

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Lawndale Healthcare & Wellness Centre LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure for 52 of 56 medically compromised and vulnerable residents who received food from the kitchen: Ensure personal water bottle were not kept at dry storage area. Ensure opened disinfecting wipes were not kept at dry storage area. Ensure expired food items were removed from the kitchen area. Ensure test strips used to test sanitation strength were not expired. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins). Findings: 1. During a concurrent observation and interview on 1/20/2026 at 8:20 a.m., with the Dietary Food Supervisor (DSS), found personal water bottle kept at dry storage area. The DSS stated no staff personal items should be kept at dry storage area due to possible cross contamination with facility food for residents. 2. During a concurrent observation and interview on 1/20/2026 at 8:25 a.m., with the DSS, found one opened disinfecting wipes at the dry storage area. The DSS stated all disinfecting wipes, and chemical solution should be placed in the designated chemical room due to possible cross contamination with the food items in the dry storage area. During a review of the facility's policy and procedure (P&P) titled, Storage of Food and Supplies, undated, the P&P indicated, Food storage areas should be used only for food and items such as bleach, soap, and other cleaning supplies should be stored in entirely separate and specific areas. 3. During a concurrent observation and interview on 1/20/2026 at 8:30 a.m., with the DSS in the kitchen, there were expired food items as follows: 9 cans of prune juice from concentrate with received date on 4/10/2025 with best buy date on 11/10/2025. 4 bags of hotdog buns with best buy date of 1/6/2026. The DSS stated dietary staff are responsible in checking all the food items in the kitchen making sure they are not expired. The DSS stated using food items past their best buy date could cause abdominal discomforts to residents that would jeopardize their health and safety. During a review of the facility's P&P titled, Dietary Department-General, dated 6/1/2024, the P&P indicated, The Primary objective of the dietary department includes maintenance of standards for quality of food. During a review of the facility's P&P titled, Storage of Food and Supplies, undated, the P&P indicated, All food products will be used per the times specified in the Dry Food Storage Guidelines. The Dry Food Storage Guidelines indicated bread to be used 5-7 days, and no food will be kept longer than the expiration date on the product. 4. During a concurrent observation and interview on 1/21/2026 at 9:28 a.m., in the kitchen dishwashing machine area, Dietary Aide 2 (DA 2) tested the dishwashing machine sanitation running water after it was sanitized with chlorine test paper strip (used to test commercial dishwasher for proper sanitation level). DA 2 stated the chlorine test paper strip bottle indicated an expiration date of 8/2025. DA 2 stated he forgot to check the expiration date of the chlorine test paper strip. During an interview on 1/21/2026 at 9:41 a.m., with the DSS, the DSS stated using an expired chlorine test paper strip will give an inaccurate reading and the plates and utensils won't be properly sanitized and putting residents at risk for infection. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Code#4-501.114, indicated Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility failed to: 1. Follow its' policy and procedures for the testing of Legionella (a serious type of pneumonia caused by Legionella bacteria found in [NAME] environments that can thrive in human-made water systems) and other opportunistic waterborne pathogens within the facility's water systems. This deficient practice had the potential to cause residents and staff to become ill with Legionnaire's disease or other opportunistic waterborne pathogens. Findings: During a review of the facility's water management binder, on 1/23/2026 at 8:25 a.m., the water management binder was observed to have blank testing logs for Legionella and other water pathogens. The facility's water management binder only contained 2 annual receipts for water backflow testing (a test used to check if plumbing valves are working to prevent contaminated water from flowing backward into the clean water supply) from the city's water company. During an interview, on 01/23/2026 at 8:30 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated the city's water company came out to the facility for water backflow testing in 2024 and 2025. The IPN stated she did not know if the city's water company tested for Legionella or other opportunistic waterborne pathogens. The IPN stated the facility did not have any documentation to show testing was completed. During an interview, on 01/23/2026 at 10:36 a.m., with the Administrator (Adm), the Adm stated the facility had their water backflow tested by the city's water company. The Adm stated he was not sure if the water was tested for Legionella and/or other waterborne pathogens. The Adm stated he was under the impression that testing was being done but said it was not. During an interview, on 01/23/2026 at 10:51 a.m., with the Maintenance Supervisor (MS), the MS stated there were no invoices that stated the company had tested for Legionella or other waterborne bacteria in the facility's water supply. The MS stated the facility's water should be tested every year for Legionella or any other waterborne pathogens. The MS stated the risk of not testing the facility's water supply for Legionella and other waterborne pathogens could result in water containing bacteria, virus, fungi and mold growth placing the residents at risk of becoming ill. During a review of the facility's policy and procedures (P&P), titled Water Management, dated 12/22/2025, the P&P indicated, The team leader will survey the facility using a risk assessment to determine its risk for Legionella growth and spread.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure: 1. Registered Nurse (RN) 2 was competent in securing medication and preparation when administering medications to Resident 27. 