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	03/23/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on interview and record review, the facility failed to perform an accurate fall assessment for one of 17 residents (Resident 49) after a fall. This deficient practice had the potential to result in Resident 49 to have recurrent falls and could have lead to improper care planning. Findings: During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was admitted to the facility on [DATE], with diagnosis of lack of coordination and muscle weakness. During a review of Resident 49's History and Physical (H&P), dated 12/24/2024, H&P indicated Resident 49 had the capacity to understand and make decisions. During a review of Resident 49's Care Plan titled Resident is high fall risk and risk for injury dated 12/31/2024, the care plan interventions indicated to follow facility fall protocol. During a review of Resident 49's Minimum Data Set ([MDS] a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 49 was able to understand and be understood by others. The MDS indicated Resident 49 required set up for eating and moderate assistance with oral hygiene. The MDS indicated Resident 49 required maximal assistance with toileting hygiene, showering/bathing, dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 49's Fall Risk Evaluation dated 3/21/2025 at 10:55 p.m., the Evaluation did not indicate Resident 49's fall on 3/21/2025. The Evaluation did not include Resident 49's level of consciousness, gait (manner of walking) and/or balance, and medications. The evaluation did not indicate a fall risk score. During a concurrent interview and record review on 3/23/2025 at 10:43 a.m. with the Director of Nursing (DON), the DON stated the Fall Risk Evaluation was not done properly and did not indicate Resident 49's fall on 3/21/2025, level of consciousness, gait and/or balance, and medications. The DON stated that not having a complete and correct assessment could lead to improper care planning and interventions for Resident 49. The DON stated it could also lead to a recurrent fall and the nurse should have completed the assessment completely to have a correct fall score and to determine the resident's risk of falling. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedures (P&P) titled Fall Management Program dated March 13, 2021, the P&P indicated a licensed nurse will conduct a new fall risk evaluation quarterly, annually, upon identification of a significant change of condition, post fall and as needed. 45657

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on interview and record review, the facility failed to develop and implement a care plan for three of four sampled residents (Resident 43 and Resident 44 and Resident 12) by failing to: 1. Develop a care plan for Resident 43's Restorative Nursing Assistance (RNA) services. 2. Develop a care plan for the use Resident 44's antipsychotic (class of medications used to treat mental illness) medication Risperdal (type of antipsychotic medication that treats mental health conditions such as schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]). 3. Implement a care plan addressing Resident 12's fingernails. These deficient practices had a potential to result in inconsistent implementation of the care plan that may place Resident 43, Resident 44, and Resident 12 at risk of inadequate health care. Findings: a. During a review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including cerebral infarction (blood flow to the brain is interrupted, leading to damage or death of brain tissue), hemiplegia and hemiparesis (hemiplegia refers to complete paralysis on one side of the body, while hemiparesis describes a more mild weakness or partial paralysis on one side), and quadriplegia unspecified (partial or complete loss of motor function in all four limbs). During a review of Resident 43's History and Physical (H&P) dated 10/1/2024, the H&P indicated Resident 43 does not have the mental capacity to understand and make medical decisions. During a review of residents 43's Minimum Data Set (MDS - a mandated resident assessment tool), dated 12/17/2024, the MDS indicated Resident 43 had cognitive impairment (ability to think and reason). The MDS indicated Resident 43 was dependent with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), transfer (moving between surfaces to and from bed, chair, and wheelchair), and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 43's physicians orders dated 9/30/2024, the physicians orders indicated an order for Restorative Nurse Assistance (RNA) program for passive range of motion (PROM, the movement of a joint by an external force, such as a therapist or a machine, without the patient's active muscle contraction) to the bilateral (pertaining to both sides) lower extremities (BLE) and bilateral upper extremities (BUE) daily, 5 times a week, as tolerated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/23/2025 at 3:00 p.m. with Registered Nurses (RN) 1, RN 1 stated the care plan was the care nurses must provide to residents. RN 1 stated the care plan was personalized and based on the residents condition. RN 1 stated residents in the RNA program would need to have an RNA care plan. RN 1 stated the care plan would include a goal and interventions for Resident 43. RN 1 stated the treatment would be evaluated if it is working or needed to be changed. RN 1 stated the care plan for Resident 43 was created 3/23/2025. RN 1 stated there was not a care plan for Resident 43 prior to 3/23/2025. b. During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including muscle wasting and atrophy (loss of muscle mass and strength), degenerative disease of the nervous system (disorder that affect the nervous system, causing progressive deterioration and loss of function), and quadriplegia unspecified (partial or complete loss of motor function in all four limbs). During a review of Resident 44's H&P dated 9/17/2024, the H&P indicated Resident 44 does not have the mental capacity to understand and make medical decisions. During a review of residents 44's MDS, dated [DATE], the MDS indicated Resident 44 had cognitive impairments. The MDS indicated Resident 44 required dependent assistance with ADLs. During a review of Resident 44's physicians orders dated 12/23/2024, the physicians orders indicated Resident 44 had an order for Risperdal oral tablet 0.5 milligrams (mg, unit