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Form Approved OMB
No. 0938-0391

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	05/22/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility staff failed to notify the physician for one of six sampled residents (Resident 2), when Resident 2 continued to refuse to take her medications: 1. Remeron (antidepressant, medication used to treat depression) 2. Buspirone (antianxiety, medication used to treat anxiety) 3. Seroquel (antipsychotic, medication used to treat schizophrenia) This deficient practice resulted in Resident 2's physician being unaware of Resident 2's change of condition, delayed medical intervention and Resident 2 experienced unnecessary hostile behavior. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia (mental illness that effects how person thinks, feels, and behaves) bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels), metabolic encephalopathy (problem in the brain), depression (loss of pleasure or interest), and anxiety (feeling fear, afraid, and worry). During a review of Resident 2's Admission Assessment, the Admission assessment indicated Resident 2's cognition status was sometimes able to makes himself-understood and sometimes understood others. During a review of Resident 2's H&P dated 5/10/2024, the H&P indicated Resident 2 had fluctuating(changing) capacity to understand and make decisions. During a review of Resident 2's Order Summary Report for the month of 5/2024, the order summary report indicated: 1. Remeron (antidepressant medication) (15 milligram ([mg]- a unit of measurement of weight), give one tablet at bedtime for depression. 2. Buspirone HCL (antianxiety medication) 15 mg, give one tablet two time a day for anxiety. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Seroquel (antipsychotic medication)25 mg, give one tablet two times a day for schizophrenia. During a review of Resident 2's Care Plan initiated 5/9/2024, the care plan indicated Resident 2 had an alteration in neurological status related to metabolic encephalopathy. The care plan goals were to give medications as ordered. The care plan also indicated Resident 2 was on psychotropic medications (drug that affects behavior, mood, and thoughts) and to administer psychotropic medications as ordered by physician. During a concurrent interview and record review on 5/22/2204 at 2:35 PM with Licensed Vocational Nurse (LVN1), Resident 2's progress notes for the month of 5/2024 was reviewed. The progress notes dated 5/9/2024 indicated Remeron 15 mg one tablet at bedtime, Buspirone 15 mg one tablet two times a day, and Seroquel 25 mg one tablet two times a day. The progress notes also indicated Resident 2 refused all three medications, when offered three (3) times by the licensed nurse. The progress notes dated 5/11/2024 indicated Resident 2 kept on refusing psychotropic(drug that affects behavior, mood, and thoughts) medications and became agitated. The progress notes dated 5/12/2024 indicated Resident 2 was hospitalized for behavioral evaluation. During a concurrent interview and record review on 5/22/2024 at 2:44 PM with LVN 1, Resident 2's Electronic Medical Record (EMR) was reviewed. The EMR did not indicate a Change of Condition (COC) was completed, or the physician was notified. LVN1 stated licensed nursing staff should have completed a COC, and the physician should have been notified after Resident 2 had refused the medications for three consecutive times. LVN 1 stated licensed nurses should have notified the physician for further interventions for Resident 2. During a concurrent interview and record review on 5/22/2024 at 3:25 PM with the Director of Nursing (DON), Resident 2's EMR was reviewed. The DON stated the COC was not completed. The DON stated there was no documented evidence the physician was notified when Resident 2 refused psychotropic medications. The DON stated the physician must be notified timely if Resident 2 had a change of condition. The DON stated Resident 2's COC was not addressed on time and would not get resolved which puts Resident 2 at risk for health complications, and hospitalization . During a review of facility's Policy and Procedure (P&P) titled Change of Condition Notification , revised 4/1/2015, the P&P indicated: 1. Change of Condition related to Attending physician notification is defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident's condition. 2. Facility will promptly inform the resident's Attending Physician when the resident endures a significant change. 3. A licensed nurse will notify the resident's Attending Physician a significant change in the resident's physical, mental or psychosocial status. During a review of facility's P&P titled Refusal of Treatment , revised 1/1/2012, the P&P indicated: 1. When a resident refuses treatment, the Charge Nurse, or Director of Nursing Services (DNS) will document information related to the refusal in the resident's medical record: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) The date and time Nursing staff tried to give a medication. b) The medication refused. c)The residents' response and reason(s) for refusal. d)The date and time the Attending Physician was notified and his or her response. e) The Attending Physician will be notified of refusal in a time frame determined by the resident's condition and potential serious consequences of the refusal. During a review of facility's P&P titled Medications-Administration , revised 1/1/2012, the P&P indicated, if resident is refusing to take medication the licensed nurse will attempt to give medications several times, but if resident continue to refuse after one-hour, licensed nurse will notify physician and document in the medical record.

