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	03/05/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure Resident 1 was free from physical abuse when Resident 2 punched Resident 1 in the face.As a result, Resident 1 sustained nasal fractures (broken bones), a nosebleed and bump on the forehead which required a transfer to the general acute care hospital (GACH) for evaluation and treatment.Findings: a. During a review of Resident 1's face sheet (admission record), the face sheet 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), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and major depressive disorder (a mental health condition characterized by persistent and intense feeling of sadness or loss of interest that interferes with daily functioning). During a review of Resident 1's history and physical (H& P), dated 2/3/2026, the H&P indicated Resident 1 had the capacity to make all decisions. During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool), dated 2/24/2026, the MDS indicated Resident 1's cognition (ability to think) was intact. The MDS indicated Resident 1 was dependent upon staff for activities of daily living including dressing, bathing and personal hygiene. Resident 1 was dependent upon a wheelchair for mobility. Resident 1 was 66 inches tall and weighed 300 pounds. Resident 1 required a mechanical lift and the assistance of 2 staff to transfer from the wheelchair. During a review of Resident 1's Change of Condition Evaluation (COC) dated 3/4/2026, the COC indicated Resident 1 was in an altercation with Resident 2 on the smoking resulting in Resident 1 being hit in the face. Resident 1's nose was bleeding and a raised area was noted on the forehead. During a review of Resident 1's plan of care (POC), dated 3/4/26, the POC indicated Resident 1 sustained a nasal fracture and was at risk for further nose bleeds, impaired respiratory exchange, nasal facial pain, edema, bruising and psychosocial issues. During a review of Resident 1's Transfer form, dated 3/4/2026, the transfer form indicated Resident 1 was transferred to the acute care hospital on 3/4/2026 at 6:15 p.m., due to a forehead bump and nosebleed after being punched in the head by Resident 2. During an interview on 3/5/2026 at 1:00 p.m., Resident 1 stated he threw coffee on him (Resident 2) because Resident 2 cussed at him and called him fat. During a review of Resident's 1's GACH emergency department (ED) note, dated 3/4/26, the note indicated Resident 1 had an altercation with another resident in which he was punched in the face. The note indicated Resident 1 was punched and had a nosebleed, hematoma in the middle of his forehead and complained of pain, headaches and dizziness. The notes indicated Resident 1 had a computed tomography (CT scan, a non-invasive imaging procedure to create detailed images of the body) of the facial bone, which revealed the resident had an undetermined nasal bone fracture and a left side orbital (eye) wall medial fracture. b. During a review of Resident 2's face sheet, the face sheet indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included cerebral ischemia (lack of blood flow to the brain causing brain cells to die) and alcohol dependance (excessive alcohol consumption). During a review of Resident 2's MDS dated [DATE] the MDS indicated Resident 2's cognition was intact. Resident 2 was independent with activities of daily living (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	including eating, upper body dressing and personal hygiene. Resident 2 required partial assistance from staff (staff does less than half the effort) with showering, Resident 2 required supervision (verbal cues only from staff with putting on footwear, lower body dressing and toileting hygiene. Resident 2 was able to walk independently but used a wheelchair for mobility. Resident 2 was 65 inches tall and weighed 142 pounds. During a review of Resident 2's H&P, dated 6/20/2025, the H&P indicated Resident 2 had capacity to understand and make all decisions. During a review of Resident 2's change of condition (COC) form, dated 3/4/2026, the COC indicated Resident 2 and Resident 1 were involved in a verbal and physical altercation resulting in Resident 1 throwing coffee on Resident 2's face. Resident 2 then stood from his wheelchair and hit Resident 1 in the face. During an interview on 3/5/2026 at 1:15 p.m., Resident 2 stated he hit Resident 1 in the nose because Resident 1 threw coffee in his face. Resident 1 was blocking the door with his wheelchair, and Resident 2 could not get out. Later, Resident 2 went out to the patio and Resident 1 said if Resident 2 called him names and cussed at him again, he will throw his coffee at Resident 2. Resident 2 stood up from his wheelchair and told Resident 1 to try it. Resident 1 threw his coffee on Resident 2's face, and Resident 2 hit Resident 1 in his face. During interview on 3/5/2026 at 2:15 p.m., with the Director of Nurses (DON), the DON stated she just received notification from the GACH that Resident 1 had a nasal fracture. When asked if a copy of the x-ray report was available the DON stated they did not have a hard copy of the report yet. During a review of the facility's policy and procedure (P&P) dated 8/1/2023 titled, Abuse Prevention and Prohibition Program indicated each resident had the right to be free from abuse, neglect, and mistreatment. Staff must not permit anyone to engage in verbal, mental, or physical abuse.