of measurement) give 1 tablet by mouth two times a day for schizophrenia (chronic mental health condition characterized by a combination of symptoms that significantly impair a person's thinking, perception, emotions, and behavior). During a review of Resident 44's medical record on 3/23/2025 at 2:00 p.m., there was not a care plan on file for the use of Risperdal or any antipsychotic medications. During a concurrent interview and record reviewed on 3/23/2025 at 2:04 p.m. with RN 2, RN 2 reviewed Resident 44 's care plans and was not able to find a care plan for Risperdal. RN 2 stated care plan is developed for any resident receiving antipsychotic medication. RN 2 stated the care plan addresses the problem, goals, and interventions needed for Resident 44 while taking this medication. RN 2 stated if nurses failed to develop a care plan, staff would be unaware of the medications efficiency. RN 2 stated nurses need to make sure that a care plan was developed and Resident 44 was receiving accurate care. During an interview on 3/23/2025 at 3:18 p.m. with the Director of Nursing (DON), the DON stated the care plans are individualized based on resident's needs. The DON stated on any occasion residents are receiving care with medications or exercises must have a care plan that reflects the residents' needs. The DON stated if nurses failed to develop a care plan Resident 43 and Resident 44 are at risk of neglect because they are not receiving the care they need. The DON stated Resident 43 and Resident 44 were at risk of health status decline which could lead to serious health complications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. During a review of Resident 12's Admission Record, dated 3/23/2025, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a change in how the brain works due to a chemical imbalance in the blood), spinal stenosis (a condition when the space inside the backbone is too small), and type 2 diabetes mellitus (a chronic condition when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 12's H&P, dated 2/21/2025, the H&P indicated Resident 12 had fluctuating capacity to understand and make decisions. During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 was able to understand and be understood by others. The MDS indicated Resident 12 was moderately cognitively impaired. The MDS indicated Resident 12 was dependent on staff for ADLs. The MDS indicated Resident 12 required substantial assistance from staff for ADLS such as upper body dressing, partial assistance from staff for oral hygiene and supervision for eating. The MDS indicated Resident 12 was dependent on staff for sitting to standing and chair to bed transfer and required substantial assistance from staff for rolling left to right, sitting to lying, and lying to sitting on the edge of bed. During a review of Resident 12's care plan titled, At risk for infection related to long nails, potential trauma/injury (scratches, abrasion), and inability to properly clean nails ., dated 3/21/2025 and revised on 3/23/2025, the care plan interventions indicated, if necessary, assist the patient in trimming nails or refer to a podiatrist or nail care specialist for proper trimming. During a concurrent observation and interview on 3/22/2025 at 9:55 a.m. with Resident 12, in Resident 12's room, Resident 12 was observed with long fingernails. Resident 12 stated her fingernails were long and no one had offered to trim her nails. Resident 12 stated she wanted her fingernails trimmed. During an interview on 3/23/2025 at 3:57 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated she looked at all the residents' nails on 3/21/2025 and Resident 12 requested to have a professional do her nails. The IPN stated she initiated the care plan on 3/21/2025 but did not finish the care plan until 3/23/2025. During a concurrent interview and record review on 3/23/2025 at 4:49 p.m. with the DON, Resident 12's care plan and care plan history was reviewed. The DON stated according to the care plan history, the care plan was created on 3/23/2025. The DON stated the care plan was not created on 3/21/2025 and it was supposed to be created at the time the problem was identified, which was 3/21/2025. The DON stated if the care plan was not created, the problem was not addressed and nothing was being done. During a review of the facility's policy and procedures (P&P) titled Restorative Nursing Program Guidelines dated 9/19/2019, the P&P indicated measurable objectives and interventions are documented in the Care plan and in the medical record. The P&P indicated if a Restorative Nursing Program is in place when a Care Plan is being revised, it is appropriate to reassess progress, goals, and duration/ frequency as part of the care planning process. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Comprehensive Person-Centered Care Planning dated 8/24/2023, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of residents to obtain or maintain the highest physical, mental and psychosocial well- being. The P&P indicated the purpose of the policy was to ensure t0hat a comprehensive person-centered care plan was developed for each resident and additional changes or updates to the resident's comprehensive care plan would be made based on the assessed needs of the resident. 46505

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to create a care plan timely for the use of side rails for one of 30 sampled residents (Resident 7). This deficient practice had the potential to cause Resident 7 to not have the appropriate interventions in place. Findings During a review of Resident 7's Admission Record, dated 3/23/2025, the Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including muscle weakness (decreased strength in the muscles), glaucoma (an eye disease that gradually damages the optic nerve and can lead to blindness), and legal blindness (a significant level of vision loss). During a review of Resident 7's History and Physical (H&P), dated 3/6/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a mandated resident assessment tool), the MDS indicated Resident 7 sometimes understand and was sometimes understood by others. The MDS indicated Resident 7 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 7 had impairments on both lower extremities (legs). The MDS indicated Resident 7 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and required substantial assistance from staff for eating