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	01/21/2026

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 - Some	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** Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 6), were protected from incidents of abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, deprivation by an individual, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being, including various forms such as physical [any intentional act of force that causes harm, injury, or trauma to another person's body] and sexual [any sexual activity or contact imposed on a person without their consent, often involving force, coercion, or exploitation of vulnerability] abuse), by failing to: 1). Ensure a care plan was developed for Resident 2 who had a history of inappropriate (improper) exposure of his private parts (sexual organ) and harassing female staff and residents when admitted to the facility on [DATE].2). Implement its policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, which indicated the facility should review and revise the comprehensive person-centered care plan when there is onset of new problems, change of condition, addressing changes in behavior and care, as appropriate or necessary. 3). Implement its P&P titled, Abuse Prevention and Management, which indicated the facility does not condone (allow) any form of resident abuse. These failures resulted in Resident 2 sexually abusing Resident 1 and Resident 6 and physically abusing Resident 6 on 12/19/2025.These failures had the potential to cause psychological harm (refers to the emotional or mental injury that an individual may experience due to various actions, experiences, leading to negative effects on their mental well-being) to Residents 1 and 6, because of Resident 2's sexually abusive behaviors.These failures had the potential to cause severe physical injuries to Resident 6 after being physically attacked by Resident 2 on 12/19/2025, that could result in hospitalization or death.Findings:1). 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]. Resident 1's diagnoses included muscle weakness and dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, problem-solving, language, and judgment, often with personality changes). During a review of Resident 1's Care Plan titled Cognitively impaired with increasing confusion, restlessness., dated 9/25/2025, one of the interventions indicated visual monitoring for safety. During a review of Resident 1's History and Physical (H&P) dated 9/26/2025, the H&P indicated Resident 1 did not have the capacity to consent (unspecified) due to dementia. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for eating, and required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) (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

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	01/21/2026

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 - Some	for oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 1 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete activity) for toileting hygiene, shower/bathe self, lower dressing and putting on/taking off footwear. The MDS indicated Resident 1 required moderate assistance with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, and walking 10 feet. During a review of Resident 1's Situation, Background, Assessment, Recommendation Communication Form (SBAR- a simple, structured communication tool used in healthcare to convey critical patient information clearly and concisely, especially during urgent situations or handoffs, ensuring all team members have essential context for decision-making and improving patient safety) dated 12/19/2025, the SBAR indicated on 12/19/2025 (time not specified), Resident 1 was exposed to inappropriate behavior (any verbal, written, or physical conduct characterized as offensive, intimidating, hostile, or demeaning, often disrupting work or causing discomfort, that violates accepted social norms, workplace policies, or safety standards. Key example includes harassment, unwanted physical contact, or aggressive communication). The SBAR note indicated Resident 1 was assessed promptly, no injuries noted, and Resident 1 denied pain or distress and remained calm. The SBAR indicated Resident 1 will be monitored for signs of emotional distress and safety measures implemented to prevent recurrence (unspecified). The SBAR indicated the facility will maintain Resident 1 separated from Resident 2. During a review of Resident 1's clinical record, Resident 1's clinical record did not indicate consent to engage in sexual activity (refers to any behavior or act intended to elicit sexual desire or result in sexual pleasure, such as kissing, touching, oral sex, vaginal or anal sex, and other forms of sexual stimulation) with Resident 2. During a review of Resident 1's Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) meeting note dated 12/22/25 at 12:43 p.m., the IDT note indicated the meeting was conducted following Resident 1's exposure to inappropriate behavior last 12/19/2025 (time not specified). The IDT notes indicated Resident 1 was alert with some confusion due to dementia. The IDT notes indicated continuous monitoring and keeping environment safe will be provided. During an interview on 1/6/2026 at 12:55 p.m., with Resident 1, Resident 1 stated sometime before Christmas (date not specified), Resident 2 went to her (Resident 1's) room. Resident 1 stated Resident 2 removed her (Resident 1) pants and then Resident 2 took off his (Resident 2) pants. Resident 1 stated Resident 2 kissed her on her face. Resident 1 stated she was traumatized (shocked, shaking, shivering) by the incident and had to sleep with the lights on for two weeks (date unspecified). Resident 1 stated she was afraid that Resident 2 would enter her room again. Resident 1 stated all the staff at the facility (unspecified) saw what Resident 2 did (removed pants and kissed) to her (Resident 1). 2). 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 muscle weakness, and schizoaffective disorder (a mental health condition in which a person experiences psychotic symptoms of schizophrenia, such as delusions, hallucinations, disorganized thinking, or flat affect, along with symptoms of a mood disorder, such as depression and/or mania) bipolar type, (a mental condition marked by alternating periods of elation and depression) and history of increasing psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) resulting in inappropriate exposure of his private parts and harassing female staff and residents, from a General Acute Care Hospital (GACH 1). During a review of Resident 2's History and Physical (H&P) dated 12/13/2025, the H&P indicated Resident 2 could make needs known but could (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 B. Wing	01/21/2026

