| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555816 | A. Building<br>B. Wing | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lawndale Healthcare & Wellness Centre LLC | 15100 S Prairie<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505<br><br>Based on observation, interview and record review, the facility failed to implement intervention in a resident's care plan titled Comprehensive Person-Centered Care Planning, which indicated hourly visual monitoring should be conducted to one of seven sampled residents (Resident 2), who was at risk for wandering(walking aimlessly)/ eloping (when a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired leaves a care-giving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge).<br><br>This deficient practice resulted in Resident 2 wandering into other resident ' s rooms and placed Resident 2 at risk for an altercation with another resident.<br><br>Findings:<br><br>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (a condition where the nerves that are located outside of the brain and spinal cord are damaged), paranoid schizophrenia (a brain disorder where a person experiences paranoia that feeds into delusions and hallucinations), and cognitive communication deficit (a disorder in which a person has difficulty communicating because of an injury to the brain that controls the ability to think).<br><br>During a review of Resident 2 ' s History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 7/19/2024, the MDS indicated Resident 2 sometimes understood and was able to sometimes understand others. The MDS indicated Resident 2 required partial assistance from staff for activities of daily living such as eating, oral hygiene, upper body dressing, and personal hygiene, substantial assistance from staff for toileting hygiene, lower body dressing, and putting on and taking off footwear, and was dependent on staff for showering. The MDS indicated Resident 2 required set up assistance from staff for walking 150 feet, supervision from staff for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and bed to chair transfer, and partial assistance for toilet transfer and shower transfer.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 2 ' s care plan, titled, Risk for wandering/elopement identified related to disturb thought processes secondary to internal stimuli as evidenced by restlessness, bizarre behavior and resident wandering aimlessly, dated 7/8/2024, the interventions indicated checking wander guard ((a system used in healthcare facilities to prevent residents with a tendency to wander from leaving monitored areas) functioning and placement every shift, and visual hourly monitoring for safety.<br><br>During a review of Resident 2 ' s order summary report, dated 8/5/2024, the order summary report indicated to monitor for number of elopements every shift. The order summary report dated 3/11/2024 indicated to apply wander guard bracelet due to elopement precautions. The order summary report dated 8/5/2024 indicated to check for wander guard placement and function every shift for elopement.<br><br>During a concurrent observation and interview on 8/2/2024 at 1:35 p.m. with Resident 1 in Resident 1 ' s room, Resident 1 stated Resident 2 came into Resident 1 ' s room at least three times that day and attacked Resident 1. Resident 1 stated Resident 2 took off Resident 1 ' s blanket and hit Resident 1. Resident 1 stated she told the Registered Nurse Supervisor (RN 1) about the incident. Resident 1 was observed lying in bed with no obvious bruises or markings.<br><br>During an observation on 8/5/2024 at 2:01 p.m. in the hallway, Resident 2 was observed going into another resident ' s room, laid down on another resident ' s bed, and went to sleep.<br><br>During a concurrent observation and interview on 8/5/2024 at 2:04 p.m. with Registered Nurse (RN 2) in the hallway, RN 2 redirected Resident 2 back to her room. RN 2 stated that was not Resident 2 ' s room and Resident 2 tends to wander into other resident ' s rooms. RN2 stated the intervention would have been to do frequent redirection.<br><br>During an interview on 8/5/2024 at 2:06 p.m. with LVN 2, LVN 2 stated Resident 2 would wander from room to room because of her dementia (a loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life). LVN 2 stated the interventions would be to redirect Resident 2 back to her room and do frequent monitoring every two hours. LVN 2 stated Resident 2 would wander into Resident 1 ' s room because Resident 1 ' s room was Resident 2 ' s previous room and when Resident 2 wandered into Resident 1 ' s room, Resident 1 would scream so they know they had to get Resident 2 out of Resident 1 ' s room. LVN 2 stated she had never seen Resident 2 hit Resident 1 and Resident 1 did not tell LVN 2 that Resident 2 hit Resident 1.<br><br>During an observation on 8/5/2024 at 2:14 p.m. in the hallway, Resident 2 was observed leaving Resident 1 ' s room. Resident 1 was sleeping in bed.