2. The facility failed to ensure annual competencies were dated and completed for five out of six randomly selected staff members. These deficient practices had the potential for staff not securing medications, providing accurate medications to the residents and inconsistent competency assessments. Findings: a. During a review of 6 employees' files, on 01/22/2026 1:16 p.m., a random audit was conducted for Certified Nurse Assistant 2 (CNA 2), CNA 3, CNA 4, Licensed Vocational Nurse 3 (LVN 3), LVN 4 and Registered Nurse 2 (RN 2) on mandatory orientation and annual (yearly) staff competencies. CNA 4 did not have any issues with the facility's orientation and annual competencies. CNA 2 had missing dates for CNA Skills Competency Log, Repositioning Competency, Mechanical Lift Competency and Sit-to-Stand Competency Log. CNA 3 had missing dates and no scores listed for Confidentiality/HIPPA Written Competency, Palliative Care/End of Life Written Competency and Change in Condition Written Competency. LVN 3 did not have any competencies for the years 2024, 2025 and 2026 in his employee file. LVN 3's last competency tests were completed in 2023. LVN 4 had a missing date for New Employee General Orientation Checklist. RN 2 had missing dates for Blood Glucose Monitoring Observations Competency, Intramuscular Injection Observational Competency, Enteral Feeding Tube Observational Competency and Nurse Medication Pass Competency. During a concurrent interview and record review, on 1/22/2026 at 1:45 p.m., with the Director of Staff Development (DSD), the DSD stated all competencies were to be completed for staff upon hire during orientation and annually. The DSD stated all competencies were to be signed and dated upon completion. The DSD stated the risk of undated and incomplete competencies could result in staff being unable to provide necessary care at a competent level and not knowing when or if a competency skill was completed. b. During a review of Resident 27's admission Record (face sheet), the admission Record indicated the facility admitted the resident on 12/11/2023 and readmitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 27's History and Physical (H&P) dated 11/8/2025, the H&P indicated the resident did not have the capacity to understand or make decisions. During a review of Resident 27's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated Resident 27 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 27 was dependent on staff for eating, toileting and bathing. During a concurrent observation and interview on 1/22/2026 at 8:05 a.m. with Registered Nurse (RN) 2 in front of Resident 27's room, a medication cup with four unlabeled medications was observed on RN 2's medication cart. RN 2 stated the medications in cup were for Resident 27, but Family Member (FM) 1 requested medications to be administered after breakfast. RN 2 placed the medication cup with unlabeled medications back into medication cart. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/22/2026 at 9:00 a.m., RN 2 was observed preparing Resident 27's medications and took out the unlabeled medication cup from the medication cart. RN 2 stated she will use the medications she prepared at 8:00 a.m. and continued to prepare the rest of the medications that were to be given at this time. During a concurrent interview and record review on 1/23/2026 at 9:22 a.m. with the Director of Nursing (DON), RN 2's Nurse Medication Pass Competency was reviewed. The Nurse Medication Pass Competency indicated RN 2 demonstrated competency with all Medication Pass tasks, but did not have a date for when competency was completed. The DON stated competencies are completed for nursing staff upon hire, annually and as needed. The DON stated competencies that are undated place staff at risk for not being evaluated consistently. The DON stated leaving medications unattended on medication cart and preparing unlabeled medications an hour before administration does not demonstrate competency in medication administration. The DON stated nurses that do not demonstrate competency in medication administration place residents at risk for medication errors. During a review of facility policy and procedure (P&P) titled Staff Competency Validation dated 3/28/2024, the P&P indicated, Staff are required to have competency validation based on their job description or assigned duties.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation and interview, the facility failed to:1.Ensure resident rights were protected from a noisy environment caused by Resident 25 yelling and screaming for one of six sampled residents (Resident 52).This deficient practice resulted in a violation of resident rights.Findings:a. During a review of Resident 52's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 52 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52 diagnoses' list included rheumatoid arthritis (a chronic, systemic autoimmune disease where the immune system mistakenly attacks healthy joint tissue), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (the long-term, progressive, and irreversible loss of kidney function, lasting 3 months or more) and polyneuropathy (a disease or disorder that causes damage to multiple peripheral nerves simultaneously). During a review of Resident 52's Minimum Data Set (MDS- a federally mandated resident assessment tool, dated 11/14/2025, the MDS indicated Resident 52's cognitive (thinking) skills were intact. The MDS also indicated Resident 52 was dependent on staff members with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). b. During a review of Resident 25's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 25's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 25's history and physical (H&P) form, dated 11/26/2025/2025, the H&P indicated Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/1/2025, the MDS indicated Resident 25's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 25 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview, on 1/20/2026 at 9:42 a.m., with Resident 52, Resident 52 stated there was a resident (Resident 25) down the hall from him who would scream loudly every 3-5 minutes every day and night for hours. Resident 52 stated the only time Resident 25 did not scream was when Resident 25 was asleep which would last for 30 minutes at a time. Resident 52 stated he informed the staff about Resident 25's screaming, but nothing had been done. Resident 52 stated Resident 25's screaming made him feel uncomfortable and angry especially when he would try to sleep. During an interview, on 1/22/2026 at 12:14 p.m., with Registered Nurse 2 (RN 2), RN 2 stated the