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 - Some	not make medical decisions. During a review of Resident 2's Progress Notes dated 12/13/2025 at 2:03 p.m., the Progress Notes indicated, on this shift (unspecified), Resident 2 exhibited inappropriate behavior (unspecified) toward nursing staff (unspecified) on two occasions (dates not specified). The Progress Note indicated Resident 2 made sexually explicit (language or behavior that clearly and openly describes sexual activity, nudity, or erotic content) and inappropriate verbal comments (unspecified) directed toward assigned Certified Nurse Assistant (CNA, not identified). The Progress Notes indicated Resident 2 was redirected by staff and Resident 2 was informed that his behaviors were inappropriate and unacceptable. The Progress Notes indicated Resident 2's behavior will be monitored. During a review of Resident 2's care plan, the care plan did not indicate addressing Resident 2's inappropriate sexual behavior towards a CNA on 12/13/2025. During a review of Resident 2's care plan titled, Risk for Wandering/ Elopement identified, dated 12/15/2025, the intervention indicated to clearly identify Resident 2's room and bathroom, engage resident in purposeful activity, identify if there is a certain time of day wandering (traveling/going from place to place, without any clear aim or purpose)/ elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision) attempts occur, implement a scheduled toileting program, implement scheduled hydration if not contraindicated and schedule time for regular walks/ appropriate activity. During a review of Resident 2's Progress Notes dated 12/15/2025 at 4:05 p.m., the Progress Notes indicated Resident 2 was seen touching a CNA (not identified) inappropriately (unspecified). The Progress Notes indicated Resident 2 told CNA (not identified) he (Resident 2) wanted to go to bed with her (CNA, not identified). During a review of Resident 2's care plan, the care plan did not indicate addressing Resident 2's inappropriate touching on a CNA on 12/13/2025. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating and oral hygiene. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear. The MDS indicated Resident 2 required supervision with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, and required moderate assistance with sitting to stand, for chair/bed to chair transfer, toilet transfer and walking 10 feet. The MDS indicated Resident 2 was independent with indoor mobility (ambulation). During a review of Resident 2's SBAR dated 12/19/2025, the SBAR indicated Resident 2 had physical aggression and was observed entering Resident 1's bedroom and lowered his pants, approached Resident 1 and Resident 2 exhibited sexually inappropriate behavior (unspecified) towards Resident 1. The SBAR indicated Resident 2 staff (unspecified) redirected Resident 2 back to his room and was shouting during redirection. The SBAR indicated Resident 2 was administered prescribed medication (unspecified) and was instructed to remain in his room. The SBAR indicated to transfer Resident 2 to a GACH for further evaluation and management of behavior. During a review of Resident 2's Order Summary Report dated 12/19/2025, the Order Summary Report indicated transferring Resident 2 to the General Acute Hospital Care (GACH) 2 for further evaluation and management of sexually/physically aggressive (attacking) behavior. During a review of Police Department (PD) Crime/ Incident Report dated 12/19/2025 at 6:55 p.m., the Incident Report indicated on 12/19/2025 at approximately 4:00 p.m., the PD officer assisted with a sexual battery (non-consensual sexual contact or touching of another person's intimate parts) report call at the facility. The Incident Report indicated that there had (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 B. Wing	01/21/2026

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 - Some	been prior calls regarding a male subject identified as Resident 2, masturbating (stimulating genitals with a hand for sexual pleasure) in a female patient's room (not specified) and an assault (attack) against another male patient. The Incident Report indicated Resident 2 was transported by LAFD to GACH 2 prior to the PD's arrival. The Incident Report indicated Resident 1 stated Resident 2, who was wearing a blue t-shirt and blue jeans, entered her room, sat down on the edge of her bed, and placed both of his hands on her (Resident 1) shoulders. The Incident Report indicated Resident 1 stated Resident 2 repeatedly shook her (Resident 1) aggressively and then Resident 2 kissed her (Resident 1) on both of her face cheeks approximately 5-6 times with his lips. The Incident Report indicated Resident 1 stated she told Resident 2 to get off her and get out of her room. The PD report indicated Resident 1 stated Resident 2 then got up and pulled his pants down to his thighs and reached into his shorts to touch his penis. The Incident Report indicated Resident 1 stated she did not actually see Resident 2's penis and his penis was not exposed. Resident 2 then sat back on the bed and put his hands inside her (Resident 1's) shorts, past her diaper, and penetrated her vagina with his fingers. The Incident Report indicated Resident 1 could not recall which hands he used or how long the assault was. The PD report indicated Resident 1 stated she continued calling for help and hospital (facility) staff came in and got Resident 2 out of the room. The Incident Report indicated there were curtains separating the beds and Resident 1's two roommates stated they did not see or hear anything. The Incident Report indicated Resident 1 stated she did not look at the suspect's face. The Incident Report indicated according to staff, that Resident 2 was wearing a blue T-shirt and blue jeans when he was transported to GACH 2. During a review of Resident 2's Progress Notes dated 12/20/2025, the Progress Notes indicated Resident 2 was readmitted to the facility on [DATE] (time not indicated) from GACH 2 after the management of aggression and sexually inappropriate behavior towards another resident. The Progress Notes indicated to continue Resident 2's plan of care and update as indicated. The Progress Notes indicated Resident 2 will be monitored closely for behavioral changes and safety concerns. During a review of Resident 2's care plan following readmission from GACH 2 on 12/20/2025, Resident 2's care plan did not indicate interventions related to Resident 2's sexually inappropriate behavior towards other resident, monitoring for behavioral changes and safety concerns. During an interview on 1/6/2026 at 2:03 p.m., with Los Angeles Fire Department Nurse Practitioner (LAFD NP), the LAFD NP stated on 12/19/2025 around 2:00 p.m., she discussed the case (Resident 2's sexual inappropriate behavior toward Resident 1) in detail with the Director of Nursing (DON) which involved the risk of having a resident with sexual intent in the facility without proper monitoring. During an interview on 1/6/2026 at 3:29 p.m., with Registered Nurse Supervisor (RN 1), RN 1 stated it was reported to her by a CNA (unknown CNA) that Resident 1 reported that Resident 2 lowered his pants and touched Resident 1's vagina. RN 1 stated the CNA (unknown) stated Resident 1 was yelling for help and the CNA (unknown) saw Resident 2 pulled down his pants. During an interview on 1/7/2026 at 1:09 p.m., with the DON, the DON stated that on 12/19/2025 right before shift change (time not specified), RN 1 reported that Resident 2 exposed himself to Resident 1. The DON stated the facility did not create a care plan to monitor Resident 2 and his whereabouts who had history of sexual misconduct (wrongdoing). The DON stated the facility did not create a care plan when Resident 2 was first admitted to the facility on [DATE] due to the history of inappropriate exposure of his private parts and harassing female staff. The DON stated the facility did not create a care plan on 12/13/2025 when Resident 2 had made a sexually explicit (language or behavior that clearly and openly describes sexual activity, nudity, or erotic content) and inappropriate verbal comments (unspecified) directed towards the assigned CNA, and on 12/15/2025, when Resident 2 was seen touching a CNA (not identified) (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 B. Wing	01/21/2026

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 - Some	inappropriately (unspecified). The DON stated if the care plans were created, it might have protected Resident 1 and Resident 6 from Resident 2's sexually inappropriate behavior and eventually protected Resident 6 from Resident 2's physical aggression. During an interview on 1/7/2026 at 2:11 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated after she and the other staff (unknown) redirected Resident 2 back to his room, few minutes later (time not specified), there was screaming heard coming from Resident 2's room. LVN 1 stated she did not think of placing Resident 2 on one to one (1:1-when an individual staff member is assigned to directly supervise no more than one resident and the staff shall stay within very close proximity to ensure constant supervision and immediate intervention if needed for safety reasons) monitoring to care for and monitor Resident 2 exclusively for their entire shift. LVN 1 stated that she should have placed Resident 2 in a single room to protect the rest of the residents from repeated sexually inappropriate behavior and physically assaulting Resident 6. During a phone interview on 1/7/2026 at 2:22 p.m., with RN 3, RN 3 stated when she entered Resident 1's room on 12/19/2025 (time not specified), she witnessed Resident 2 put back his pants on pulled his (Resident 2) pants down when the resident saw RN 3 in the room. RN 3 stated Resident 1 reported to her that Resident 2 kissed her, touched her and put his fingers inside her vagina. RN 3 stated Resident 1 gave the same story to the LAFD and PD. RN3 stated Resident 2 kept pushing into her attempting to go back inside Resident 1's room. RN 3 stated LVN 1 walked Resident 2 back to his room. 3). During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included muscle weakness and low back pain. During a review of Resident 6's H&P dated 11/30/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 was able to understand and be understood by others. The MDS indicated Resident 6 required set-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) for eating. The MDS indicated Resident 6 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) for oral hygiene The MDS indicated Resident 6 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete activity) on staff for toileting hygiene, shower/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 6 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with rolling from left to right, and was dependent for sitting to lying, lying to sitting on side of the bed, sitting to stand, for chair/bed to chair transfer, toilet transfer, and for tub/shower transfer. During a review of Resident 6's Progress Notes dated 12/19/2025 at 00:31 a.m., the Progress Notes indicated Resident 6 was being monitored due to being struck by Resident 2 on his legs three times. During a review of Resident 6's COC dated 12/19/2025 at 03:00 (3 a.m.), the COC indicated on 12/19/2025 (time not specified), Resident 6 reported that his legs were struck three times by Resident 2. The COC indicated Resident 2 was removed immediately from Resident 6's room. During a review of PD's Crime/ Incident Report dated 12/19/2025 at 6:12 p.m., the Incident Report indicated on 12/19/2025 at approximately 4:50 p.m., Police Officers were in the facility regarding a sexual battery report. The Incident Report indicated while at the location (facility), Family Member (FM) 1 approached the Police Officer to report that Resident 6 was assaulted (unspecified). The Incident Report indicated the Police Officer went to Resident 6's room who was bedridden, reported that on 12/19/2025 at approximately 3:16 p.m., Resident 2 (Resident 6's roommate) entered the room (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 B. Wing	01/21/2026

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 - Some	and requested to suck Resident 6 dick (perform oral sex). The Incident Report indicated Resident 6 told Resident 2 to leave the room but Resident 2 disregarded Resident 6's request and Resident 2 began advancing forward. The Incident Report indicated Resident 2 requested to suck Resident 6's dick again and told Resident 2 to leave the room and Resident 2 continued advancing forward. The Incident Report indicated Resident 2 continued advancing forward and when Resident 2 was close to Resident 6, Resident 2 pulled Resident 6's blanket down to potentially expose Resident 6's penis. The Incident Report indicated Resident 6 physically resisted and prevented the blanket from being pulled down. The Incident Report indicated Resident 2 eventually stopped his attempts to remove the blanket near Resident 6's penis and became frustrated. The Incident Report indicated Resident 2 proceeded to punch Resident 6's right knee approximately (3) times with a balled-up fist, then Resident 2 left the room. The Incident Report indicated the Police Officers determined that Resident 2 was the suspect regarding the sexual battery investigation. During a review of Resident 6's clinical record, Resident 6's clinical record did not indicate consent to engage in sexual activity (refers to any behavior or act intended to elicit sexual desire or result in sexual pleasure, such as kissing, touching, oral sex, vaginal or anal sex, and other forms of sexual stimulation) with Resident 2. During an interview on 1/6/2026 at 2:03 p.m., with LAFD NP, the LAFD NP stated Resident 6 was one of Resident's 2 alleged victims on 12/19/2025 around 2:00 p.m. During an interview on 1/7/2026 at 8:30 a.m., with Resident 6, Resident 6 stated on 12/19/2025 at 2:55 p.m., Resident 2 came back to the room and told him (Resident 6) that he (Resident 2) wanted to suck his (Resident 6) penis. Resident 6 stated Resident 2 asked him to suck his penis again. Resident 6 stated Resident 2 attempted to pull down his blanket to expose his penis. Resident 6 stated Resident 2 could not pull his blankets off, and Resident 2 hit him on his right leg three times. During an interview on 1/7/2026 at 9:48 a.m., with CNA 3, CNA 3 stated on 12/19/2025 at around 2:55 p.m., she heard Resident 6 screaming and calling for help. CNA 3 stated when she entered the room, Resident 6 was alleged that Resident 2 asked him to suck his dick. CNA 3 stated she called LVN 1 and reported the incident. During a concurrent interview and record review on 1/7/2026 at 3:00 p.m., with the Administrator (ADM), the P&P titled Abuse Prevention and Management dated 5/30/2024, was reviewed. The ADM stated the P&P indicated that sexual abuse is a non-consensual sexual contact of any type, sexual harassment, sexual coercion or sexual assault. The ADM stated the facility should identify, correct and intervene in situation where abuse or exploitation is more likely to occur as indicated in the P&P. The ADM stated the P&P indicated the ADM or designated representative should provide a safe environment for the resident as indicated by the situation. The ADM stated the time in the SBAR in Resident 6's COC dated 12/19/2025 at 03:00 (3 a.m.), was a typo. The correct time was 3 p.m. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated the comprehensive care plan should be periodically reviewed and revised by IDT. The P&P indicated, the comprehensive care plan should be reviewed and revised when there is onset of new problems, change of condition, to address changes in behavior and care and other times as appropriate or necessary. During a review of the facility's P&P titled, Abuse Prevention and Management, dated 5/30/2024, the P&P indicated the facility does not condone any form of resident abuse. The P&P indicated sexual abuse was defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault. The P&P indicated Physical abuse was defined as, but not limited to, hitting, slapping, punching, and/or kicking. The P&P indicated the facility would identify, correct, and intervene in situations in which abuse is more likely to occur.

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	01/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to report allegations of sexual and/or physical abuse to the California Department of Public Health (CDPH), for two of three sampled residents (Residents 1 and 6) when: Resident 1 informed the facility that Resident 2 entered her room, lowered his pants, kissed her and touched her vagina on 12/19/2026. Resident 6 informed the facility that Resident 2 hit him on his leg and told him (Resident 6) he wanted to suck his penis on 12/19/2026. This deficient practice resulted in a delay in investigation by the CDPH and placed Resident 1 and Resident 6 at risk for continued abuse. 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]. The admission Record indicated Resident 1's diagnoses included hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body) and hemiparesis (weakness on one side of the body affecting the arm, leg and/or face) following cerebral infarction (loss of blood flow to a part of the brain) affecting left non-dominant side, dementia (a progressive state of decline in mental abilities), depression and anxiety disorder (mental health condition characterized by excessive worry, fear and nervousness that can interfere with daily life).During a review of Resident 1's History and Physical (H&P) dated 9/26/2025, the H&P indicated Resident 1 did not have the capacity to consent.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort. Helper lifts, holds or supports drunk or limbs, but provides less than half the effort) to maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) for Activities of Daily Living (ADLs) such as oral hygiene, upper body dressing, personal hygiene, bed mobility (the ability to roll from lying on back to left and right side, and return to lying on back on the bed) and transfers (the ability to transfer to and from a bed to a chair or wheelchair). Resident 1 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete activity) for toileting hygiene, showering/bathing self, lower dressing and walking 10 feet. During a review of Resident 1's Situation, Background, Assessment, Recommendation Communication Form (SBAR- a communication tool used by healthcare workers when there is a resident change in condition) dated 12/19/2025, the SBAR indicated Resident 1 was exposed to inappropriate behavior (by Resident 2). During an interview on 1/6/2026 at 12:55 p.m., with Resident 1, Resident 1 stated sometime before Christmas (date not specified), a Resident (Resident 2) went into her room, removed his and her (Resident 1) pants off and kissed her face. Resident 1 stated she was traumatized by the incident, and she tried not to think about it. During an interview on 1/6/2026 at 3:29 p.m., with Registered Nurse Supervisor (RN 1), RN 1 stated on 12/19/2026, Resident 2 was yelling for help, and a Certified Nurse Assistant (CNA [unable to recall name] saw Resident 2 in Resident 1's room, lowering his pants. Resident 1 reported to the CNA and RN 1 that Resident 2 touched her (Resident 1) vagina. RN 1 stated, she reported the incident to the Director of Nursing (DON). 