and oral hygiene. The MDS indicated Resident 7 was dependent on staff for sitting to standing and for chair to bed transfer. The MDS indicated Resident 7 required substantial assistance from staff for rolling left and right, sitting to lying, and lying to sitting on the side of the bed. During a review of Resident 7's order summary report, dated 2/26/2025, the report indicated bedside railings (1/2) applied on bed due to poor bed mobility and poor trunk control. During a review of Resident 7's bed rail assessment, dated 3/4/2025, the assessment indicated bilateral (pertaining to both sides) side rails were recommended, and side rails were indicated. The assessment indicated the side rails served as an enabler to promote independence. During a review of Resident 7's care plan titled, The resident has high risk for falls, dated 3/4/2025, the care plan interventions indicated the resident needed a safe environment. During a review of Resident 7's Situation, Background, Assessment, Recommendation (SBAR) communication form, dated 3/15/2025, the SBAR communication form indicated on 3/15/2025, Resident 7 fell and was observed sitting on the floor. The SBAR communication form indicated there was a small red lump on Resident 7's forehead but no bleeding noted and Resident 7 stated she did not have pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's bed rail assessment, dated 3/15/2025, the assessment indicated bilateral side rails were recommended, and side rails were indicated and served as an enabler to promote independence. During a review of Resident 7's care plan titled, Resident uses bilateral full side rails for bed mobility and repositioning, dated 3/18/2025, the care plan interventions included monitoring the resident for any signs of discomfort, entrapment, or injury and to regularly check bed rails during ADL care. During a concurrent interview and record review on 3/22/2025 at 1:44 p.m. with RN 1, Resident 7's bed rail assessment, dated 3/4/2025 was reviewed. RN 1 stated the side rail recommendation was for bilateral side rails and side rails were indicated and served as an enabler to promote independence. RN 1 stated side rails were recommended since 3/4/2025 and there was supposed to be side rails at the time of Resident 7's fall on 3/15/2025. During a concurrent interview and record review on 3/23/2025 at 2:04 p.m. with the Director of Nursing (DON), Resident 7's care plan dated 3/4/2025 and 3/18/2025 was reviewed. The DON stated Resident 7's family requested to have side rails for fall precautions and as an enabler because Resident 7 was legally blind and the side rails were for the resident to hold on to when staff provided care. The DON stated there should have been side rails since 3/4/2025 because the bed rail assessment indicated Resident 7 needed side rails. The DON stated Resident 7 did not have side rails at the time of her fall on 3/15/2025. The DON stated the bed rail assessment was created on 3/4/2025 but the bed rail care plan was created on 3/18/2025. The DON stated the care plan should have been done at the time of the assessment and the bed rail care plan was late and so the problem was not addressed and the interventions were not in place. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 8/24/2023, the P&P indicated additional changes or updates to the resident's comprehensive care plan would be made based on the assessed needs of the resident. During a review of the facility's P&P titled, Bed Rails, dated 5/30/2024, the P&P indicated a care plan would be developed regarding the use of bed rails.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on observation, interview, and record review, the facility failed to ensure one of 30 sampled residents (Resident 12) was provided care and services to maintain good grooming and personal hygiene. This deficient practice resulted in Resident 12 not receiving nail care and had the potential to cause an infection or injury from the long fingernails. Findings During a review of Resident 12's Admission Record, dated 3/23/2025, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a change in how the brain works due to a chemical imbalance in the blood), spinal stenosis (a condition when the space inside the backbone is too small), and type 2 diabetes mellitus (a chronic condition when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 12's History and Physical (H&P), dated 2/21/2025, the H&P indicated Resident 12 had fluctuating capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS, a mandated resident assessment tool), dated 3/6/2025, the MDS indicated Resident 12 was able to understand and be understood by others. The MDS indicated Resident 12 was moderately cognitively impaired (ability to think and reason). The MDS indicated Resident 12 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 12 required substantial assistance from staff for ADLS such as upper body dressing, partial assistance from staff for oral hygiene and supervision for eating. The MDS indicated Resident 12 was dependent on staff for sitting to standing and chair to bed transfer and required substantial assistance from staff for rolling left to right, sitting to lying, and lying to sitting on the edge of the bed. During a concurrent observation and interview on 3/22/2025 at 9:55 a.m. with Resident 12, in Resident 12's room, Resident 12 was observed with long fingernails. Resident 12 stated her fingernails were long and no one had offered to trim her nails. Resident 12 stated she wanted her fingernails trimmed. During a concurrent observation and interview on 3/23/2025 at 1:23 p.m. with Certified Nursing Assistant (CNA 5), Resident 12's fingernails were observed. CNA 5 stated Resident 12's nails could be shorter for safety. During an interview on 3/23/2025 at 1:27 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 12's fingernails were long, and dirt and germs could get underneath them. LVN 1 stated Resident 12 could scratch herself which could lead to an infection. LVN 1 stated Resident 12's fingernails could use a trim. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/23/2025 at 1:52 p.m. with the Director of Nursing (DON), Resident 12's fingernails were observed. The DON stated Resident 12's fingernails were really long. The DON stated if the fingernails were long, dirt and bacteria could catch underneath the fingernails and the resident could get an infection from scratching herself or from eating. The DON stated Resident 12 could injure herself or other people if her nails break. The DON stated the CNAs should have noticed Resident 12's nails were long during daily bedside care and if the charge nurse missed the long fingernails, the CNA could report it to the charge nurse and both the CNA and licensed nurse could have spoken to the resident about trimming the nails. The DON stated no one brought up Resident 12's fingernails to her. During a review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, dated 10/21/2021, the P&P indicated fingernails are trimmed by CNAs, except for residents with diabetes or circulatory impairments. The P&P indicated a Licensed Nurse would trim those residents' nails.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to ensure two of seven residents (Resident 43 and Resident 44), with limited range of motion (ROM, the extent of movement of a joint), received restorative nursing program (designed to improve or maintain the functional ability of residents) care five times a week daily as indicated in the physician order. This deficient practice had the potential to place Residents 43 and 44 at increased risk for ROM decline. Findings: a. During a review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including cerebral infarction (blood flow to the brain is interrupted, leading to damage or death of brain tissue), hemiplegia and hemiparesis (hemiplegia refers to complete paralysis on one side of the body, while hemiparesis describes a more mild weakness or partial paralysis on one side), and quadriplegia unspecified (partial or complete loss of motor function in all four limbs). During a review of Resident 43's History and Physical (H&P) dated 10/1/2024, the H&P indicated Resident 43 does not have the mental capacity to understand and make medical decisions. During a review of residents 43's Minimum Data Set (MDS - a mandated resident assessment tool), dated 12/17/2024, the MDS indicated Resident 43 had cognitive impairments (ability to think and reason). The MDS indicated Resident 43 was dependent with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), transfer (moving between surfaces to and from bed, chair, and wheelchair), and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 43's physicians orders dated 9/30/2024, the physicians orders indicated for Restorative Nurses Assistance (RNA) program for passive range of motion (PROM, the movement of a joint by an external force, such as a therapist or a machine, without the patient's active muscle) to the bilateral (pertaining to both sides) lower extremities (BLE) and bilateral upper extremities (BUE) daily 5 times a week as tolerated. During a review of Resident 43's Nursing Rehab/Restorative report dated 2/2025, the report indicated Resident 43 did not receive RNA services on 2/3/2025, 2/4/2025, 2/12/2025, 2/14/2025, 2/17/2025, 2/21/2025, 2/25/2025, 2/26/2025, 2/27/2025, and 2/28/2025 During a review of Resident 43's Nursing Rehab/Restorative report dated 3/2025, the report indicated Resident 43 did not receive RNA services on 3/3/2025, 3/6/2025, and 3/11/2025, (continued on next page)

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	555816	A. Building B. Wing	03/23/2025

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Lawndale Healthcare & Wellness Centre LLC	15100 S Prairie Lawndale, CA 90260

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 43's Weekly Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) progress notes - Restorative Nursing, the progress notes indicated there was no weekly progress notes for the weeks ending 3/7/2025, 3/14/2025 and 3/21/2025. During an interview on 3/23/2025 at 9:56 a.m. with RNA 1, RNA 1 stated Resident 43 received RNA services 5 times a week. RNA 1 stated the services for the upper and lower extremities usually took about 15 minutes. RNA 1 stated the RNAs have a weekly meeting with the Director of Staff Development (DSD) and Director of Nursing (DON) to see if the residents are improving or not and if the residents needed to be referred to the physical therapist (PT). RNA 1 stated the DSD and DON documented the weekly progress notes. b. During an observation on 3/22/2025 at 9:56 a.m. in Resident 44's room, Resident 44 was observed lying in bed. Resident 44's bilateral hands and fingers were contracted (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including muscle wasting and atrophy (loss of muscle mass and strength), degenerative disease of nervous system (disorders that affect the nervous system, causing progressive deterioration and loss of function), and quadriplegia unspecified (partial or complete loss of motor function in all four limbs). During a review of Resident 44's H&P dated 9/17/2024, the H&P indicated Resident 44 does not have the mental capacity to understand and make medical decisions. During a review of residents 44's MDS, dated [DATE], the MDS indicated Resident 44 had cognitive impairments. The MDS indicated Resident 44 was dependent with ADLs and transfer. During a review of Resident 44's physicians orders dated 12/23/2024, the physicians orders indicated RNA program for PROM to the BLE and BUE daily 5 times a week as tolerated. During a review of Resident 44's Nursing Rehab/Restorative report dated 2/2025, indicated Resident 44 did not receive RNA services on 2/3/2025, 2/4/2025, 2/13/2025, 2/17/2025, 2/21/2025, 2/25/2025, 2/26/2025, 2/27/2025, and 2/28/2025. During a review of Resident 44's Nursing Rehab/Restorative dated 3/2025, indicated Resident 44 did not receive RNA services on 3/3/2025, 3/6/2025, and 3/11/2025. During a review of Resident 44's Weekly IDT progress notes - Restorative Nursing, the progress notes indicated there were no weekly progress notes for the weeks ending 3/14/2025 and 3/21/2025. During an interview on 3/23/2025 at 8:00 a.m. with RNA 1, RNA 1 stated Resident 44 received RNA therapy 5 days a week and tolerated all the exercises. RNA 1 stated Resident 44 used a hand roll daily for his hand contractures. RNA 1 stated she had not documented the therapy Resident 44 received. RNA 1 stated the missing days were 3/14/2025 and 3/21/2025 because the DSD was not at the facility. RNA 1 stated, I understand it is not a good reason, but we had not had the weekly meetings. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/23/2025 at 10:47 a.m. with RNA 1, Resident 44's Nursing Rehab/Restorative dated 2/2025 was reviewed. RNA 1 stated every time treatment was done it needed to be documented. RNA 1 stated the orders for RNA services needed to be follow. RNA 1 stated if the order was for 5 days a week, it needed to reflect 5 days of documentation. RNA 1 stated sometimes I forgot to document. RNA 1 stated I know that if I do not document it means that the therapy was not done. RNA 1 stated, I understand the documentation needs to be consistent. During an interview on 3/23/2025 at 10:20 a.m. with the DON, the DON stated it was important to document a weekly progress and therapy provided daily. The DON stated the documented information would indicate how Resident 43 and Resident 44 were doing with the RNA therapy. The DON stated based on the information, the facility can see if the residents needed any recommendations from PT or any changes of condition that needed to be reported. The DON stated the facility needed to prevent Resident 43 and Resident 44 from experiencing a decrease in their mobility. During a review of the facility's policy and procedures (P&P) titled Restorative Aid- Job Description undated, the P&P indicated to document on the RNA sheet daily what was done and how the resident responded. The P&P indicated to summarize this in a weekly progress note and follow the physicians orders as written. During a review of the facility P&P titled Documentation dated 1/1/2012, the P&P indicated Daily RNA charting and weekly documentation will be done on the RNA flow sheet. During a review of the facility's P&P titled Restorative Nursing Program Guidelines dated 9/19/2019, the P&P indicated measurable objectives and interventions are documented in the Care plan and in the medical record. The P&P indicated good clinical practice would indicate that the results of the reassessment should be documented in the residents' medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to provide side rails as ordered for one of 30 sampled residents (Resident 7). This deficient practice caused Resident 7 to fall and had the potential to cause Resident 7 to have injuries from the fall. Findings During a review of Resident 7's Admission Record, dated 3/23/2025, the Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including muscle weakness (decreased strength in the muscles), glaucoma (an eye disease that gradually damages the optic nerve and can lead to blindness), and legal blindness (a significant level of vision loss). During a review of Resident 7's History and Physical (H&P), dated 3/6/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a mandated resident assessment tool), the MDS indicated Resident 7 sometimes understand and was sometimes understood by others. The MDS indicated Resident 7 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 7 had impairments on both lower extremities (legs). The MDS indicated Resident 7 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and required substantial assistance from staff for eating and oral hygiene. The MDS indicated Resident 7 was dependent on staff for sitting to standing and for chair to bed transfer. The MDS indicated Resident 7 required substantial assistance from staff for rolling left and right, sitting to lying, and lying to sitting on the side of the bed. During a review of Resident 7's order summary report, dated 2/26/2025, the report indicated bedside railings (1/2) applied to the bed due to poor bed mobility and poor trunk control. During a review of Resident 7's bed rail assessment, dated 3/4/2025, the assessment indicated bilateral side rails were recommended. The assessment indicated the side rails were indicated and served as an enabler to promote independence. During a review of Resident 7's care plan titled, The resident has high risk for falls, dated 3/4/2025, the care plan interventions indicated the resident needed a safe environment. During a review of Resident 7's Situation, Background, Assessment, Recommendation (SBAR) communication form, dated 3/15/2025, the SBAR communication form indicated on 3/15/2025, Resident 7 fell and was observed sitting on the floor. The SBAR communication form indicated there was a small red lump on Resident 7's forehead but no bleeding noted and Resident 7 stated she did not have pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's bed rail assessment, dated 3/15/2025, the assessment indicated bilateral side rails were recommended, and side rails were indicated and served as an enabler to promote independence. During an interview on 3/22/2025 at 1:27 p.m. with Registered Nurse (RN 1), RN 1 stated on 3/15/2025, RN 1 saw Resident 7 sitting on the floor. RN 1 stated Resident 7 was sitting on the floor and she did not have side rails in place. RN 1 stated Resident 7 did not have side rails until 3/17/2025. During a concurrent interview and record review on 3/22/2025 at 1:44 p.m. with RN 1, Resident 7's bed rail assessment, dated 3/4/2025 was reviewed. RN 1 stated the side rail recommendation was for bilateral side rails to serve as an enabler to promote independence. RN 1 stated side rails were recommended since 3/4/2025 and there was supposed to be side rails at the time of Resident 7's fall on 3/15/2025. During an interview on 3/23/2025 at 2:04 p.m. with the Director of Nursing (DON), the DON stated Resident 7's family requested Resident 7 to have side rails for fall precautions and as an enabler because Resident 7 was legally blind. The DON stated the side rails were for Resident 7 to hold on to when staff provided care. The DON stated there should have been side rails since 3/4/2025 since the bed rail assessment indicated Resident 7 needed side rails but Resident 7 did not have side rails at the time of her fall on 3/15/2025. The DON stated she was not sure how long Resident 7 did not have side rails. The DON stated not having the side rails in place did not honor the family's preference and the side rails could have prevented the fall from occurring. During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated 3/13/2021, the P&P indicated the purpose is to provide residents a safe environment that minimizes complications associated with falls. During a review of the facility's P&P titled Bed Rails, dated 5/30/2024, the P&P indicated the licensed nurse would complete the bed rail evaluation prior to the use and or installation of any bed rail and notify the maintenance department to install the bed rails, inspect fixed bed rail, or remove them as appropriate.

