

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Imperial Crest Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11834 Inglewood Avenue Hawthorne, CA 90250	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH), within two hours, when one out of three residents, Resident 1, alleged a Registered Nurse (RN) hit her on the right side of the face on 3/1/2025.</p> <p>This deficient practice had the potential to place Resident 1 at risk for further abuse and resulted in a delay in investigation of alleged abuse.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included muscle weakness and anxiety disorder (mental health condition characterized by excessive, persistent, and often irrational worry, fear, and unease that can interfere with daily life).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 2/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Admission Reassessment document dated 2/19/2025, the reassessment indicated Resident 1 had a puffy face and the peri-orbital (around eyes) area.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 2/24/2025, the MDS indicated Resident could sometimes make herself understood and was understood by others. The MDS indicated Resident 1 was dependent for oral hygiene, toileting hygiene, shower/bath, dressing, putting on/taking off footwear and for personal hygiene.</p> <p>During an interview on 3/13/2025 at 12:27 p.m., with Family Member 2 (FM 2), FM 2 stated on 3/1/2025 around 2 p.m., when FM 2 visited Resident 1, RN entered the room and Resident 1 covered her face. FM 2 stated Resident 1 told FM 2 the RN hit her (Resident 1). FM2 stated the RN told her (FM 2) that Resident 1 was confused and hitting Resident 1 did not happen.</p> <p>(continued on next page)</p>

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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 3/13/2025 at 1:00 p.m., with Resident 1, Resident 1 had a puffy periorbital area of both eyes (as also indicated in the reassessment dated [DATE]), no swelling or bruising observed. Resident 1 had dark skin discoloration on the face. Resident 1 stated RN hit her on the face, pointing to her right eye and could not remember the date it happened. Resident 1 stated RN was handling her g-tube (gastrostomy tube, a tube surgically inserted through the abdomen into the stomach, used to deliver food, liquids, and medications) when RN hit her. Resident 1 stated she had a black eye. Resident 1 stated FM 2 saw her eye, but no one saw when RN hit her.</p> <p>During an interview on 3/13/2025 at 1:55 p.m., with Licensed Vocational (LVN 1), LVN 1 stated on 3/1/2025, FM2 was very hateful towards RN. LVN1 stated FM2 seemed drunk or drugged. LVN 1 stated RN remained calm when FM 2 told RN that she hit Resident 1. LVN 1 stated RN did not enter Resident 1 ' s room on the morning of 3/1/2025 because RN was doing the assignment that morning from 10:00 a.m. to 11:30 a.m. LVN 1 stated he thought RN would not report the incident because FM2 seemed intoxicated and believed it was an outburst due to her state. LVN 1 stated he went inside Resident 1 ' s room, and did not observe any signs of abuse. LVN 1 stated he did not see any bruising, swelling when he entered Resident 1 ' s room.</p> <p>During an interview on 3/13/2025 at 2:14 p.m., with RN, RN stated on 3/1/2025, Resident 1 was very agitated and confused. RN stated Resident 1 was pulling her g-tube and went to assess Resident 1 while FM 2 was visiting. RN stated she could not hear what Resident 1 was saying. RN stated FM 2 told her that Resident 1 stated RN hit Resident 1. RN stated that she told FM 2 she did not hit Resident 1. RN stated she did not report the incident to Administrator because she was going through personal issues. RN 1 stated she forgot and was shocked to be accused of hitting a resident. RN stated that according to the facility ' s policy, staff was supposed to report any suspicion or allegation of abuse. RN 1 stated she did not report the allegation within two hours so it could be investigated, because she did not know. RN stated she reported the incident the following day 3/2/2025 around 10:00 a.m. when Family Member 1 (FM 1) showed up at the facility alleging RN had hit Resident 1.</p> <p>During an interview on 3/13/2025 at 3:30 p.m. with the Administrator (ADM), the ADM stated he was informed on 3/2/2025 about the alleged abuse that happened on 3/1/2025, reason why it was only reported to the SA on 3/2/2025 around 10:30 a.m. The ADM stated the facility was supposed to report allegation of abuse to the SA within two hours, to investigate promptly and to safeguard the safety of the residents.</p> <p>During a review of the policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/2022, the P&P indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury.</p>		