STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555816	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawndale Healthcare & Wellness Centre LLC	15100 S Prairie Lawndale, CA 90260

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 - Minimal harm or potential for 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** 48343 Based on interview and record review, the facility failed to ensure the residents have the right to be free from verbal abuse for one of three sampled residents (Resident 1). This deficient practice had the potential for Resident 1 to have psychological distress. Findings: A review of Resident 1's Admission Record (Face Sheet), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), muscle weakness (a lack of strength in the muscles), diabetes (high blood sugar), and heart failure (a condition in which the heart doesn't pump enough blood to meet the body needs). A review of Resident 1's History and Physical (H&P) dated 11/15/2023, indicated Resident 1 could make needs known but could not make medical decisions. A review of Resident 1's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool) dated 3/20/2024, indicated Resident 1 could make himself understood, and understand others. The MDS indicated Resident 1 required moderate assistance from staff for dressing, toilet use, personal hygiene, and bathing. A review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR) Communication form dated 4/5/2024, indicated Resident 1 was threatened by staff on 4/3/2024. A review of Resident 1's Psychiatric Evaluation dated 4/6/2024, indicated Resident 1 reported being threatened by staff and that the staff member cursed at Resident 1 on 4/3/2024. During a concurrent observation and interview on 4/15/2024 at 1:05 PM, with Resident 1, in Resident 1's room, Resident 1 was observed seating on the bed, well groomed, and dressed appropriately. Resident 1 stated in the morning of 4/3/2024, he exited his room to go the outdoor patio. Resident 1 stated Housekeeper 1 was in front of Resident 1's room and the resident cut off Housekeeper 1. Resident 1 stated Housekeeper 1 verbally threatened Resident 1 using curse words and profanity. Resident 1 stated he felt frustrated and scared. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 2:15 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he did not witness the verbal altercation between Resident 1 and Housekeeper 1. LVN 1 stated on 4/3/2024 during the morning shift (7:00 AM- 3:30 PM), he heard a loud verbal altercation in the hallway. LVN 1 stated he went to the hallway and saw Resident 1 wheeling himself to the outside patio as Housekeeper 1 stood in the hallway. LVN 1 stated he was told by Housekeeper 1 that there was a verbal altercation between Resident 1 and Housekeeper 1. LVN 1 stated Resident 1 was evaluated and did not see, or suspect that abuse occured. LVN 1 stated verbal altercations were not reported or documented. During a telephone interview on 4/15/2024 at 3:38 PM, with Housekeeper 1, Housekeeper 1 stated on 4/3/2024 around 8:30 AM, Housekeeper 1 was preparing laundry cards in front of Resident 1's room. Housekeeper 1 stated Resident 1 came out of his room and cut me off . Housekeeper 1 stated there was a loud verbal altercation with Resident 1, in which curse words and profanity were used. Housekeeper 1 stated he reported the incident to an unidentified certified nursing assistant (CNA) and his supervisor. Housekeeper 1 stated two days after the incident he was suspended. During an interview on 4/15/2024 at 4:11 PM, with the Director of Nursing (DON), the DON stated she was made aware of the verbal altercation between Housekeeper 1 and Resident 1 on 4/5/2024 and an investigation was started right way. The DON stated Resident 1 informed the ADM of the incident. During an interview on 4/15/2024 at 4:30 PM with Housekeeper 3, Housekeeper 3 stated on 4/3/2024 around 8: 30 AM, he was in his office and heard yelling, screaming, and cursing in the hallway. Housekeeper 3 stated he came out of his office and saw Resident 1 and Housekeeper 1 in the hallway having a loud conversation. Housekeeper 3 stated Resident 1 was yelling at Housekeeper 1 and Housekeeper 1 was talking back at Resident 1 with a loud voice and cursing. Housekeeper 3 stated he told Housekeeper 1 and Resident 1 to go their separate ways, then Resident 1 went to the outside patio. Housekeeper 3 stated Housekeeper 1 was asked what happened, and stated nothing had happened. Housekeeper 3 stated he asked Resident 1 if he was OK and Resident 1 stated, Yes, I am OK . Housekeeper 3 stated he reported the incident to the facility's Social Services Designee (SSD) on 4/3/2024, but was not sure what was done after that. Housekeeper 3 stated all staff were responsible for reporting alleged abuse, verbal abuse, or any other types of abuse must be reported immediately to the ADM and DON. Housekeeper 3 stated he should have reported the incident to the ADM, but he did not. During an interview on 4/15/2024 at 4:40 PM with the ADM, the ADM stated he was made aware of the verbal altercation between Resident 1 and Housekeeper 1 on 4/5/2024 by Resident 1. The ADM stated he started an investigation right way. The ADM stated Housekeeper 1 was suspended and the SSD resigned. The ADM stated residents should be treated with respect, dignity, and free from abuse. A review of the facility's Policy and Procedure (P&P) titled, Reporting Abuse revised 1/8/2014, indicated the following: 1. Facility will ensure that the resident has the right to be free from verbal, sexual, physical, and mental abuse. 2. Facility staff are mandatory reporters. 3. Facility staff will report known or suspected instances of abuse to the Administrator, or his/her designee. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P tiled, Abuse-Prevention, Screening, & Training Program , revised 7/2018, indicated: 1. Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, physical or chemical restraint not required to treat symptoms and/or imposed for the purposes of discipline or convenience, intimidation, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the neglect and deprivation of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, mental abuse, or abuse facilitated or enabled by the use of technology that causes physical harm, pain, or mental anguish. 2. Verbal abuse is defined as any use of oral, written, gestured communication, or sounds that willfully includes disparaging and derogatory terms directed to residents within their hearing distance, regardless of age, ability to comprehend, or disability.

