STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555368	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Century Villa, Inc	301 Centinela Ave Inglewood, CA 90302

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents right to be free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1), who was physically attacked by Resident 2, who had a known history of agitation and aggressive behaviors toward others. The facility failed to:1. Implement its policy and procedure (P&P) titled, Abuse, Neglect and Exploitation which indicated each resident had the right to be free from abuse and neglect.2. Implement its P&P titled Behavior Management Plan, which indicated, residents with behavioral concerns will have a behavioral management plan to ensure they received appropriate services and interventions to meet their needs. These deficient practices resulted in Resident 2 punching Resident 1 on the right side of the face causing Resident 1 to sustain a hematoma (broken blood vessels) on the head and left ear bleeding, that required hospitalization in a general acute care hospital (GACH), where he was diagnosed with a right frontal (to the front and adjacent to the forehead) scalp (the skin covering the head) hematoma. Resident 1 underwent a repair of a one-centimeter ([cm] - unit of measurement) laceration (skin cut) to the left ear that required sutures (a basic wound closure technique where individual stitches are placed and tied separately along the length of the wound). Resident 1 was still admitted to the GACH as of 8/20/2025.Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and major depressive disorder ([MDD] - a mood disorder that cause a persistent feeling of sadness and loss of interest). During a review of Resident 1's History and Physical (H&P), dated 4/22/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 6/26/2025, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 sometimes had the ability to make self-understood and understand others. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) from staff with activities of daily living (ADL's - routine tasks/activities) such as oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's Change in Condition Evaluation ([COC] - a communication tool used to communicate a resident's change of condition), dated 7/28/2025, the COC indicated Resident 1 was found on the floor with Resident 2 on top of him. The COC indicated Resident 1 stated Resident 2 hit him and pushed him to the floor. The COC indicated Resident 1 was bleeding from the left ear and had a hematoma on the right side of his face. The COC indicated Resident 1 was transferred to the GACH for evaluation and treatment. During a review of Resident 1's GACH Emergency Report (ER), dated 7/28/2025, the report indicated Resident 1 presented to the ER with injuries to his head, hand, neck, and a left ear laceration. The ER Report indicated Resident 1's Computed Tomography scan ([CT] process of taking pictures of body parts to diagnose and treat disease and injury) of the head indicated Resident 1 had a right frontal hematoma. The ER Report indicated Resident 1 had a 1-centimeter ([cm] - unit of measurement) laceration to his left ear that required sutures (a basic wound closure technique where individual stitches are placed and tied separately along the length of the wound). During a review of Resident 2's Face Sheet, the Face Sheet indicated, Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 2's H&P, dated 6/28/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's MDS assessment, dated 7/10/2025, the MDS indicated Resident 2's cognitive skills for daily decision making were intact. The MDS indicated Resident 2 was independent (Resident completes the activity by themself with no assistance from a helper) on ADLs such as eating, toileting hygiene, and upper body dressing. During a review of Resident 2's GACH Psychiatric Evaluation Notes prior to admission to the facility, dated 6/14/2025, the notes indicated Resident 2 was admitted to the GACH on a 5150 (an involuntary 72-hour psychiatric

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) was completed accurately for one of three sampled residents (Resident 2) by failing to:1. Ensure Resident 2's Depakote (an anticonvulsant used to treat seizure disorder and other psychiatric conditions) medication was encoded as anticonvulsant and reflected in the MDS assessment under Section N (N0415 High-Risk Drug Classes) medication. This deficient practice resulted in incorrect data transmitted to Center for Medicare and Medicaid Services (CMS) related to inappropriate MDS care screening and assessment tool practices. Findings:During a review of Resident 2's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 2's History and Physical (H&P), dated 6/28/2025, the H&P indicated, Resident 2 could make needs known but cannot make medical decisions. During a review of Resident 2's MDS assessment, dated 7/10/2025, the MDS indicated, Resident 2 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 2 was independent (Resident completes the activity by themself with no assistance from a helper) with eating, toileting hygiene, and upper body dressing. During a review of Resident 2's Order Summary Report (a document containing active orders), dated 8/6/2026, the Order Summary Report indicated, the physician placed a telephone order on 6/27/2025 for Resident 2 to start on Depakote 500 milligrams ([mg] - metric unit of measurement, used for medication dosage/and or amount) by mouth to give 1 tablet by mouth every 12 hours (9 a.m. and 9 p.m.) for bipolar disorder manifested by fluctuation in mood as evidenced by sudden angry outburst due to responding to internal stimuli for no form of provocation. During a concurrent interview and record review on 8/6/2025 at 1:21 p.m., with the Minimum Data Set Nurse (MDSN), Resident 2's MDS assessment, dated 7/10/2025, was reviewed. The MDSN stated Resident 2 was taking Depakote which is considered as anti-convulsant medication. The MDSN stated there should a check marked on MDS Section N0415 under anticonvulsant medication. The MDSN stated the MDS assessment was completed inaccurately. The MDSN stated per Resident Assessment Instrument ([RAI] - a guide that helps nursing home staff use to assess residents and develop care plans) manual coding of medications should be based on the pharmacological (relating to the use of drugs to treat a condition) classification of the medication not based on the reason it was prescribed. The MDSN stated he had not been coding Depakote medication as anticonvulsant in the past and it was not a red flagged. The MDSN stated accuracy of assessment in the MDS was important because it entails the condition and needs of the resident and for continuity of care. During a review of the facility's undated policy and procedure (P&P), titled Conducting an Accurate Resident Assessment, the P&P indicated, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas.