STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA 1) did not continue to have access to one of two sampled residents (Resident 1) after an allegation of physical abuse. This deficient practice resulted in CNA 1 still being assigned to the care of Resident 1 ' s roommates after Resident 1 ' s allegation of abuse. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included low back pain, muscle weakness (when muscles did not have the strength they normally do), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 1 ' s cognition (process of thinking) was intact. The MDS indicated Resident 1 required supervision with eating; partial assistance (helper did less than half the effort) with oral hygiene and showering/bathing; substantial assistance (helper did more than half the effort) with personal hygiene and getting in-and-out of bed/ chair; and was dependent (helper did all the effort) with toileting hygiene. The MDS indicated Resident 1 used a walker and wheelchair for mobility. During a review of Resident 1 ' s History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 1 was alert and oriented to person, place, and time. During a review of Resident 1 ' s Social Service Progress Notes, dated 3/17/2025 at 5:50 p.m., the notes indicated Resident 1 informed Social Service Designee (SSD) 1 that on the night of 3/15/2025, CNA 1 hit her (Resident 1) on the back near the right shoulder followed by pressing on Resident 1 ' s back while in bed. The notes indicated Resident 1 stated she yelled for help when CNA 1 ran out of the room and closed the door behind her. The notes indicated Resident 1 reported the incident to her nurse (unidentified). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/2025 at 9:59 a.m. with Resident 1, Resident 1 stated on 3/15/2025 during the night, CNA 1 shoved her into the bed during a transfer from the wheelchair to the bed. Resident 1 stated CNA 1 pushed her and she hit her head on the side rail. Resident 1 stated CNA 1 grabbed her by the back of the legs, pushed her, and hit her on the right upper back during repositioning. Resident 1 stated while repositioning to the left side, CNA 1 squeezed her on the back. Resident 1 stated she told CNA 1 not to hit her. Resident 1 stated CNA 1 told her to be quiet and to not scream. Resident 1 stated on 3/15/2025 she told LVN 1 that CNA 1 hit her. During a telephone interview on 4/1/2025 at 12:20 p.m. with CNA 1, CNA 1 stated on 3/15/2025, as she was assisting Resident 1 with repositioning and adjusting the resident in bed Resident 1 screamed. CNA 1 stated she stepped out of the room and asked Licensed Vocational Nurse (LVN) 1 for assistance. CNA 1 stated LVN 1 told her not to go to Resident 1 anymore because Resident 1 stated CNA 1 was hitting her (Resident 1). CNA 1 stated LVN 1 told her that she had to continue providing care to Resident 1 ' s roommates (Resident 3 and Resident 4). CNA 1 stated she worked the rest of the shift on 3/15/2025. During a telephone interview on 4/1/2025 at 1:14 p.m. with Resident 1 ' s responsible party (RP 1), RP 1 stated on 3/16/2025, during her visit with Resident 1 in the facility, Resident 1 was crying. RP 1 stated Resident 1 stated that CNA 1 hit her on the back with CNA 1 ' s fist. RP 1 stated Resident 1 stated she was scared, felt lots of fear, and could not sleep because of what happened on 3/15/2025. During an interview on 4/2/2025 at 7:41 a.m. with LVN 1, LVN 1 stated on 3/15/2025, CNA 1 informed her that Resident 1 would like to speak with her. LVN 1 stated Resident 1 did not share anything with her during care. LVN 1 stated she did not ask Resident 1 what happened with CNA 1 because it was Resident 1 ' s baseline behavior (referred to a resident's typical or usual way of acting and reacting in a specific situation, serving as a reference point) to have preferred CNAs. LVN 1 stated she informed CNA 1 that she would reassign Resident 1 to another nurse because of Resident 1 ' s preferences. LVN 1 stated if she did not know Resident 1 ' s baseline behavior, she would have asked Resident 1 why she wanted another CNA and what the problem was. LVN 1 stated the negative outcome of not investigating the abuse allegation was a delayed investigation. LVN 1 stated something might have happened which was also a safety concern. LVN 1 stated it put other residents at risk when CNA 1 was still working on the floor on 3/15/2025. During a review of the facility ' s P&P titled Abuse Investigations, dated 10/30/2019, the P&P indicated, All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The P&P indicated The Director of Nursing or designee, will start an immediate investigation of the alleged incident. The P&P indicated, Employees who have been accused of resident abuse will be immediately reassigned or suspended from duty until the Administrator has reviewed the results of the investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview, and record review, the facility failed to document records completely for one of two sampled residents (Resident 1) when: 1. Resident 1 had concerns with Certified Nurse Assistant (CNA) 1 during care on 3/15/2025. 