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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** 48343 Based on interview and record review, the facility staff failed to timely report the allegation of verbal abuse regarding one of three sampled Residents (Resident 1) to the facility Administrator (ADM), and to other officials including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities. These deficient practices had the potential to place Resident 1 at risk of further abuse, and neglect. Findings: A review of Resident 1's Admission Record (Face Sheet), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), muscle weakness (a lack of strength in the muscles), diabetes (high blood sugar), and heart failure (a condition in which the heart doesn't pump enough blood to meet the body needs). A review of Resident 1's History and Physical (H&P) dated 11/15/2023, indicated Resident 1 could make needs known but couldnot make medical decisions. A review of Resident 1's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool) dated 3/20/2024, indicated Resident 1 could make himself understood, understand others. The MDS indicated Resident 1 required moderate assistance from staff for dressing, toilet use, personal hygiene, and bathing. A review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR) Communication form dated 4/5/2024, indicated there was an altercation where Resident 1 was threatened by staff (Housekeeper 1) on 4/3/2024. A review of Resident 1's Psychiatric Evaluation dated 4/6/2024, indicated Resident 1 reported, I was threatened by staff (Housekeeper 1) and the staff member cursed at Resident 1. During a concurrent observation and interview on 4/15/2024 at 1:05 PM, with Resident 1, in Resident 1's room, Resident 1 was observed sitting on the bed, well groomed, and dressed appropriately. Resident 1 stated on the morning of 4/3/2024, he was exiting out of his room to go the outdoor patio, Resident 1 stated Housekeeper 1 verbally threatened Resident 1 using curse words and profanity. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 2:15 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/3/2024 during the morning shift (7:00 AM- 3:30 PM), he heard a loud verbal altercation in the hallway. LVN 1 stated he went to the hallway and saw Resident 1 wheeling himself to the outside patio and saw Housekeeper 1 standing in the hallway. LVN 1 stated Housekeeper 1 stated that there was a verbal altercation between him and Resident 1. LVN 1 stated the verbal altercation between Resident 1 and Housekeeper 1 was not reported or documented. LVN 1 stated all staff were mandated to report alleged abuse immediately to the Administrator (ADM), ombudsman, and California Department of Public Health (CDPH). LVN 1 stated it was important to report alleged abuse timely, and to be investigated timely to prevent the incident from happening again and to ensure residents ' safety. During a telephone interview on 4/15/2024 at 3:38 PM with Housekeeper 1, Housekeeper 1 stated on 4/3/2024 during the morning shift (7:00 AM- 3:30 PM) around 8:30 AM, there was a verbal altercation with curse words and profanity between he and Resident 1. Housekeeper 1 stated he reported the incident to an unidentified certified nursing assistant (CNA), and his supervisor. Housekeeper 1 stated he was not aware he needed to report the incident to the ADM. During an interview on 4/15/2024 at 4:11 PM with the Director of Nursing (DON), the DON stated she was made aware of the verbal altercation between Housekeeper 1 and Resident 1 on 4/5/2024. The DON stated the ADM was made aware of the incident by Resident 1 , and the ADM reported immediately within two hours to the ombudsman, and (CDPH). The DON stated all alleged abuse must be reported immediately within two hours to the ADM, ombudsman, police, and CDPH per facility policy. The DON stated the verbal altercation between Housekeeper 1 and Resident 1 should have been reported immediately to the ADM, DON or change nurse. The DON stated facility staff failed to report the alleged verbal abuse timely. The DON stated was important to report abuse to ensure timely investigation and to prevent future abuse, and resident safety. During an interview on 4/15/2024 at 4:30 PM with Housekeeper 3, Housekeeper 3 stated on 4/3/2024 around 8: 30 am, he was in his office and heard yelling, screaming, and cursing in the hallway. Housekeeper 3 stated Resident 1 was yelling at Housekeeper 1 and Housekeeper 1 was cursing at Resident 1. Housekeeper 3 stated he report the incident to the Social Services Designee (SSD) on 4/3/2024, but not sure what was done after that. Housekeeper 3 stated all staff were responsible to report alleged abuse, verbal abuse, or any other types of abuse immediately to the ADM, and DON. Housekeeper 3 stated he should have reported the incident to the ADM, but he did not. During an interview on 4/15/024 at 4:40 PM with the ADM, the ADM stated he was made aware of the verbal altercation between Resident 1 and Housekeeper 1 on 4/5/2024 by Resident 1. The ADM stated he started the investigation right away and reported to the ombudsman, and CDPH within two hours. The ADM stated the facility staff should have reported the alleged verbal altercation immediately to him on 4/3/2024 so the incident could have been investigated timely but he was not aware until 4/5/2024. A review of facility's Policy and Procedure (P&P) titled, Reporting Abuse revised 1/8/2014, indicated facility staff will report known or suspected instances of abuse to the Administrator, or his/her designee. The P&P indicated facility staff members shall be notified that the Administrator, or his/her designee, has the responsibility, and that inquiries concerning resident abuse and reporting requirements should be referred to the Administrator, or his/her designee