STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555719	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Crest Health Care Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review the facility failed to ensure one out of three sampled residents (Resident 4) an accusation of sexual abuse was reported within two hours. This deficient practice of not reporting the accusation of sexual abuse by Resident 4 had the potential to cause psychosocial harm (factors that could harm someone ' s mental health). Findings: During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 4 diagnoses dementia (a progressive state of decline in mental abilities), depressive disorder (a mental condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that can significantly impair daily functioning), and transient cerebral ischemic attack (a lack of blood flow to the brain). During a review of Resident 4 ' s History and Physical (H&P), dated 6/4/2024, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4 ' s Minimum Data Set ([MDS]- a resident assessment tool), dated 5/9/2025 the MDS indicated Resident 4 ' s cognition (ability to learn, reason, remember, understand, and make decisions) had the ability to understand. The MDS indicated Resident 4 was dependent (helper does all of the effort. Residents do none of the effort to complete the activity) on staff for showering, toileting hygiene, and dressing. During a review of facility ' s Social Services Notes, dated 5/16/2025, the Social Services Notes indicated Centinela Hospital Social Worker called to notify that resident reported she had been sexually assaulted at the facility. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/21/25 at 1:49 p.m. with Social Service Director (SSD), Resident 4 ' s Social Services Notes were reviewed. The Social Services Notes indicated Centinela Hospital Social Worker called to notify that resident reported she had been sexually assaulted at the facility. The SSD stated the Social Worker from Centinela Hospital Social Worker had called and told her Resident 4 had stated she was sexually assaulted at the facility. The SSD stated when Resident 4 had returned on 5/20/2025 I had asked her was she sexually abused and she had said Yes,. The SSD stated accusation of sexual assault is considered abuse. The SSD stated she was a mandated reporter when there was an accusation of sexual abuse. The SSD stated she did not notify the Administrator when she had received the call from Centinela Hospital about the sexual allegation. The SSD stated that when there is an abuse allegation we are to report within two hours even if the resident is confused, start the investigation, and take care of Resident 4 as fast as possible. The SSD stated not initiating the investigation sooner could make Resident 4 feel dismissed and cause psychological harm. During an interview on 5/21/2025 at 4:00 p.m. with the Administrator (ADM), the ADM stated the staff is to report Abuse of any kind. The ADM stated the process is to report anytime the staff suspects, hears anything, and they are to report within 2 hours. The ADM stated it was important to report within 2 hours to prevent the behavior from continuing which could cause more abuse. During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 3/2023, the P&P indicated all reports of resident abuse findings of all investigations are documented and reported. The P&P indicated abuse was suspected it must be reported immediately to the administrator and to other officials. The P&P indicated immediately is defined as within two hours of an allegation involving abuse.

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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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on record review and interview, facility licensed staff failed to ensure the Medical Director (a licensed physician who oversees and manages the medical aspects of a healthcare organization or facility) was notified after licensed staff could not reach the primary physician for one out of three sampled residents (Resident 1). This deficient practice resulted in facility staff had to call 911 to transport the resident to the General Acute Care Hospital (GACH) . Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (COPD, a chronic lung disease causing difficulty in breathing), obstructive uropathy (refers to any condition where the normal flow of urine is blocked or impeded within the urinary tract), and anemia (a condition where the body doesn ' t have enough healthy red blood cells). During a review of Resident 1 ' s History and Physical (H&P), dated 4/22/2025, the H&P indicated Resident 1 did not follow commands, was non-responsive (a patient who is not reacting or responding to external stimuli, such as verbal commands, touch or pian, and non-verbal (communication that conveys messages without using spoken or written words and involves facial expression). During a review of Resident 1 ' s change of conditions (COC) interact assessment form, dated 4/26/2025, the COC indicated at 8:00 p.m. Resident 1 had no significant urine output and to transfer the resident tothe GACH. The COC indicated GACH had no available beds. The COC indicated at 10:00 p.m. the physician was made aware with no reply. The COC indicated Resident 1 blood pressure ([BP] -the force of circulating blood on the walls of the arteries) was 118/72 millimeters of mercury ([mm/hg] -a unit of pressure commonly used to measure blood pressure). During a review of Resident 1 ' s COC, dated 4/27/2025, the COC indicated Resident 1 had hematuria (the presence of blood in the urine) with reduced urine output and an order from the physician to transfer resident to the GACH. The COC indicated Resident 1 could not be transferred to GACH and 911 was called at 8:27 a. m. The COC indicated at 8:38 a.m. the physician was informed of the changes in the transfer plans but no response. The COC indicated the BP was 103/60mmhg. During a review of Resident 1 ' s Minimum Data Set (MDS] a resident assessment tool), dated 5/12/2025 the MDS indicated Resident 1's cognition (ability to learn, reason, remember, understand, and make decisions) rarely/never understands. The MDS indicated Resident 1 was dependent (helper does all of the effort. Residents do none of the effort to complete the activity) on staff for showering, toileting hygiene, and dressing. The MDS indicated Resident 1 had an indwelling catheter (a medical device used to drain urine from the bladder and allow it to flow into a collection bag). (continued on next page)

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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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/19/2025 at 4:14 p.m. with Director of Nursing (DON), Resident 1's COC, dated 4/26/2025 and 4/27/2025 was reviewed. The COC dated 4/26/2025 indicated the COC indicated at 8:00 p.m. Resident 1 had no significant urine output and transferred the resident to the GACH. The COC form indicated the GACH had no available beds. The COC indicated at 10:00 p.m. the physician was made aware with no reply. The COC dated 4/27/2025 indicated Resident 1 had hematuria with reduced urinary output and an order from the physician to transfer resident to the GACH. The COC indicated Resident 1 could not be transferred to the GACH and 911 was called at 8:27 a.m. The COC indicated at 8:38 a.m. the physician was informed of the changes in the transfer plans but no response. The DON stated Resident 1 had hematuria in the urine and it was considered a change of condition. The DON stated the physician did not return the licensed staff call on 4/26/2025 p.m. and on 4/27/2025. The DON stated that when the physician did not return our calls the next step was to call the Medical Director. The DON stated the Medical Director was not called from 10:00 p.m. to 8:27 a.m. and there was a lot that could have happened; the resident could have been bleeding from somewhere in the body. The DON stated 911 was called because the physician did not return our call, and the blood pressure had dropped from 118/72 mm/hg to 103/60 mm/hg. During a telephone interview on 5/20/2025 at 2:25 p.m. with the Medical Director, the Medical Director stated staff should have called him if the primary physician did not return their call. The Medical Director stated the facility can call anytime of the day or night if the physician does not call back. The Medical Director stated the facility needed to have followed the protocol once the physician had not returned their call and the resident is not doing well. During a review of facility ' s policy and procedures (P&P) titled, Change of Condition, date unknown, the P&P indicated the facility is to ensure proper assessment and follow through for any resident with change of condition. The P&P indicated upon a change of condition for any reason, nursing staff members are to take the following if for some reason physician cannot be reached, alternative physician shall be contacted. The P&P indicated if alternate cannot be reached, the Medical Director is to be contacted.