protocol for a loud and noisy resident was to talk to the loud resident and attempt to redirect to stop the behavior. RN 2 stated if redirection did not work for the resident, another solution was to administer medication as ordered. RN 2 stated Resident 52 had complained previously about Resident 25's constant yelling. RN 2 stated the facility received a physician's order for medication related to Resident 25's constant screaming but Resident 25 hadn't been administered the prescribed medication. RN 2 stated a noisy environment due to a yelling resident could affect other residents as they would not be able to sleep, violating their resident's rights. During a review of the facility's policy and procedures (P&P), titled Residents Rights, dated 1/1/2012, the P&P indicated, Residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care, subject to the Facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:Ensure one out of 14 sampled residents (Resident 6) was provided a homelike environment and did not have chipped paint on the bathroom door.This deficient practice of not providing a homelike environment for Resident 6 had the potential to negatively impact her quality of life.Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), muscle weakness, and neuralgia (intense, sharp, or stabbing pain caused by damage, irritation, or compression of nerve).During a review of Resident 6's History and Physical (H&P), dated 7/20/2025, the H&P indicated, Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/2/2025, the MDS indicated, Resident 6 was independent (decisions consistent/reasonable) on cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 6 had the ability to make self-understood and understand others. The MDS indicated, Resident 6 was dependent (helper does all of the effort) from staff with toileting hygiene and lower body dressing.During a concurrent observation and interview on 1/20/2026 at 10:01 a.m., with Resident 6 in her room, there was scattered chipped paint on the bathroom door. Resident 6 stated she had already informed the management about the scattered chipped paint on the bathroom door, but nothing had been done. Resident 6 stated she felt depressed and it was not a homelike environment seeing scattered peeling chipped paint in her room.During an interview on 1/21/2026 at 12:54 p.m., with the Maintenance Supervisor (MS), the MS stated Resident 6's bathroom door needs to be repaired and painted. The MS stated he did not have a log to show that Resident 6's room was maintained in a sanitary condition.During an interview on 1/21/2026 at 2:20 p.m., with the Administrator in Training (AIT), the AIT stated it is not aesthetically (the look and feel of things as they are presented to the senses) pleasing for having a chipped paint on resident's room.During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, dated 1/1/20212, the P&P indicated, To provide residents with a safe, clean, comfortable and home like environment.During a review of the facility's P&P titled, Resident Rights-Accommodation of Needs, dated 1/1/20212, the P&P indicated, To ensure that the facility provides an environment and services that meet resident's individual needs.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility failed to: 1.Report to the California Department of Public Health (CDPH- the state department responsible for public health in California) of an abuse allegation for one of three sampled residents (Resident 16). This deficient practice resulted in a delay of an onsite inspection by CDPH and had potential to place residents at risk for abuse.Findings: During a review of Resident 16's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 16 was admitted on [DATE] and readmitted on [DATE]. Resident 16's diagnoses list included psychosis (a severe mental condition in which thoughts and emotions are so affected that contact is lost with reality), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (apprehensive uneasiness or nervousness usually over an impending or anticipated misfortune) and cerebral infarction (stroke). During a review of Resident 16's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/23/2025, the MDS indicated Resident 16's cognitive (thinking) skills were moderately impaired. The MDS indicated Resident 16 required maximal assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 16's Change of Condition (COC form), dated 11/20/2025, the COC note indicated staff noted bruising to the resident's left forearm and hand during rounds and notified the charge nurse. The COC indicated bruising on the left forearm appeared reddened to purplish with no swelling, open areas, or pain. The COC indicated when asked what happened, Resident 16 stated 'staff beat me' but could not provide names or details. The COC indicated Resident 16 frequently bangs her bed remote on the rails to gain attention which may contribute to bruising. The COC form indicated Resident 16 had a history of vague or exaggerated stories about being hurt. During an interview, on 1/23/2026 at 11:19 a.m., with Resident 16, Resident 16 stated she could not recall being hit on 11/20/2025. Resident 16 stated she felt safe at the moment. During an interview, on 1/23/2026 at 2:15 p.m., with the Director of Nursing, (DON), the DON stated on 11/20/2025, Resident 16 stated staff had hit her on her arms. The DON stated she called and informed the police and ombudsman. The DON stated she reported the abuse allegation to the Administrator who stated he would report the allegation to the appropriate agencies. The DON stated the time frame for reporting abuse was within 2 hours. The DON stated the risk of not reporting in a timely manner could result in further abuse. During an interview, on 1/23/2026 at 2:35 p.m., with the Administrator (Admin), the Admin stated he reported Resident 16's November 2025 abuse allegation but couldn't provide any documentation or evidence to show that the facility reported in a timely manner. the report for abuse allegations in [DATE] for [NAME]. The Admin stated he was responsible for reporting abuse allegations within 2 hours. The Admin stated the three agencies that the facility was supposed to report to were the ombudsman, LAPD (law enforcement) and CDPH. The Admin stated the risk of not reporting abuse allegations in a timely manner could result in harm to other residents if it is not reported. During a review of the facility's policy and procedures (P&P), titled Abuse Prevention and Management, dated 6/12/2024, the P&P indicated, The Administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practicably possible, but no longer than (2) hours of an initial report AND send a written SOC341 report to the Ombudsman, Law Enforcement, and CDPH Licensing and Certification within (2) hours.