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	555816	A. Building B. Wing	03/23/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on interview and record review, the facility failed to provide sufficient staff for resident care and safety for one of 30 sampled residents (Resident 7). This deficient practice caused a delayed response to care for Resident 7 after Resident 7's fall and the potential to affect the entire facility. Findings During a review of Resident 7's Admission Record, dated 3/23/2025, the Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including muscle weakness (decreased strength in the muscles), glaucoma (an eye disease that gradually damages the optic nerve and can lead to blindness), and legal blindness (a significant level of vision loss). During a review of Resident 7's History and Physical (H&P), dated 3/6/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a mandated resident assessment tool), the MDS indicated Resident 7 sometimes understand and was sometimes understood by others. The MDS indicated Resident 7 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 7 had impairments on both lower extremities (legs). The MDS indicated Resident 7 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and required substantial assistance from staff for eating and oral hygiene. The MDS indicated Resident 7 was dependent on staff for sitting to standing and for chair to bed transfer. The MDS indicated Resident 7 required substantial assistance from staff for rolling left and right, sitting to lying, and lying to sitting on the side of the bed. During a review of Resident 7's Situation, Background, Assessment, Recommendation (SBAR) communication form, dated 3/15/2025, the SBAR communication form indicated on 3/15/2025, Resident 7 fell and was observed sitting on the floor. The SBAR communication form indicated there was a small red lump on Resident 7's forehead but no bleeding noted. Resident 7 stated she did not have pain. During a review of the facility's Census and Direct Care Service Hours Per Patient Day (DHPPD), dated 3/15/2025, the scheduled Certified Nursing Assistant (CNA) direct hours of care per patient day was 2.4 but the actual CNA direct hours of care per patient day was 1.75. During a review of the facility's staff assignments, dated 3/15/2025, the staff assignments indicated on 3/15/2025, only four CNAs worked the morning shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/23/2025 at 3:50 p.m. with the Director of Nursing (DON), the DON stated on 3/15/2025, there were supposed to be seven CNAs scheduled to work the morning shift but only had four CNAs working. The DON stated Resident 7's assigned CNA was with another resident at the time of the resident's fall. The DON stated another CNA was the one that saw Resident 7 on the floor. The DON stated the progress notes did not specify how long Resident 7 was on the floor, and by having only four CNAs, that could have led to a delayed response to tend to Resident 7. The DON stated Resident 7 had a bump on her head and was sent to the hospital but was negative for any findings. During a review of the facility's policy and procedure (P&P) titled, Resident Safety, dated 4/15/2021, the P&P indicated to observe the safety and well being of the residents, a resident check would be made at least every two hours around the clock by nursing service personnel and any staff member who identifies an unsafe situation, practice, or environmental risk factors should immediately notify their supervisor or charge nurse.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45657 Based on observation, interview, and record review, the facility failed to follow the pureed diet (diet that involves consuming foods that are blended, mashed, or strained to a smooth, pudding-like consistency, making them easier to swallow for individuals with chewing or swallowing difficulties) recipe during breakfast by serving liquid consistency French toast. This deficient practice had the potential to result in inadequate nutrition status and placed the residents at a high risk of choking (person can not breath due to blocked airway). Findings: During a concurrent observation and interview on 3/22/2025 at 7:32 a.m. with [NAME] 1, [NAME] 1 was observed plating a pureed diet, which consisted of pureed French toast and pureed eggs. The French toast plated in a cup was liquidly. [NAME] 1 stated the plate was a pureed diet and the bread should have more consistency and not be as watery. [NAME] 1 stated he would add more bread and blend it to make it the French toast pureed. [NAME] 1 was observed blending more French toast with milk to get more a pureed consistency. [NAME] 1 did not follow or review the pureed recipe. [NAME] 1 stated it was important to do it right for the residents safety and to avoid any problems with choking. During an interview on 3/23/2025 at 1:34 p.m. with the Kitchen Supervisor (KS), the KS stated the recipes were to be followed by the cook. The KS stated when preparing pureed diets, the preparation needed to be done as described in the recipe. The KS stated it was important to follow the recipe to maximize the residents nutrition. The KS stated the puree consistency must be like pudding and a smooth consistency. The KS stated if the food was not pureed it would be difficult for residents with a stroke (a medical emergency that occurs when blood flow to the brain is interrupted) to swallow. The KS stated not preparing the food correctly could cause a loss of nutrients and it would not be appealing look for residents. During an interview on 3/23/2025 at 3:25 p.m. with the Director of Nursing (DON), the DON stated a pureed diet was mashed, ground, grinded, or blended and did not have a watery or liquid consistency. The DON stated residents could choke with a liquid pureed diet. The DON stated resident were at risk of aspiration (the accidental inhalation of foreign substances, such as food, liquid, or saliva, into the lungs). The DON stated the cook must follow the recipe for a pureed diet to prevent any accidents. During a review of the facility's policy and procedures (P&P) titled Recipe: Pureed Level 4 Breads, dated 2024, the P&P indicated the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation practices in the kitchen when: 1. The cook (Cook 1) and dietary aid (DA) were not wearing a mask while plating breakfast trays. 2. The DA did not change gloves when returning to the tray line (a system of food preparation, used in hospitals, in which trays move along an assembly line) after touching non-food items. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness for residents who received food from the kitchen. 3. Expired foods were stored in the kitchen and accessible for use while preparing foods. This deficient practice had the potential to result in the residents ingesting expired food and the potential for foodborne illnesses leading to symptoms such as nausea, vomiting, stomach cramps, and diarrhea, and a decrease in food flavoring and taste. Findings: a. During an observation of the tray line service for breakfast on [DATE] at 7:12 a.m., [NAME] 1 and the DA were observed plating breakfast trays without wearing a mask. b. During a concurrent observation and interview on [DATE] at 7:30 a.m. with the DA, the DA was observed at the tray line wearing gloves. The DA was then observed touching items from the dry food storage and returning to the tray line to plate food without washing his hands or changing gloves. The DA stated it was important to change gloves while in contact with food items during the tray line due to cross contamination. c. During an observation on [DATE] at 11:00 a.m., of the bread rack, one package of sliced bread was observed with an expiration date of [DATE] and one package of sliced bread had no labeled expiration date. During an observation on [DATE] at 11:05 a.m., in the dry food storage, observed two bags of mini marshmallows with an expiration date of [DATE], ground cumin spice container with an expiration date of [DATE], pumpkin pie spice container with an expiration date of [DATE], mustard flour container with an expiration date of [DATE] and one box containing 12 cartons of 1% Low-fat chocolate milk with an expiration date of [DATE]. During an interview on [DATE] at 10:30 a.m. with the DA, the DA 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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during breakfast on [DATE], [NAME] 1 and the DA forgot to use a face mask while plating breakfast trays. The DA stated it was necessary to use a face mask while food handling for the prevention of the transmission of any contagious diseases. The DA stated a face mask should be always used during food handling. The DA stated he did not change his gloves when he left the tray line to get more items from the storage room. The DA stated it was important to change gloves due to cross contamination. The DA stated every time he went to another zone, he must wash his hands and change his gloves to prevent food contamination and prevent the risk of acquiring any diseases. During an interview on [DATE] at 1:34 p.m. with the Kitchen Supervisor (KS), the KS stated staff that work in the kitchen need to wear a face mask while serving food. The KS stated gloves were changed after finishing any tasks. The KS stated hands needed to be washed and clean gloves applied for infection control prevention and cross contamination. The KS stated if the staff failed to follow the guidelines the residents could be at risk of gastrointestinal (GI) problems, such as abdominal pain or loose stool. The KS stated it was the facility's responsibility to protect the residents' health. The KS stated when food products are received, the products are stamped with the date that was received. The KS stated she usually checked the products for expiration dates. The KS stated giving expired products to residents could cause GI problems and infection. During an interview on [DATE] at 3:25 p.m. with the Director of Nursing (DON), the DON stated the facility policy was to wear a face mask while preparing food due to infection control. The DON stated the if the food must be clean and uncontaminated from any foreign particles. The DON stated the expired food concussion will cause a health hazard. The DON stated residents can developed nausea, vomiting, diarrhea symptoms of food poisoning. During a review of the facility's policy and procedure (P&P) titled Dry Goods Storage Guidelines, dated 2018, the P&P indicated do check expiration dates on boxes or containers to be sure the length of time is correct. During a review of the facility's P&P titled Gloves use Policy, dated 2020, the P&P indicated the appropriate use of gloves is essential in preventing food borne illness. The P&P indicated gloves need to be changed before beginning a different task. During a review of the facility's P&P titled Respiratory Protection Program, dated [DATE], the P&P indicated the employee is responsible for being aware of the respiratory protection requirements for their work areas. The P&P indicated wearing the appropriate respiratory protection according to manufactures instructions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation and interview, the facility failed to implement infection control interventions to prevent the spread of germs in accordance with the facility's Respiratory Protection Program policy and