary objective of the staff development program was to ensure that staff had the knowledge, skills, and critical thinking necessary to provide