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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 a resident was free from verbal abuse for one of six sampled residents, (Resident 1). This deficient practice had the potential for Resident 1 to have psychological distress and caused Resident 1 to experience feelings of humiliation and disrespect. Finding: A. A review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes (high blood sugar), hypertension (high blood pressure), dysphagia (difficulty swallowing), depression (loss of pleasure or interest), and anxiety (feeling fear, afraid, and worry). A review of Resident 1's History and Physical (H&P) dated 4/18/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool) dated 4/11/2024, the MDS indicated Resident 1 was totally dependent (helper does all the effort) from staff for oral, toileting, and personal hygiene. The MDS also indicated Resident 1was self-understood and able to understand others. B. A review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia (mental illness that effects how person thinks, feels, and behaves) bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels), depression, and anxiety. A review of Resident 2's H&P dated 5/10/2024, the H&P indicated Resident 2 had fluctuating (changing) capacity to understand and make decisions. During a concurrent observation and interview on 5/22/2024 at 10:00 AM at, Resident 1's bedside, Resident 1 stated on 5/12/2024 early morning hours, doesn't remember the time, she had a verbal altercation (argument) with her roommate, Resident 2. Resident 1 stated Resident 2 was calling her (Resident 1) bad names like n*gg*r , using curse words, and profanity (a type of language that include dirty words). Resident 1 stated she felt angry, sad, upset, and disrespected. During an interview on 5/22/2024 at 11:22 AM with Certified Nursing Assistant 1(CNA1), CNA1 stated she was aware of the verbal altercation between Resident 1 and Resident 2. CNA1 stated on 5/12/2024 around 7:00 AM she was passing breakfast trays for Resident 1 and Resident 2. CNA1 stated, Resident 1 told her that Resident 2 was verbally aggressive and was calling her (Resident 1) bad words, using curse words and profanity. CNA1 stated she did not report right way to change nurse. CNA1 stated verbal altercation is abuse and should be reported immediately. CNA1 stated all staff, facility employees are mandated to report abuse immediately to change nurse, Director of Nursing (DON), and Administrator (ADM). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 11:30 AM with CNA1, CNA1 stated on 5/12/2024 at 7:30 AM was passing breakfast trays for residents at the facility and heard yelling and screaming coming from across the hallway from Resident 1's and Resident 2's room. CNA1 stated she went into Resident 1's and Resident 2's room right way and saw Resident 2 standing by Resident 1's bed and was yelling n*gg*r word, and profanity. CNA1 stated she should have reported verbal abuse when Resident 1 told her earlier on 5/12/2024 at 7:00 AM. CNA1 stated was important to report abuse timely, to be investigated timely to prevent from happening again. During an interview on 5/22/2024 at 11:43 AM with Licensed Vocational Nurse1 (LVN1), LVN1 stated she was made aware of verbal altercation between Resident 1 and Resident 2 by CNA1 on 5/12/2024 around 7:30 AM. LVN stated on 5/12/2024 at 7:35 AM she checked Resident 2 status and was observed Resident 2 lying in bed, talking to herself. LVN1 stated she did not transfer Resident 2 to a different room. LVN 1 stated upon her assessment at that time, Resident 2 did not appear aggressive, or hostile, and so she did not transfer Resident 2 into a different room in the facility. During an interview on 5/22/2024 at 11:47 AM with LVN1, LVN1 stated on 5/22/2024 around 9:30 AM heard a commotion and loud yelling coming out of Resident 1's and Resident 2's room. LVN1 stated she went into Resident 1's and Resident 2's room and observed CNA1 redirecting Resident 2 to her (Resident2) bed. LVN1 stated Resident 2 became very agitated, and verbally abusive toward Resident 1 and staff. LVN 1 stated she should have transferred Resident 2 into a different room earlier to prevent verbal altercation for happening again. LVN 1 stated not separating Resident 1 from Resident 2 right way was safety issues and placed Resident 1 at risk for continue verbal abuse. During an interview on 5/22/2024 at 1:35 PM with the Director of Nursing (DON), The DON stated she was made aware by LVN 1 of the verbal altercation between Resident 1 and Resident 2 on 5/12/2024 at 9:30 AM. The DON stated was not aware that Resident 2 was not transferred right way from Resident 1's room. The DON stated facility staff should have separate both residents' right way, transfer Resident 2 into different available room at the facility. The DON stated facility staff failed to take appropriate actions for verbal abuse and failed to prevent verbal abuse for happening again to Resident 1. The DON stated residents should be treated with respect, and free from abuse. During a review of facility's Policy and Procedure (P&P) tiled Abuse-Prevention, Screening, & Training Program , revised 7/2018, the P&P 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's P&P titled Resident -To-Resident Altercations , revised 11/1/2015, the P&P indicated: 1. To protect the health and safety of residents ensuring altercations between residents are promptly reported, investigated, and addressed by the facility: a) Facility staff observes residents for aggressive or inappropriate behavior toward other residents. b) Any occurrence of such behavior is promptly reported to the Charge Nurse, the Director of Nursing Services, and the Administrator. c) Separate the residents, and institute measures to calm the situation. d) Review the events with the Change Nurse and Director of Nursing Services, including interventions staff can take to prevent additional incidents.

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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 failed to provide the State Survey Agency (Bureau of Health Facility Licensing, Certification and Resident Assessment, within the Department of Public Health), a written report of findings for the investigation of an allegation of abuse within five (5) working days for an incident of verbal abuse for one of six samples residents, (Resident 1).

This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from further abuse.