procedure (P/P) impacting 57 of 57 residents and staff, with the improper wear of a N95 (a type of filtering facepiece respirator designed to provide protection from inhaling certain airborne particles) Respirator Mask while in a resident care area. This deficient practice had the potential to lead to the spread of COVID 19 (infectious disease caused by the SARS-CoV-2 virus) to residents and staff. Findings: During an observation on 3/22/2025 at 2:50 p.m., observed Certified Nurse Assistant (CNA 1) entering room [ROOM NUMBER] with a N95 respirator. The string was hanging to the front of the mask. During an interview on 3/22/2025 at 2:55 p.m., with CNA 1, CNA 1 stated she had entered room [ROOM NUMBER] wearing her mask improperly and that wearing the mask with the string to the front did not provide a proper seal and could lead to germs entering or escaping causing further spread of COVID 19. CNA 1 stated she was supposed to place the first string of the mask at the nape (back of the neck) of her head and the second string at the crown of her head. CNA 1 stated she needed to ensure there was a tight seal and blow air to ensure there was no air escaping. During an interview on 3/22/2025 at 3:09 p.m., with the Infection Prevention Nurse (IP), the IP stated she would do a re-in-service training for staff on the proper method of wearing an N95 respirator to prevent the spread of germs and COVID 19. During a review of the facility's policy and procedure (P&P) titled Respiratory Protection Program, dated 9/9/2021, P&P indicated the respirator shall not be used in a manner for which it is not certified by NIOSH ([National Institute for Occupational Safety and Health] federal agency that conducts research and makes recommendations to prevent work-related injuries and illnesses) or by its manufacturer. The P&P indicated all employees shall conduct positive and negative pressure user seal checks each time they wear a respirator.

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	03/23/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach and accessible for one out of one sampled resident (Resident 8) who needed assistance. This deficient practice resulted in Resident 8 feeling unheard and forgotten while screaming for assistance. Findings: During a review of Residents 8's Admission Record, the Admission Record, indicated Resident 8 was originally admitted to the facility on [DATE], with diagnoses including a history of muscle weakness and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 8's History and Physical (H/P), dated 3/12/2025, the H/P indicated Resident 8 could make needs known but could not make medical decisions. During a review of Resident 8's Care plan titled High Risk for Falls dated 3/12/2025, the care plan's interventions included to place the resident's call light within reach and encourage the use of the call light. During a review of Resident 8's Minimum Data Set ([MDS] a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 8 usually had the ability to understand and be understood by others. The MDS indicated Resident 8 required substantial assistance for eating and oral hygiene and was dependent for bed mobility, toileting hygiene, showering/bathing, dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 3/22/2025 at 7:57 a.m., with Resident 8, observed Resident 8 screaming for help. Resident 8 stated he did not know where the call light was. Resident 8's roommate pressed his own call light to get assistance for Resident 8. During a concurrent observation and interview on 3/22/2025 at 8:12 a.m., with Certified Nurse Assistant (CNA 2), observed CNA 2 looking for Resident 8's call light. CNA 2 found the call light on the floor in which the clip on the call light was broke. CNA 2 stated that was the reason the call light had fallen on the floor. CNA 2 stated not having a call light within reach could lead to accidents such as Resident 8 falling from the bed or leave the resident feeling neglected. During an interview on 3/22/2025 at 8:15 a.m. with Resident 8, Resident 8 stated the clip on the call light had been broken for three days. Resident 8 stated he had to scream for help every day and that made him feel angry and forgotten. (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	03/23/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/23/2025 at 7:52 a.m., with Resident 8 and CNA 3, observed Resident 8 was screaming for help. Resident 8 stated he could not find his call light. Resident 8's roommate was observed using his call light to call the staff on Resident 8's behalf. CNA 3 entered the room and stated she was not assigned to Resident 8, but she noticed the call light and entered to assist the resident. CNA 3 stated the call light was supposed to be on the bed, but it kept falling. CNA 3 stated the call light did not have a clip which was why the call light kept falling. CNA 3 stated she did not know long the clip had been broken. CNA 3 stated not having the call light within reach could lead to an accident. During an interview on 3/23/2025 at 9:15 a.m. with the Maintenance Director, the Maintenance Director stated he had plenty of clips for the call lights and he was just told that morning (3/23/2025) about Resident 8's call light. During a review of the facility's policy and procedures (P/P) titled Communication - Call System, revised 8/24/2024, the P/P indicated the call alert device would be placed within the resident's reach. The P/P indicated if the call alert system was defective, it would be reported to maintenance for immediate repair. The P&P indicated if the call system could not be repaired immediately, an alternative call alert process would be put in place (i.e. tap bells, auxiliary aids, etc.).