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 schizoaffective disorder bipolar type, (a mental illness that can affect thoughts, mood and behavior with episodes of mania [high energy, euphoria/irritability] and sometimes depression).During a review of Resident 2's H&P dated 12/13/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions.During a review of Resident 2's MDS dated [DATE], the (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 B. Wing	01/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required partial/moderate assistance from staff for ADLs such as toileting hygiene, dressing, transfers and walking 10 feet. The MDS indicated Resident 2 exhibited behavior symptoms (physical symptoms such as hitting or scratching self, pacing, public sexual acts and disrobing in public). During a review of Resident 2's SBAR dated 12/19/2025, the SBAR indicated Resident 2 was observed entering Resident 1's room. Resident 2 lowered his pants, approached a female resident (Resident 1) and exhibited sexually inappropriate behavior towards the resident. The Note indicated Resident 2 was redirected back to his room and Resident 2 was shouting during redirection. The Note indicated Resident 2 was administered prescribed medication and for the resident to transfer to the General Acute Care Hospital (GACH) for further evaluation and management of behavior. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 6's diagnoses included muscle weakness, and low back pain.During a review of Resident 6's H&P dated 11/30/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 was able to understand and be understood by others. The MDS indicated Resident 6 was dependent on staff for ADLs such as personal hygiene, dressing, sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), lying to sitting on side of the bed, sit to stand (the ability to come to a standing position from sitting in a chair, or on the side of the bed), and transfers. During a review of Resident 6's Change in Condition Evaluation (COC) dated 12/19/2025, the COC indicated on 12/19/2025, Resident 6 reported he was physically assaulted by another resident (Resident 2). The COC indicated Resident 6 was struck on his legs three times (by Resident 2). During an interview on 1/7/2026 at 8:30 a.m., with Resident 6, Resident 6 stated on 12/19/2025, Resident 2 entered his room and told him he (Resident 2) wanted to suck his penis. Resident 6 stated Resident 2 attempted to pull his blankets off to expose him (Resident 6) and when Resident 2 could not pull the blankets off, the resident hit him on the right leg three times. Resident 6 stated CNA 3 was aware of the incident, and he also reported the incident to the Assistant Administrator (AADM). During an interview on 1/7/2026 at 9:48 a.m., with CNA 3, CNA 3 stated (on 12/19/2026), she heard Resident 2 scream for help. CNA 3 stated, Resident 6 informed her that Resident 2 wanted to suck his penis and the resident (Resident 2) hit him on his leg. CNA 3 stated she reported the incident to Licensed Vocational Nurse (LVN) 1. During an interview on 1/7/2026 at 10:21 a.m., with LVN 1, LVN 1 stated (on 12/19/2026) Resident 6 informed her that Resident 2 hit him on his leg and asked him if he could suck his (Resident 6) private part. LVN 3 stated the facility reported the incident to the police, but she was not sure whether a report was made to the CDPH. LVN 1 stated that the allegation of abuse should have been reported [to the CDPH] to ensure a thorough investigation was completed. During an interview on 1/7/2026 at 1:09 p.m. with the DON, the DON stated on 12/19/2025, RN 1 informed her that Resident 1 entered Resident 2's room and exposed his private part to the resident (Resident 2). The DON stated on 12/19/2025, LVN 1 informed her that Resident 6 alleged Resident 1 punched him on his knee. The DON stated she did not report the incidents to the CDPH because she did not think Resident 1 exposing himself to Resident 2 and Resident 1 hitting Resident 6 on the leg were considered abuse. During a concurrent record review and interview on 1/7/2026 at 3:00 p.m., with the Administrator (ADM), the facility's Policies & Procedures (P&P) titled, Abuse Prevention and Management dated 6/12/2024 was reviewed. The ADM stated he was informed about the [allegations of abuse] incidents between Resident 1 and Resident 2 as well as Resident 2 and Resident 6 on 12/19/2025. The ADM stated he did not report both incidents to the CDPH. The ADM stated any (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 B. Wing	01/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegations of abuse should have been reported to the CDPH and investigated to prevent further abuse of the residents. During a review of the facility's P&P titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated abuse is defined as willful, deliberate infliction of injury and also includes physical (hitting, slapping, punching and/or kicking) and sexual abuse (non-consensual sexual contact of any type, sexual harassment, sexual coercion or sexual assault). The P&P indicated for all allegations of abuse, the Administrator or designated representative will submit a written (SOC 341 [Report of Suspected Dependent Adult/Elder Abuse Form]) report to the CDPH Licensing and Certification within two hours. During a review of the facility's P&P titled, Abuse-Reporting and Investigations dated 3/2018, the P&P indicated the facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. The facility promptly reports allegations of resident abuse, mistreatment and suspicions of crimes. The P&P indicated the Administrator, or designated representative will report to the CDPH Licensing and Certification with two hours.