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:Ensure a physician order to wear lumbosacral orthosis ([LSO] - a back brace that supports the lower spine and sacrum (large, triangular bone at the base of the spine) when out of bed was followed for one of one sampled resident (Resident 38).This deficient practice had the potential to place Resident 38 for increased pain and muscle spasms.Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 38's diagnoses included low back pain, chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 38's History and Physical (H&P), dated 1/12/2026, the H&P indicated, Resident 38 can make needs known but could not make medical decisions.During a review of Resident 38's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/6/2026, the MDS indicated, Resident 38's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor). The MDS indicated, Resident 38 had the ability to make self-understood and understand others. The MDS indicated, Resident 38 required setup assistance (helper assists only prior to or following the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of Resident 38's care plan, titled Resident may wear LSO when out of bed for back pain, dated 1/19/2026, indicated goal for resident to use LSO brace as ordered to maintain spinal support and improve mobility, until next reviews in 3 months. The care plan intervention included to apply LSO brace as ordered.During a review of Resident 38's Physician Progress Notes, dated 1/19/2026, the Physician Progress Notes indicated, per therapy team patient intermittently wears LSO brace when out of bed and appears to help with his pain.During a review of Resident 38's Order Summary Report (a document containing active orders), dated 1/20/2026, the Order Summary Report indicated the physician placed a telephone order on 1/12/2026 for Resident 38 to wear LSO when out of bed for back pain.During a concurrent observation and interview on 1/21/2026 at 2:00 p.m., in the activity room, observed Resident 38 with no LSO brace. Resident 38 stated the nurse did not put his back brace and he is supposed to use it every day. Resident 38 stated he has back pain and he needs his brace to reduce his pain.During an interview on 1/21/2026 at 2:18 p.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated she was not aware that Resident 38 needs the back brace when he gets out of bed.During an interview on 1/21/2026 at 2:30 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she was not aware that Resident 38 has a physician order to wear LSO brace when he gets out of bed.During an interview on 1/21/2026 at 2:45 p.m., with the Physical Therapist (PT), the PT stated the physician of Resident 38 made the determination for Resident 38 to wear LSO brace when out of bed. The PT stated the physician order should be followed. The PT stated she believed that Resident 38 needs the LSO brace only for comfort measures only and it may or may not relieve his pain.During an interview on 1/23/2026 at 8:49 a.m., with the Director of Nursing (DON), the DON stated Resident 38's physician prescribed the LSO brace for Resident 38 as conservative treatment (any therapy that does not involve pharmacological or surgical intervention) to minimize his pain. The DON stated failure to follow physician order for Resident 38 to wear LSO brace when out of bed would result in more discomfort that could affect his quality of life.During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Quality of Life, dated 3/2017, the P&P indicated, To ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.		

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NAME OF PROVIDER OR SUPPLIER Lawndale Healthcare & Wellness Centre LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 S Prairie Lawndale, CA 90260	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1.Ensure low air loss mattresses settings were correct for one of six sampled residents (Resident 1). This deficient practice had the potential to result in further skin breakdown.Findings: During a review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses included acute respiratory failure (a sudden, life-threatening syndrome where the respiratory system fails to properly oxygenate the blood or remove carbon dioxide), sepsis (a life-threatening blood infection), schizophrenia (a mental illness that is characterized by disturbances in thought) and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's history and physical (H&P) form, dated 12/17/2025, the H&P indicated Resident 1 had the capacity to make needs know but not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/23/2025, the MDS indicated Resident 1's cognitive (thinking) skills were moderately impaired. The MDS also indicated Resident 1 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation, on 1/20/2026 at 2:21 p.m., Resident 1 was observed lying in bed on a low air loss mattress with weight settings at 450 pounds. During a record review, on 1/20/2025 at 3:01 p.m., of Resident 1's weight, Resident 1's weight indicated he weighed 197 pounds. During a observation, on 1/22/2026 at 9:31 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 1's low air loss mattress was set to 450 pounds. During a concurrent interview and observation, on 1/22/2026 at 9:34 a.m., with LVN 2, LVN 2 stated all low air loss mattresses settings was based on a resident's weight in pounds. LVN 2 stated the purpose of a low air loss mattress was to prevent further skin breakdown in residents with pressure ulcers or skin issues. LVN 2 stated that Resident 1 weighed 197 pounds. LVN 2 stated Resident 1's low air loss mattress setting was incorrect. LVN 2 stated the risk of setting a low air loss mattress on a wrong weight or setting could result in further skin breakdown. During a review of the facility's policy and procedures (P&P), titled Mattresses, dated 1/1/2012, the P&P indicated, 1. The Facility will provide mattresses capable of meeting the following needs of residents: B. To provide stimulation and pressure relief to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure.		