<br><br>During an observation on 8/5/2024 at 2:18 p.m. in the hallway, Resident 2 was observed leaving and entering two other residents ' rooms.<br><br>During an interview on 8/5/2024 at 2:28 p.m. with RN 1, RN 1 stated Resident 1 never told him about Resident 2 attacking her. RN 1 stated Resident 2 was very confused and was always wandering into other resident ' s rooms and staff would try to redirect Resident 2.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 8/5/2024 at 3:52 p.m. with the Director of Nursing (DON), Resident 2 ' s care plan, dated 7/8/2024, and order summary report, dated 8/5/2024, were reviewed. The care plan indicated, on 7/8/2024, the intervention for Resident 2 ' s risk for wandering and elopement included visual hourly monitoring. The DON stated there were no visual hourly monitoring done for Resident 2 from 7/6/2024 through 8/5/2024. The DON stated Resident 2 ' s care plan which indicated to conduct hourly visual monitoring was not followed. The DON stated the facility placed Resident 2 at risk for altercation if Resident 2 wandered into a resident ' s room.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated the facility should ensure to develop a comprehensive person-centered for each resident to provide a person-centered, comprehensive, and interdisciplinary care that reflected best practice standards for meeting resident ' s needs. The P&P indicated the baseline care plan should address resident-specific health and safety concerns and would identify needs for supervision as necessary.<br><br>Based on observation, interview and record review, the facility failed to implement intervention in a resident's care plan titled Comprehensive Person-Centered Care Planning, which indicated hourly visual monitoring should be conducted to one of seven sampled residents (Resident 2), who was at risk for wandering(walking aimlessly)/ eloping (when a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired leaves a care-giving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge).<br><br>This deficient practice resulted in Resident 2 wandering into other resident's rooms and placed Resident 2 at risk for an altercation with another resident.<br><br>Findings:<br><br>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (a condition where the nerves that are located outside of the brain and spinal cord are damaged), paranoid schizophrenia (a brain disorder where a person experiences paranoia that feeds into delusions and hallucinations), and cognitive communication deficit (a disorder in which a person has difficulty communicating because of an injury to the brain that controls the ability to think).<br><br>During a review of Resident 2's History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 7/19/2024, the MDS indicated Resident 2 sometimes understood and was able to sometimes understand others. The MDS indicated Resident 2 required partial assistance from staff for activities of daily living such as eating, oral hygiene, upper body dressing, and personal hygiene, substantial assistance from staff for toileting hygiene, lower body dressing, and putting on and taking off footwear, and was dependent on staff for showering. The MDS indicated Resident 2 required set up assistance from staff for walking 150 feet, supervision from staff for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and bed to chair transfer, and partial assistance for toilet transfer and shower transfer.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 2's care plan, titled, Risk for wandering/elopement identified related to disturb thought processes secondary to internal stimuli as evidenced by restlessness, bizarre behavior and resident wandering aimlessly, dated 7/8/2024, the interventions indicated checking wander guard ((a system used in healthcare facilities to prevent residents with a tendency to wander from leaving monitored areas) functioning and placement every shift, and visual hourly monitoring for safety.<br><br>During a review of Resident 2's order summary report, dated 8/5/2024, the order summary report indicated to monitor for number of elopements every shift. The order summary report dated 3/11/2024 indicated to apply wander guard bracelet due to elopement precautions. The order summary report dated 8/5/2024 indicated to check for wander guard placement and function every shift for elopement.<br><br>During a concurrent observation and interview on 8/2/2024 at 1:35 p.m. with Resident 1 in Resident 1's room, Resident 1 stated Resident 2 came into Resident 1's room at least three times that day and attacked Resident 1. Resident 1 stated Resident 2 took off Resident 1's blanket and hit Resident 1. Resident 1 stated she told the Registered Nurse Supervisor (RN 1) about the incident. Resident 1 was observed lying in bed with no obvious bruises or markings.