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	01/21/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 2's incidents of abuse abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, deprivation by an individual, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being, including various forms such as physical [any intentional act of force that causes harm, injury, or trauma to another person's body] and sexual abuse [any sexual activity or contact imposed on a person without their consent, often involving force, coercion, or exploitation of vulnerability]) on two of three sampled residents (Resident 1 and Resident 6) were investigated, as indicated in the facility's policy and procedure (P&P) titled, Abuse Prevention and Management. This deficient practice placed Residents 1 and 6 at risk for further sexual abuse. This deficient practice placed Resident 6 at risk for further physical abuse. This deficient practice had the potential for continued sexual and physical abuse by Resident 2 among other vulnerable residents.Findings: 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]. Resident 1's diagnoses included muscle weakness and dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, problem-solving, language, and judgment, often with personality changes). During a review of Resident 1's History and Physical (H&P) dated 9/26/2025, the H&P indicated Resident 1 did not have the capacity to consent (unspecified) due to dementia. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for eating, and required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) for oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 1 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete activity) for toileting hygiene, shower/bathe self, lower dressing and putting on/taking off footwear. The MDS indicated Resident 1 required moderate assistance with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, and walking 10 feet. During a review of Resident 1's Situation, Background, Assessment, Recommendation Communication Form (SBAR- a simple, structured communication tool used in healthcare to convey critical patient information clearly and concisely, especially during urgent situations or handoffs, ensuring all team members have essential context for decision-making and improving patient safety) dated 12/19/2025, the SBAR indicated on 12/19/2025 (time not specified), Resident 1 was exposed to inappropriate behavior (any verbal, written, or physical conduct characterized as offensive, intimidating, hostile, or demeaning, often disrupting work or causing discomfort, that violates accepted social norms, workplace policies, or safety standards. Key example includes harassment, unwanted physical contact, or aggressive communication [incident]). The SBAR note indicated Resident 1 was assessed promptly, no injuries noted, and Resident 1 denied pain or distress and remained calm. The SBAR indicated Resident 1 will be monitored for signs of emotional distress and safety measures implemented to prevent recurrence (unspecified). The SBAR indicated the facility will maintain Resident 1 separated from Resident 2. During an interview on 1/6/2026 at 12:55 p.m., with Resident 1, Resident 1 stated sometime before Christmas (date not specified), Resident 2 went to her (Resident 1's) room. Resident 1 stated (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 B. Wing	01/21/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 removed her (Resident 1) pants and then Resident 2 took off his (Resident 2) pants. Resident 1 stated Resident 2 kissed her on her face. Resident 1 stated she was traumatized (shocked, shaking, shivering) by the incident and had to sleep with the lights on for two weeks (date unspecified). Resident 1 stated she was afraid that Resident 2 would enter her room again. Resident 1 stated all the staff at the facility (unspecified) saw what Resident 2 did (removed pants and kissed) to her (Resident 1). During a review of Resident 1's clinical records, Resident 1's clinical records had no documentation that an investigation was conducted regarding the incident (Resident 2 sexually abused Resident 1) on 12/19/2025. 2). 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 muscle weakness, and schizoaffective disorder (a mental health condition in which a person experiences psychotic symptoms of schizophrenia, such as delusions, hallucinations, disorganized thinking, or flat affect, along with symptoms of a mood disorder, such as depression and/or mania) bipolar type, (a mental condition marked by alternating periods of elation and depression) and history of increasing psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) resulting in inappropriate exposure of his private parts and harassing female staff and residents, from a General Acute Care Hospital (GACH 1). During a review of Resident 2's History and Physical (H&P) dated 12/13/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating and oral hygiene. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear. The MDS indicated Resident 2 required supervision with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, and required moderate assistance with sitting to stand, for chair/bed to chair transfer, toilet transfer and walking 10 feet. The MDS indicated Resident 2 was independent with indoor mobility (ambulation). During a review of Resident 2's SBAR dated 12/19/2025, the SBAR indicated Resident 2 had physical aggression and was observed entering Resident 1's bedroom and lowered his pants, approached Resident 1 and Resident 2 exhibited sexually inappropriate behavior toward the opposite sex (Resident 1). The SBAR indicated Resident 2 staff (unspecified) redirected Resident 2 back to his room and was shouting during redirection. The SBAR indicated Resident 2 was administered prescribed medication (unspecified) and was instructed to remain in his room. The SBAR indicated to transfer Resident 2 to a GACH for further evaluation and management of behavior. During a review of Resident 2's clinical records, Resident 2's clinical records had no documentation that an investigation was conducted regarding the incidents (sexually assaulting Residents 1 and 6, and physically assaulting Resident 6) on 12/19/2025. 3). During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included muscle weakness and low back pain.During a review of Resident 6's History and Physical (H&P) dated 11/30/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 was able to understand and be understood by others. The MDS indicated Resident 6 required set-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.) for eating. The MDS (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 B. Wing	01/21/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 6 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort) for oral hygiene The MDS indicated Resident 6 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete activity) on staff for toileting hygiene, shower/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 6 required moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with rolling from left to right, and was dependent for sitting to lying, lying to sitting on side of the bed, sitting to stand, for chair/bed to chair transfer, toilet transfer, and for tub/shower transfer. During a review of PD's Crime/ Incident Report dated 12/19/2025 at 6:12 p.m., the Incident Report indicated on 12/19/2025 at approximately 4:50 p.m., Police Officers were in the facility regarding a sexual battery report. The Incident Report indicated while at the location (facility), Family Member (FM) 1 approached the Police Officer to report that Resident 6 was assaulted (unspecified). The Incident Report indicated the Police Officer went to Resident 6's room who was bedridden, reported that on 12/19/2025 at approximately 3:16 p.m., Resident 2 (Resident 6's roommate) entered the room and requested to suck Resident 6 dick (perform oral sex). The Incident Report indicated Resident 6 told Resident 2 to leave his room but Resident 2 disregarded Resident 6's request and Resident 2 began advancing forward. The Incident Report indicated Resident 2 requested to suck Resident 6's dick again and told Resident 2 to leave the room and Resident 2 continued advancing forward. The Incident Report indicated Resident 2 continued advancing forward and when Resident 2 was close to Resident 6, Resident 2 pulled Resident 6's blanket down to potentially expose Resident 6's penis. The Incident Report indicated Resident 6 physically resisted and prevented the blanket from being pulled down. The Incident Report indicated Resident 2 eventually stopped his attempts to remove the blanket near Resident 6's penis and became frustrated. The Incident Report indicated Resident 2 proceeded to punch Resident 6's right knee approximately (3) times with a balled-up fist, then Resident 2 left the room. The Incident Report indicated the Police Officers determined that Resident 2 was the suspect regarding the sexual battery investigation. During an interview on 1/7/2026 at 8:30 a.m., with Resident 6, Resident 6 stated on 12/19/2025 at 2:55 p.m., Resident 2 came back to the room and told him (Resident 6) that he (Resident 2) wanted to suck his (Resident 6) penis. Resident 6 stated Resident 2 asked him to suck his penis again. Resident 6 stated Resident 2 attempted to pull down his blanket to expose his penis. Resident 6 stated Resident 2 could not pull his blankets off, and Resident 2 hit him on his right leg three times. During a review of Resident 6's clinical records, Resident 6's clinical records had no documentation that an investigation was conducted regarding the sexual abuse and physical assault by Resident 2 on 12/19/2025. During an interview on 1/7/2026 at 3:00 p.m., with the Administrator (ADM), the ADM stated on 12/19/2025 (time not specified), he was informed regarding Resident 2 sexually assaulting Resident 1 and Resident 6, and Resident 2 hitting Resident 6, but did not do an investigation because it had happened on a Friday afternoon. The ADM stated the Social Services department, and the Director of Nursing (DON) should have investigated all the incidents by interviewing staffs and residents. During a review of the facility's P&P titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated the Administrator or designated representative conducting the investigation should interview individuals who may have information relevant to the allegation or suspected crime. The P&P indicated witnesses include, but are not limited to the resident, witnesses to the incident, other residents under the care of the staff member involved, roommates, family, visitors, etc.

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	01/21/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 3), was provided quality care and services, and assistance with activities of daily living, necessary to ensure the resident was kept clean, dry and comfortable. This failure placed Resident 3 to experience feelings of neglect, anger and sadness. This failure placed Resident 3 at risk of skin breakdown.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included muscle weakness and hypertension (high blood pressure). During a review of Resident 3's History and Physical (H&P) dated 10/21/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 3 usually was able to understand and be understood by others. The MDS indicated Resident 3 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating and moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral hygiene. The MDS indicated Resident 3 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) for toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 3 required maximal assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for upper body dressing. The MDS indicated Resident 3 required maximal assistance with rolling from left to right, for sitting to lying, and was dependent for chair/bed to chair transfer. During a review of Resident 3's Care Plan titled, Self-care deficit and needs assistance with Activities of Daily Living (ADL) and mobility, dated 12/16/2025, the interventions indicated to assist with ADLs as needed. During a concurrent observation and interview on 1/6/2026 at 11:39 a.m., Resident 3 stated she had not been cleaned all morning and that she had been sitting in urine for hours. Resident 3 stated she was not sure how long she had been in urine. Resident 3 stated she kept calling staff to assist her, but no one responded. Resident 3 was observed pressed the call light to call for assistance and observed Certified Nurse Assistant (CNA) 1 walked past Resident 3's room and did not answer Resident 3's call light. Resident 3 stated it had always been like that; staff do not respond to her call light and ignored me. During a concurrent observation and interview on 1/6/2026 at 12:06 p.m., with CNA 1 and Resident 3, CNA 1 entered Resident 3's room. CNA 1 stated she did not notice the call light was on. CNA 1 stated CNA 2 is the assigned nurse and was assisting a different resident and is now on break. CNA 1 was observed walked out of Resident 3's room while Resident 3 screamed, I need help, I am uncomfortable. Resident 3 was observed