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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** Based on interview and record review, the facility failed to:Ensure smoking assessment was completed accurately for one of one sampled resident (Resident 38).This deficient practice had the potential to place Resident 38 at risk for injury and inadequate care planning.Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 38's diagnoses included low back pain, chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs), and nicotine (cigarette) dependence.During a review of Resident 38's History and Physical (H&P), dated 1/12/2026, the H&P indicated, Resident 38 can make needs known but could not make medical decisions.During a review of Resident 38's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/6/2026, the MDS indicated, Resident 38's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor). The MDS indicated, Resident 38 had the ability to make self-understood and understand others. The MDS indicated, Resident 38 required setup assistance (helper assists only prior to or following the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 38's care plan, titled Risk for injury related to smoking, resident is an assisted smoker requiring supervision, dated 1/11/2026, indicated goal for resident not to suffer injury from unsafe smoking practices, until next reviews in 3 months. The care plan intervention included to conduct smoking safety evaluation on admission and as needed.During an interview on 1/21/2026 at 1:15 p.m., with Activity Assistant 1 (AA 1), AA 1 stated Resident 38 needed supervision during smoking.During a concurrent interview and record review on 1/22/2026 at 10:41 a.m., with the Minimum Data Set Nurse (MDSN), Resident 38's Smoking and Safety assessment, dated 1/11/2026, was reviewed. The MDSN stated Resident 38's Smoking and Safety assessment, indicated Resident 38 is an independent smoker. The MDSN stated Resident 38's Smoking and Safety assessment was not completed accurately. The MDSN stated there should be a checked mark on Smoking and Safety assessment number 6 (balance problems while sitting or standing) and number 14 (unable to light tobacco or other smoking products safely). The MDSN stated Resident 38 needs to be supervised during smoking because he has poor cognition. The MDSN stated it is important to complete the Smoking and Safety assessment accurately for the safety of the resident and the facility.During an interview on 1/23/2026 at 9:11 a.m., with the Director of Nursing (DON), the DON stated Smoking and Safety assessment is a tool to identify the status of the resident if he could smoke cigarette safely. The DON stated inaccurate smoking assessment of resident could lead to fire.During a review of the facility's policy and procedure (P&P) titled, Smoking by Residents, dated 8/18/2023, the P&P indicated, The facility will accommodate residents who smoke and will take reasonable precautions by providing a safe environment and protecting the non-smoking residents.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure two liters of oxygen was administered as ordered by physician for two of ten sampled residents (Resident 1 and Resident 23). This deficient practice had the potential to place residents at risk for not receiving oxygen therapy as prescribed by the physician and complications such as decreased breathing drive (result of too much oxygen in the body reducing the urge to breathe) and carbon dioxide retention (less breathing resulting in less carbon dioxide exhalation and increase of carbon dioxide in blood). a. During a review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses included acute respiratory failure (a sudden, life-threatening syndrome where the respiratory system fails to properly oxygenate the blood or remove carbon dioxide), sepsis (a life-threatening blood infection), schizophrenia (a mental illness that is characterized by disturbances in thought) and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's physician orders, dated 12/16/2025, the physician orders indicated Resident 1 was to receive oxygen at 2 liters per minute via nasal cannula to keep oxygen saturation at 92% or above every shift for shortness of breath. During a review of Resident 1's history and physical (H&P) form, dated 12/17/2025, the H&P indicated Resident 1 had the capacity to make needs know but not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/23/2025, the MDS indicated Resident 1's cognitive (thinking) skills were moderately impaired. The MDS also indicated Resident 1 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation, on 1/20/2026 at 2:22 p.m., Resident 1 was observed lying in bed with oxygen running at 3 liters per minute via Resident 1's nasal cannula. During an observation, on 1/22/2026 11:58 a.m., with Registered Nurse 2 (RN 2), RN 2 stated Resident 1's oxygen was running at 3 liters per minute via nasal canula. During a concurrent interview and record review, on 01/22/2026 12:19 p.m., with Registered Nurse 2 (RN 2), RN 2 stated the protocol for oxygen was to obtain a physician's order and follow the instructions given by the physician. RN 2 stated Resident 1 had a physician order for oxygen at 2 liters per minute via nasal cannula keep O2 sat above 92%. RN 2 stated Resident 1 should not have received 3 liters of oxygen. RN 2 stated Resident 1 should've been receiving 2 liters as stated in the physician's order. RN 2 stated the risk of administering more oxygen than ordered could result in a decline in a resident breathing status. b. During a review of Resident 23's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 7/17/2024 with diagnoses including pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's History and Physical (H&P) dated 1/9/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 23 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 23 was dependent on staff for toileting and required substantial assistance from staff for bathing and personal hygiene. During a review of Resident 23's physician orders dated 1/12/2026 indicated Oxygen at two liters per minute via nasal cannula (medical device used to deliver oxygen to the respiratory system) to keep oxygen saturation at or above 92% every shift for COPD. During a concurrent observation and interview on 1/21/2026 at 1:26 p.m. with Licensed Vocational Nurse (LVN) 4 in Resident 23's room, Resident 23 was observed on four liters of oxygen via nasal cannula. LVN 4 stated Resident 23 should be on two liters of oxygen as per physician orders. LVN 4 stated oxygen should be administered as ordered by physician. LVN 4 stated administering more oxygen than ordered can have a negative effect on residents' respiratory system, and places residents at risk of carbon dioxide and oxygen imbalances. During an interview on 1/23/2026 at 9:30 a.m. with the Director of Nursing (DON), the DON stated staff should follow physician orders for oxygen administration because the physicians' assessments of residents and their diagnoses determine orders that are clinically appropriate for the resident. The DON stated residents with COPD are at risk for carbon dioxide retention and decreased breathing drive when receiving oxygen therapy and should not be receiving more oxygen than ordered. During a review of facility policy and procedure (P&P) titled Oxygen Therapy dated 10/10/2025, the P&P indicated, Administer oxygen and obtain oxygen saturation levels as ordered by the provider.