Findings:

A.A review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes (high blood sugar), hypertension (high blood pressure), dysphagia (difficulty swallowing), depression (loss of pleasure or interest), and anxiety (feeling fear, afraid, and worry).

A review of Resident 1's History and Physical (H&P) dated 4/18/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions.

A review of Resident 1's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool) dated 4/11/2024, the MDS indicated Resident 1 was totally dependent (helper does all the effort) from staff for oral, toileting, and personal hygiene.

B.A review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia (mental illness that effects how person thinks, feels, and behaves) bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels), depression, and anxiety.

A review of Resident 2's H&P dated 5/10/2024, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.

During an interview on 5/22/2024 at 11:47 AM with LVN, LVN1 stated on 5/22/2024 around 9:30 AM heard a commotion and loud yelling coming out of Resident 1's and Resident 2's room. LVN1 stated she went into Resident 1's and Resident 2's room and was observed CNA1 redirecting Resident 2 to her (Resident 2) bed. LVN1 stated Resident 2 became very agitated, and verbally abusive toward Resident 1. LVN1 stated Resident 2 was calling Resident 1 bad name n*gg*r , using curse words, and profanity (a type of language that include dirty words).

A review of an SOC 341 (this form, as adopted by the California Department of Social Services CDSS, is required under Welfare and Institutions Code WIC, to report suspected dependent adult/elder abuse), indicated that the incident was reported to the State Survey Agency on 5/12/2024 via email.

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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 5/22/2024 at 2:14 PM with LVN1, Resident 2's progress note dated 5/12/2024 was reviewed. The progress note indicated Resident 2 was verbally aggressive and calling Resident 1 a n*gg*r repeatedly. The progress notes also indicated Resident 2 was transferred to the hospital for a behavioral evaluation. During a telephone interview on 5/22/2024 at 2:28 PM with the Administrator (ADM), the ADM stated, I will be honest with you regarding the five days investigation report, it was not reported to the Health Department. A review of facility's Policy and Procedure (P&P), titled Reporting Abuse , revised 1/8/2018, the P&P indicated: 1. Ensure compliance with federal and state laws and regulations regarding reporting of incidents and suspected incidents of abuse. 2. Facility will ensure that resident has the right to be free from verbal abuse. 3. Facility will report known or suspected abuse. 4. The Administrator, or his or her designee, shall provide the appropriate agencies or individuals with written report of the findings of the investigation within five (5) working days of the incident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review, the facility failed to implement the baseline care plan for one of six sampled residents, (Resident 2) by failing to: 1. Monitor Resident 2's psychotropic (drug that affects behavior, mood, and thoughts) medications side effects every shift. 2. Monitor Resident 2's mental status closely and report changes to the physician. 3. Assess Resident 2's for signs of distress or anxiety (feeling fear, afraid, and worry). These deficient practices had the potential to result in inconsistent implementation of the care plan that could lead to a delay or lack of delivery of care and services. Findings: A review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia (mental illness that effects how person thinks, feels, and behaves) bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels), metabolic encephalopathy (problem in the brain), depression (loss of pleasure or interest), and anxiety. A review of Resident 2's Admission Assessment, the Admission assessment indicated Resident 2's sometimes makes himself-understood and sometimes understood others. A review of Resident 2's H&P dated 5/10/2024, the H&P indicated Resident 2 had fluctuating (changing)capacity to understand and make decisions. A review of Resident 2's Care Plan initiated 5/9/2024, the care plan indicated Resident 2 had an alteration in neurological (damage to the brain) status related to metabolic encephalopathy. The care plan indicated Resident 2 was on psychotropic medications (drug that affects behavior, mood, and thoughts) and to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift. The care plan interventions indicated to monitor and record occurrence of behavior symptoms (inappropriate response to verbal communication, physical and verbal aggression) and document in the Medication administration Record (MAR). During a concurrent interview and record review on 5/22/2024 at 2:44 PM with LVN 1, LVN 1 stated medication side effects and behavior monitoring should be documented in the MAR. Resident 2's MAR for month of 5/2024 was reviewed. LVN 1 stated there were no documented evidence that licensed staff monitored and recorded Resident 2's medications side effects or behaviors. LVN 1stated if it was not documented, that means it was not done. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/22/2024 at 3:25 PM with the Director of Nursing (DON), Resident 2's EMR was reviewed. The DON stated care plan was resident specific to care, needs, goals, and interventions. The DON stated there was no documentation for Resident 2's medication side effects, or behavior monitoring as indicated on care plan. The DON stated licensed staff did not implement interventions in accordance with the care plan. The DON stated not implementing care plan interventions, put Resident 2 at risk for delay of care and treatment. During a review of facility's Policy and Procedure (P&P) titled Comprehensive Person-Centered Care Plan , revised 11/2018, the P&P indicated: 1. This facility to provide person-centered care that reflects best practice standards for meeting health, safety, psychosocial, behavioral needs of residents to obtain or maintain the highest physical, mental, and psychosocial well-being. 2. The baseline Care Plan should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions. 3. The Baseline Care Plan will be developed and implemented using the necessary combination of problem specific care plans.