attempting to speak to CNA 1 but CNA 1 interrupted Resident 3. CNA 1 stated she had already responded to Resident 3's call light several times and was too busy to assist Resident 3 because she already had nine residents. CNA 1 stated Resident 3 had requested her bed to be put up then to be put down. CNA 1 stated she had to take care of her own residents. CNA 1 stated she didn't have time to come and assist Resident 3 constantly. During a concurrent observation and interview on 1/6/2026 at 12:14 p.m. with CNA 1, CNA 2 and Resident 3, CNA 2 was observed entered Resident 3's room. Resident 3 told CNA 2 she needed to be cleaned because she is very uncomfortable. CNA 2 stated that she could not clean her (Resident 3) now because she is about to pass trays. CNA 2 stated that there is nothing she can do for (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 B. Wing	01/21/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 right now because she is just following the facility's rules. CNA 2 stated Resident 3 would be okay waiting in urine for hours until there was someone available to assist Resident 3. CNA 1 and CNA 3 were observed and heard raising their voices (speaking out) stating that all the residents had to wait while trays were being passed because those were the rules of the facility and they could not clean residents during tray pass. During an interview on 1/6/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated residents should not be left in urine for a long period of time even if it was during mealtimes. The DON stated leaving residents in urine for a long period of time could lead to skin breakdown and it could also make residents feel neglected or ignored. During an observation on 1/6/2026 at 12:42 p.m. with the Infections Prevention Nurse (IP), CNA 2 and Resident 3, observed IP being informed by CNA 2 that she (CNA 2) had not cleaned Resident 3 all morning because Resident 3 had refused care. Resident 3 stated CNA 2 never asked her to be cleaned that morning. During a review of the facility's policy and procedure (P&P) titled, Bowel and Bladder, dated 1/30/2025, the P&P indicated the facility must ensure that a resident who is incontinent of bowel and bladder receives services and assistance to attain/maintain continence. The policy indicated residents who are incontinent of urine, feces, or both, must be kept clean, dry and comfortable.

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	01/21/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its infection prevention and control measures for one of three sampled residents (Resident 3) by failing to ensure: Certified Nurse Assistant (CNA) 2 replaced/doffed (remove) gloves, and performed hand performed hand hygiene (washing hands or using an alcohol-based hand sanitizer) during incontinence (lack of voluntary control over urination and/or defecation) care for Resident 3. This deficient practice had the potential to result in cross contamination (transfer of harmful bacteria or viruses from one place, object or person to another) and increased the risk of transmitting disease-causing organisms leading to illness for residents. Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3's diagnoses included muscle weakness and hypertension (high blood pressure).During a review of Resident 3's History and Physical (H&P) dated 10/21/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 3 usually was able to understand and be understood by others. The MDS indicated Resident 3 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for bed mobility (rolling left and right in bed, sitting to lying on the side of bed to lying flat on the bed) and was dependent (helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) for toileting hygiene, lower body dressing and transfers (the ability to transfer to and from a bed to a chair). During a concurrent observation and interview on 1/6/2026 at 12:30 p.m., in Resident 3's room, CNA 2 was observed performing incontinence care for Resident 3. CNA 2 was observed wearing gloves, opened Resident 2's soiled incontinence brief, cleaned the resident's pubic area, proceeded to touch the bed remote control to move the resident's bed up, then turned/repositioned the resident to the left side to clean the resident's buttocks and buttocks fold, remove the soiled incontinence brief and place a new clean incontinence brief without replacing gloves and performing hand hygiene. CNA 3 left Resident 3's room without doffing or replacing gloves nor performing hand hygiene to obtain a clean gown to put on the Resident. CNA 3 stated she did not realize she had not changed her gloves while cleaning Resident 3 because she was trying to finish (incontinence care) quickly. During an interview on 1/6/2026 at 12:42 p.m. with the Infections Prevention Nurse (IP), the IP stated staff should change their gloves and wash or sanitized hands when moving from dirty to clean areas. IP stated not changing gloves and not washing/sanitizing hands could lead to spread of germs and placed residents at risk for infections. The IP stated soiled gloves could transfer germs into clean areas and items such as blankets, bed rails and devices used to move the beds. It was important for staff to perform hand hygiene between glove change and once staff were done with tasks. During a review of the facility's Policy and Procedure (P&P) titled, Personal Protective Equipment (PPE- clothing and equipment such as gloves that is worn or used to provide protection against hazardous substances and/or environments) dated 1/1/2012, the P&P indicated Facility staff wear gloves whenever there is touching blood, body fluids, secretions and excretions. Gloves are used only once and are discarded into the appropriate receptacle location in the room in which the procedure is being performed. Hands are washed before and after removing gloves. During a review of the facility's P&P titled, Hand Hygiene, dated 9/1/2020, the P&P indicated the facility's policy considered hand hygiene as the primary means to prevent the spread of infections. The P&P indicated (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 B. Wing	01/21/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand hygiene meant cleaning your hands by handwashing (washing hands with soap and water), antiseptic hand wash or antiseptic hand rub (i.e. alcohol-based hand rub [ABHR] including foam or gel). The P&P indicated appropriate hand hygiene is required after contact with blood, other body fluids, secretions, excretions, before donning and after doffing PPE and immediately upon entering and exiting a resident room.