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:Ensure one of one sampled resident (Resident 6) was evaluated by a physician initially in the first 90 days of admission and document his visit in resident's clinical records.This deficient practice had the potential for Resident 6's current medical condition not timely assessed by a physician that can lead to delay in necessary care and treatment.Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), muscle weakness, and neuralgia (intense, sharp, or stabbing pain caused by damage, irritation, or compression of nerve).During a review of Resident 6's History and Physical (H&P), dated 7/20/2025, the H&P indicated, Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/2/2025, the MDS indicated, Resident 6 was independent (decisions consistent/reasonable) on cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 6 had the ability to make self-understood and understand others. The MDS indicated, Resident 6 was dependent (helper does all of the effort) from staff with toileting hygiene and lower body dressing.During an interview on 1/20/2026 at 10:01 a.m., with Resident 6, Resident 6 stated she had not seen her physician in the facility for 4 months. Resident 6 stated she would like to see her physician so she could discuss her multiple medical conditions.During a concurrent interview and record review on 1/21/2026 at 2:15 p.m., with the Director of Nursing (DON), Resident 6's clinical records were reviewed. The DON stated Resident 6 was readmitted to the facility on 11/2025 for skilled care services (high-level medical, nursing, or rehabilitative treatments that must be performed by licensed professionals such as nurses or therapist under doctor's supervision). The DON stated there was no initial comprehensive visit by Resident 6's physician within the first 30 days of readmission. The DON stated Resident was last visited by her physician on 7/20/2025. The DON stated Resident 6 was visited by a Nurse Practitioner ([NP] - a nurse who has advanced clinical education and training) not by a physician on 11/26/2025, 12/7/2025, and 1/4/2026. The DON stated physician should come and visit resident monthly and as needed. The DON stated physician visit is necessary so he could review the condition of the resident and adjust the plan of care as necessary.During a review of the facility's policy and procedure (P&P) titled, Physician Services and Visits, dated 11/11/2025, the P&P indicated, Physician services shall include but are not limited to resident evaluation including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission. The P&P indicated for the first 90 days, the initial visit must be conducted by attending physician.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility failed to: 1.Ensure appropriate medication treatment was administered for one of six sampled residents (Resident 25) who was observed yelling loudly throughout various shifts for 4 days. This deficient practice had the potential to result in escalation of behavioral issues.Findings: During a review of Resident 25's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 25's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 25's history and physical (H&P) form, dated 11/26/2025/2025, the H&P indicated Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/1/2025, the MDS indicated Resident 25's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 25 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation, on 01/20/2026 at 9:32 a.m., of Resident 25, Resident 25 was observed lying in bed, yelling and screaming in his room, while looking up at the ceiling. Resident 25 did not appear to be in any distress. Resident 25 was unable to be interviewed. During an observation, on 01/20/2026 at 2:07 p.m., of Resident 25, Resident 25 continued to be observed yelling and screaming in his room throughout various work shifts. Resident 25 did not appear to be in any type distress. During an observation, on 01/21/2026 at 12:00 p.m., of Resident 25, Resident 25 was observed yelling and screaming every 3 to 5 minutes while in his room. Resident 25 had been yelling since 7:30 a.m. During a record review of Resident 25's January 2026 Medication Administration Record (MAR), the MAR indicated Resident 25 had a physician's order for Ativan 0.5 milligrams (mg) 1 tablet every 6 hours as needed for anxiety manifested by constant screaming with a start date of 1/13/2026. The MAR also non-pharmacological interventions had been attempted but was ineffective. The MAR indicated Resident 25's medication had not been administered since the start date. During a concurrent interview and record review, on 01/22/2026 at 12:10 p.m., with Registered Nurse 2 (RN 2), RN 2 stated the protocol for a resident who constantly yells after non-pharmacological interventions were ineffective was to administer medication to a resident. RN 2 stated although Resident 25 had been constantly yelling and screaming for 3 days, no medication was administered to him. RN 2 stated Resident 25 should have had medication administered as ordered. RN 2 stated the risk of not administering medication when a resident displays behavioral issues could result in disturbing other residents and cause altercations. During a review of the facility's policy and procedures (P&P), titled Behavior/Psychoactive Drug Management, dated 11/14/2025, 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.