<br><br>During an observation on 8/5/2024 at 2:01 p.m. in the hallway, Resident 2 was observed going into another resident's room, laid down on another resident's bed, and went to sleep.<br><br>During a concurrent observation and interview on 8/5/2024 at 2:04 p.m. with Registered Nurse (RN 2) in the hallway, RN 2 redirected Resident 2 back to her room. RN 2 stated that was not Resident 2's room and Resident 2 tends to wander into other resident's rooms. RN2 stated the intervention would have been to do frequent redirection.<br><br>During an interview on 8/5/2024 at 2:06 p.m. with LVN 2, LVN 2 stated Resident 2 would wander from room to room because of her dementia (a loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life). LVN 2 stated the interventions would be to redirect Resident 2 back to her room and do frequent monitoring every two hours. LVN 2 stated Resident 2 would wander into Resident 1's room because Resident 1's room was Resident 2's previous room and when Resident 2 wandered into Resident 1's room, Resident 1 would scream so they know they had to get Resident 2 out of Resident 1's room. LVN 2 stated she had never seen Resident 2 hit Resident 1 and Resident 1 did not tell LVN 2 that Resident 2 hit Resident 1.<br><br>During an observation on 8/5/2024 at 2:14 p.m. in the hallway, Resident 2 was observed leaving Resident 1's room. Resident 1 was sleeping in bed.<br><br>During an observation on 8/5/2024 at 2:18 p.m. in the hallway, Resident 2 was observed leaving and entering two other residents' rooms.<br><br>During an interview on 8/5/2024 at 2:28 p.m. with RN 1, RN 1 stated Resident 1 never told him about Resident 2 attacking her. RN 1 stated Resident 2 was very confused and was always wandering into other resident's rooms and staff would try to redirect Resident 2.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 8/5/2024 at 3:52 p.m. with the Director of Nursing (DON), Resident 2's care plan, dated 7/8/2024, and order summary report, dated 8/5/2024, were reviewed. The care plan indicated, on 7/8/2024, the intervention for Resident 2's risk for wandering and elopement included visual hourly monitoring. The DON stated there were no visual hourly monitoring done for Resident 2 from 7/6/2024 through 8/5/2024. The DON stated Resident 2's care plan which indicated to conduct hourly visual monitoring was not followed. The DON stated the facility placed Resident 2 at risk for altercation if Resident 2 wandered into a resident's room.<br><br>During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated the facility should ensure to develop a comprehensive person-centered for each resident to provide a person-centered, comprehensive, and interdisciplinary care that reflected best practice standards for meeting resident's needs. The P&P indicated the baseline care plan should address resident-specific health and safety concerns and would identify needs for supervision as necessary.<br><br>Based on observation, interview and record review, the facility failed to implement intervention in a resident's care plan titled Comprehensive Person-Centered Care Planning, which indicated hourly visual monitoring should be conducted to one of seven sampled residents (Resident 2), who was at risk for wandering(walking aimlessly)/ eloping (when a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired leaves a care-giving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge).<br><br>This deficient practice resulted in Resident 2 wandering into other resident's rooms and placed Resident 2 at risk for an altercation with another resident.<br><br>Findings:<br><br>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (a condition where the nerves that are located outside of the brain and spinal cord are damaged), paranoid schizophrenia (a brain disorder where a person experiences paranoia that feeds into delusions and hallucinations), and cognitive communication deficit (a disorder in which a person has difficulty communicating because of an injury to the brain that controls the ability to think).<br><br>During a review of Resident 2's History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 7/19/2024, the MDS indicated Resident 2 sometimes understood and was able to sometimes understand others. The MDS indicated Resident 2 required partial assistance from staff for activities of daily living such as eating, oral hygiene, upper body dressing, and personal hygiene, substantial assistance from staff for toileting hygiene, lower body dressing, and putting on and taking off footwear, and was dependent on staff for showering. The MDS indicated Resident 2 required set up assistance from staff for walking 150 feet, supervision from staff for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and bed to chair transfer, and partial assistance for toilet transfer and shower transfer.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 2's care plan, titled, Risk for wandering/elopement identified related to disturb thought processes secondary to internal stimuli as evidenced by restlessness, bizarre behavior and resident wandering aimlessly, dated 7/8/2024, the interventions indicated checking wander guard ((a system used in healthcare facilities to prevent residents with a tendency to wander from leaving monitored areas) functioning and placement every shift, and visual hourly monitoring for safety.<br><br>During a review of Resident 2's order summary report, dated 8/5/2024, the order summary report indicated to monitor for number of elopements every shift. The order summary report dated 3/11/2024 indicated to apply wander guard bracelet due to elopement precautions. The order summary report dated 8/5/2024 indicated to check for wander guard placement and function every shift for elopement.<br><br>During a concurrent observation and interview on 8/2/2024 at 1:35 p.m. with Resident 1 in Resident 1's room, Resident 1 stated Resident 2 came into Resident 1's room at least three times that day and attacked Resident 1. Resident 1 stated Resident 2 took off Resident 1's blanket and hit Resident 1. Resident 1 stated she told the Registered Nurse Supervisor (RN 1) about the incident. Resident 1 was observed lying in bed with no obvious bruises or markings.<br><br>During an observation on 8/5/2024 at 2:01 p.m. in the hallway, Resident 2 was observed going into another resident's room, laid down on another resident's bed, and went to sleep.<br><br>During a concurrent observation and interview on 8/5/2024 at 2:04 p.m. with Registered Nurse (RN 2) in the hallway, RN 2 redirected Resident 2 back to her room. RN 2 stated that was not Resident 2's room and Resident 2 tends to wander into other resident's rooms. RN2 stated the intervention would have been to do frequent redirection.<br><br>During an interview on 8/5/2024 at 2:06 p.m. with LVN 2, LVN 2 stated Resident 2 would wander from room to room because of her dementia (a loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life). LVN 2 stated the interventions would be to redirect Resident 2 back to her room and do frequent monitoring every two hours. LVN 2 stated Resident 2 would wander into Resident 1's room because Resident 1's room was Resident 2's previous room and when Resident 2 wandered into Resident 1's room, Resident 1 would scream so they know they had to get Resident 2 out of Resident 1's room. LVN 2 stated she had never seen Resident 2 hit Resident 1 and Resident 1 did not tell LVN 2 that Resident 2 hit Resident 1.<br><br>During an observation on 8/5/2024 at 2:14 p.m. in the hallway, Resident 2 was observed leaving Resident 1's room. Resident 1 was sleeping in bed.<br><br>During an observation on 8/5/2024 at 2:18 p.m. in the hallway, Resident 2 was observed leaving and entering two other residents' rooms.<br><br>During an interview on 8/5/2024 at 2:28 p.m. with RN 1, RN 1 stated Resident 1 never told him about Resident 2 attacking her. RN 1 stated Resident 2 was very confused and was always wandering into other resident's rooms and staff would try to redirect Resident 2.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 8/5/2024 at 3:52 p.m. with the Director of Nursing (DON), Resident 2's care plan, dated 7/8/2024, and order summary report, dated 8/5/2024, were reviewed. The care plan indicated, on 7/8/2024, the intervention for Resident 2's risk for wandering and elopement included visual hourly monitoring. The DON stated there were no visual hourly monitoring done for Resident 2 from 7/6/2024 through 8/5/2024. The DON stated Resident 2's care plan which indicated to conduct hourly visual monitoring was not followed. The DON stated the facility placed Resident 2 at risk for altercation if Resident 2 wandered into a resident's room.<br><br>During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated the facility should ensure to develop a comprehensive person-centered for each resident to provide a person-centered, comprehensive, and interdisciplinary care that reflected best practice standards for meeting resident's needs. The P&P indicated the baseline care plan should address resident-specific health and safety concerns and would identify needs for supervision as necessary. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505<br><br>Based on observations, interviews, and record review, the facility failed to ensure the call light for one of seven sampled residents (Resident 1) was placed within reach while Resident 1 was in bed.<br><br>This deficient practice had the potential to cause Resident 1 to not be able to get the help she needed in a timely manner.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (a condition where the nerves that are located outside of the brain and spinal cord are damaged), dementia (the loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), and paranoid personality disorder (a mental disorder characterized by exaggerated distrust and suspicion of other people).