2. The facility failed to document a change of condition when Resident 1 had an allegation of abuse on 3/17/2025. These deficient practices had the potential to result in a lack of or a delay in communication between the staff and could interrupt provision of care/intervention to Resident 1. Findings: 1.During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included low back pain, muscle weakness (when muscles did not have the strength they normally do), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 1 ' s cognition (process of thinking) was intact. The MDS indicated Resident 1 required supervision with eating; partial assistance (helper did less than half the effort) with oral hygiene and showering/bathing self; substantial assistance (helper did more than half the effort) with personal hygiene and getting in-and-out of bed/ chair; and was dependent (helper did all the effort) with toileting hygiene. The MDS indicated Resident 1 had impairments on extremities and used walker and wheelchair for mobility devices. During a review of Resident 1 ' s History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 1 was alert and oriented to person, place, and time. During a review of Resident 1 ' s Social Service Progress Notes, dated 3/17/2025 at 5:50 p.m., the notes indicated Resident 1 informed Social Service Designee (SSD) 1 on 3/15/2025 on the night shift, CNA 1 hit her (Resident 1) on the back near the right shoulder followed by pressing on Resident 1 ' s back while in bed. The notes indicated Resident 1 stated she yelled for help when CNA 1 ran out and closed the door behind her. The notes indicated Resident 1 reported the incident to her nurse (unidentified). During an interview on 4/1/2025 at 9:59 a.m. with Resident 1, Resident 1 stated on 3/15/2025 night, she told Licensed Vocational Nurse (LVN) 1 that CNA 1 hit her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/2/2025 at 10:36 a.m. with the Director of Nursing (DON), Resident 1 ' s Nursing Progress Notes, dated 3/2025, was reviewed. The DON stated there was no documentation regarding Resident 1 ' s concerns of not liking CNA 1 on 3/15/2025. The DON stated any concerns brought up by the residents, should be in a grievance, so facility would know how to educate staff and the area to focus to improve. The DON stated the goal was to keep residents safe. The DON stated LVN 1 should have documented on the Progress Notes when made aware of Resident 1 ' s concerns of not liking CNA 1, and implemented interventions. The DON stated staff need to document so others would know what happened and continue to care for residents. The DON stated LVN 1 documented on the 24-hour communication that Resident 1 requested not to have CNA 1 as the assigned nurse. The DON stated LVN 1 did not document on Resident 1 ' s Progress Note because it was Resident 1 ' s baseline behavior (referred to a resident's typical or usual way of acting and reacting in a specific situation, serving as a reference point) of picking a preferred CNA. The DON stated it was not considered a concern and was just Resident 1 ' s behavior. During a review of the facility ' s policy and procedure (P&P) titled Grievance, dated 1/2024, the P&P indicated Any complaint or grievance, either submitted verbally or in writing, shall be recorded and submitted promptly to facility Administrator or designee. 2. During a review of Resident 1 ' s Change of Condition (COC) Assessment, dated 3/17/2025, the COC Assessment indicated Resident 1 stated on 3/15/2025 at night, CNA 1 shook both her (Resident 1) shoulders and hit her back with a fist during care. During a concurrent interview and record review on 4/2/2025 at 10:36 a.m. with the DON, Resident 1 ' s Nursing Progress Notes, dated 3/2025, was reviewed. The DON stated there was no documentation regarding Resident 1 ' s COC on 3/18/2025, 7 a.m. to 3 p.m. (morning) shift. The DON stated the nurses were required to document per shift and as needed on the nurse progress notes when there was a COC. The DON stated the purpose of documenting was for resident ' s safety. The DON stated if there were any changes of condition, staff could intervene as needed. The DON stated it was the standard of practice to follow protocol to document every shift. During a concurrent interview and record review on 4/2/2025 at 10:36 a.m. with the DON, the facility ' s P&P titled Condition Change of Resident, dated 12/2018, was reviewed. The P&P indicated, Document per facility policy. The DON stated facility did not have a policy specify to document on COC every shift, but it was a good standard of practice for nurse to monitor and document accordingly. During a concurrent interview and record review on 4/2/2025 at 10:36 a.m. with the DON, the Job Description for LVN, undated, was reviewed. The Job Description indicated the duties and responsibilities of LVN was to assure that documentation is complete in the resident's medical record, and record and monitor all progress of residents. The DON stated Progress Notes were part of the medical record, and it was not complete when there was no documentation.