<br><br>During a review of Resident 1 ' s history and physical (H&P), dated 2/29/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/30/2024, the MDS indicated Resident 1 was usually understood and was usually able to understand others. The MDS indicated Resident 1 required supervision from staff for activities of daily living such as eating, partial assistance from staff for oral hygiene, substantial assistance from staff for personal hygiene, and was dependent on staff or toileting hygiene, upper and lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 was dependent on staff for mobility such rolling left and right, sit to lying, lying to sitting on edge of bed, toilet transfer, and shower transfer.<br><br>During an observation on 8/2/2024 at 1:30 p.m. at Resident 1 ' s room, Resident 1 ' s call ligha ws behind the bedside table.<br><br>During an interview on 8/2/2024 at 1:35 p.m. with Resident 1, Resident 1 stated she did not have a call light at bedside and she did not have a phone so she had to yell to get help from staff.<br><br>During a concurrent observation and interview on 8/2/2024 at 4:03 p.m. with the Director of Nursing (DON) in Resident 1 ' s room, Resident 1 ' s call light was on the floor behind Resident 1 ' s bed. The DON stated the call light was supposed to be within reach of the residents. The DON stated the call light on the floor was not within reach of the resident and if the resident needed help, they would not be able to get help if the call light was not within reach.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Communication-Call System, dated 1/1/2012, the P&P indicated the purpose of the call light system was to provide a mechanism for residents to promptly communicate with nursing staff. The P&P indicated call cords will be placed within the resident ' s reach in the resident ' s room.<br><br>(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) |
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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observations, interviews, and record review, the facility failed to ensure the call light for one of seven sampled residents (Resident 1) was placed within reach while Resident 1 was in bed.<br><br>This deficient practice had the potential to cause Resident 1 to not be able to get the help she needed in a timely manner.<br><br>Findings<br><br>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (a condition where the nerves that are located outside of the brain and spinal cord are damaged), dementia (the loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), and paranoid personality disorder (a mental disorder characterized by exaggerated distrust and suspicion of other people).<br><br>During a review of Resident 1's history and physical (H&P), dated 2/29/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/30/2024, the MDS indicated Resident 1 was usually understood and was usually able to understand others. The MDS indicated Resident 1 required supervision from staff for activities of daily living such as eating, partial assistance from staff for oral hygiene, substantial assistance from staff for personal hygiene, and was dependent on staff or toileting hygiene, upper and lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 was dependent on staff for mobility such rolling left and right, sit to lying, lying to sitting on edge of bed, toilet transfer, and shower transfer.<br><br>During an observation on 8/2/2024 at 1:30 p.m. at Resident 1's room, Resident 1's call ligha ws behind the bedside table.<br><br>During an interview on 8/2/2024 at 1:35 p.m. with Resident 1, Resident 1 stated she did not have a call light at bedside and she did not have a phone so she had to yell to get help from staff.<br><br>During a concurrent observation and interview on 8/2/2024 at 4:03 p.m. with the Director of Nursing (DON) in Resident 1's room, Resident 1's call light was on the floor behind Resident 1's bed. The DON stated the call light was supposed to be within reach of the residents. The DON stated the call light on the floor was not within reach of the resident and if the resident needed help, they would not be able to get help if the call light was not within reach.<br><br>During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 1/1/2012, the P&P indicated the purpose of the call light system was to provide a mechanism for residents to promptly communicate with nursing staff. The P&P indicated call cords will be placed within the resident's reach in the resident's room.<br><br>Based on observations, interviews, and record review, the facility failed to ensure the call light for one of seven sampled residents (Resident 1) was placed within reach while Resident 1 was in bed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555816 | A. Building<br>B. Wing | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lawndale Healthcare & Wellness Centre LLC | 15100 S Prairie<br>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.

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