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered at the time of preparation for one of three sampled residents (Resident 27). This failure had the potential to place resident at risk for medication errors. Findings: During a review of Resident 27's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 12/11/2023 and was readmitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 27's History and Physical (H&P) dated 11/8/2025, the H&P indicated the resident did not have the capacity to understand or make decisions. During a review of Resident 27's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated Resident 27 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 27 was dependent on staff for eating, toileting and bathing. During a concurrent observation and interview on 1/22/2026 at 8:05 a.m. with Registered Nurse (RN) 2 in front of Resident 27's room, a medication cup with four unlabeled medications was observed on RN 2's medication cart. RN 2 stated the medications in cup were for Resident 27, but Family Member (FM) 1 requested medications to be administered after breakfast. RN 2 placed the medication cup with unlabeled medications back into medication cart. During a concurrent observation and interview on 1/22/2026 at 9:00 a.m., RN 2 was observed preparing Resident 27's medications and took out the unlabeled medication cup from the medication cart. RN 2 stated she will use the medications she prepared at 8:00 a.m. and continued to prepare the rest of the medications that were to be given at this time. During an interview on 1/22/2026 at 12:30 p.m. with RN 2, RN 2 stated she should not have stored unlabeled medications prepared for Resident 27. RN 2 stated per facility policy medications should be administered right after preparation. RN 2 stated administering medications that were prepared an hour in advance and unlabeled places resident at risk for medication errors. During a concurrent interview and record review on 1/23/2026 at 9:22 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines dated November 2021 was reviewed. The P&P indicated Medications are administered at the time they are prepared. The DON stated administering unlabeled medications an hour after preparation places residents at risk for medication errors.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were secured and visible to registered nurse administering medications for one of three sampled residents (Resident 27). This deficient practice had the potential to result in safety issues such as unauthorized resident access to medications and medication errors. Findings: During a review of Resident 27's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 12/11/2023 and was readmitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 27's History and Physical (H&P) dated 11/8/2025, the H&P indicated the resident did not have the capacity to understand or make decisions. During a review of Resident 27's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated Resident 27 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 27 was dependent on staff for eating, toileting and bathing. During an observation on 1/22/2026 at 8:00 a.m. in front of Resident 27's room, a cup with four medications was observed on top of medication cart with no nursing staff or licensed personnel present. Registered Nurse (RN) 2 was observed coming out of Director of Nursing's (DON) office at 8:05 a.m. and returned to medication cart. During an interview on 1/22/2026 at 12:30 p.m. with RN 2, RN 2 stated she left Resident 27's medications unsupervised on top of medication cart while she went into the DON's office. RN 2 stated medications should never be left unattended or out of nursing staff's line of sight. RN 2 stated medications left unattended can be accessed by ambulatory residents walking around the facility and places residents at risk for medication errors. During an interview on 1/23/2026 at 9:22 a.m. with the DON, the DON stated skilled nurses need to make sure medications are always secured and never left unattended. The DON stated there was a risk of another resident taking medication, switching medications or medication errors when medications are left unattended and out of nursing staff's line of sight. During a review of facility policy and procedure (P&P) titled, Medication Administration - General Guidelines dated November 2021, indicated During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.		

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NAME OF PROVIDER OR SUPPLIER Lawndale Healthcare & Wellness Centre LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 S Prairie Lawndale, CA 90260	
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Implement the physician's orders to draw laboratory tests (a medical analysis of a body sample (blood, urine, tissue) to check health, diagnose diseases and monitor chronic conditions) for two of two sampled residents (Residents 5 and 9). This deficient practice had the potential to result in the delay of identification of medical concerns, delaying the care and services necessary for the affected residents. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included cerebral infarction (a condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), heart failure (a heart disorder that causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dementia (a progressive state of decline in mental abilities). During a review of Resident 5's History and Physical (H&P), dated 12/8/2025, the H&P indicated, Resident 5 can make needs known but could not make medical decisions. During a review of Resident 5's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/14/2025, the MDS indicated, Resident 5's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor). The MDS indicated, Resident 5 had the ability to make self-understood and understand others. The MDS indicated, Resident 5 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene, showering, and lower body dressing. During a review of Resident 5's Order Summary Report (a document containing active orders), dated 1/20/2026, the Order Summary Report indicated the physician placed a telephone order on 1/7/2026 for Resident 5 to have laboratory orders for Complete Blood Count ([CBC] a blood test that checks the overall health of the blood by measuring the number and types of cells) and Comprehensive Metabolic Panel ([CMP] a blood test that measures 14 key substances in the blood, assessing electrolyte balance, kidney, liver function, and blood sugar). During a concurrent interview and record review on 1/21/2026 at 1:50 p.m., with Registered Nurse 1 (RN 1), Resident 5's laboratory results, were reviewed. RN 1 stated Resident 5's order for CBC and CMP were not drawn and results were not available. RN1 stated it was important to complete laboratory tests as ordered by the physician to know and identify medical condition of the resident and give appropriate treatment immediately. 2. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included cerebral infarction (a condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it), heart failure (a heart disorder that causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 9's History and Physical (H&P), dated 12/12/2025, the H&P indicated, Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/17/2025, the MDS indicated, Resident 9's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 9 was dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 9's Order Summary Report (a document containing active orders), dated 1/20/2026, the Order Summary Report indicated the physician placed a telephone order on 1/15/2026 for Resident 9 to have laboratory orders for B-type natriuretic peptide ([BNP] - a blood test that measures levels of protein called BNP that is made by your heart and blood vessels), and prothrombin time panel ([PT] - a blood test that measures how many seconds it takes for liquid plasma to form a clot). During a concurrent interview and record review on 1/21/2026 at 1:55 p.m., with Registered Nurse 1 (RN 1), (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 9's laboratory results, were reviewed. RN 1 stated Resident 9's order for BNP and PT panel were not drawn and results were not available. RN 1 stated the process for ordering laboratory tests was to place the order electronically and place the laboratory order form in the binder. RN 1 stated failure to monitor Resident 9's PT panel would put her at risk for bleeding. RN 1 stated it was important to check Resident 9's BNP level to monitor for signs and symptoms of heart failure such as swelling and shortness of breath. During an interview on 1/21/2026 at 2:10 p.m., with the Director of Nursing (DON), the DON stated it was important to complete all laboratory test of all residents as ordered by the physician so they would have a baseline and to monitor their health condition. During a review of the facility's policy and procedure (P&P) titled, Laboratory Services, dated 1/1/2012, the P&P indicated, The facility should provide laboratory services in an accurate and timely manner to meet the needs of residents per attending physician orders.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure one of one sampled resident (Resident 38) was referred to Dental service for readjustment of his dentures. This deficient practice had the potential to result in inability to chew food and weight loss for Resident 38. Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 38's diagnoses included low back pain, chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 38's History and Physical (H&P), dated 1/12/2026, the H&P indicated, Resident 38 can make needs known but could not make medical decisions. During a review of Resident 38's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/6/2026, the MDS indicated, Resident 38's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor). The MDS indicated, Resident 38 had the ability to make self-understood and understand others. The MDS indicated, Resident 38 required setup assistance (helper assists only prior to or following the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 38's care plan, titled Risk for oral infections related to edentulism and denture use, dated 1/11/2026, indicated goal for resident to manage his oral health effectively and maintain proper nutrition, until next reviews in 3 months. The care plan intervention included to coordinate with Social Service Director to arrange for regular dental check-ups to monitor the condition of dentures and oral tissues. During a concurrent observation and interview on 1/20/2026 at 9:33 a.m., in Resident 38's room, Resident 38 had no upper and lower dentures. Resident 38 stated he does not use his dentures because it falls out and does not fit properly. Resident 38 stated he informed the staff 2 weeks ago about the problem of his dentures. Resident 38 stated he had a hard time eating without his dentures. During an interview on 1/21/2026 at 11:17 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 38 refused to wear his dentures because it was loose. During an interview on 1/21/2026 at 11:20 a.m., with the Social Service Director (SSD), the SSD stated the facility has outside dental provider that comes to see residents regularly. The SSD stated dental services are one of the ancillaries (secondary/supplementary) services provided by the facility to all residents. The SSD stated she was not aware that Resident 38 had a problem with his dentures. The SSD stated Resident 38 was last seen by the dentist on 12/5/2025 and recommended to have a new full upper and lower dentures when eligible. The SSD stated Resident 38's could have been referred to the dentist for denture adjustment or reline. The SSD stated ill-fitting dentures could result on resident's not properly to eat that would lead to weight loss. During an interview on 1/21/2026 at 1:20 p.m., with the Director of Nursing (DON), the DON stated loose fitting dentures could cause discomfort to the resident. During a review of the facility's policy and procedure (P&P) titled, Oral Healthcare and Dental Services, dated 7/14/2017, the P&P indicated, The facility will provide oral healthcare and dental services for preventive care and treatment. During a review of the facility's Social Service Coordinator Job Description, the Social Service Coordinator Job Description indicated, to arrange ancillary services that have been determined necessary to maintain the resident's concrete needs.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility failed to: 1.Ensure resident identifiable documentation was accurate for one of six sampled residents (Resident 25).This deficient practice had the potential to negatively impact Resident 25's psychological needs.Findings: During a review of Resident 25's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 25's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 25's history and physical (H&P) form, dated 11/26/2025/2025, the H&P indicated Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/1/2025, the MDS indicated Resident 25's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 25 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 25's January 2026 Medication Administration Record (MAR), the MAR indicated staff had documented Resident 25 had 0 behaviors while monitoring for anxiety m/b constant screaming in January 2026 despite resident being heard and observed constantly screaming and yelling throughout various times of the day in the facility. During a review of Resident 25's nursing progress note, dated 1/19/25, the nursing progress noted indicated Resident 25 was alert & oriented x3 (A&Ox3- a medical abbreviation assessing a patient's cognitive status by checking if they are awake (alert), know their name/identity (person), current location (place), and the approximate date/time (time), communicated verbally with clear speech and was able to understand and be understood when speaking. During a concurrent interview and record, on 01/22/2026 at 12:05 p.m., with Registered Nurse 2 (RN 2), RN 2 stated types of non-pharmacological interventions (NPIs) included redirecting a resident, repositioning a resident, having a resident watch television or allowing a resident to talk on the phone. RN 2 stated when NPIs are ineffective for a resident, the staff will proceed to administer medication. RN 2 acknowledged hearing Resident 25 constantly screaming. RN 2 stated Resident 25's behavioral log was mostly charted as no behaviors which was inaccurate while NPI's were charted as ineffective. RN 2 stated Resident 25 should have been administered medication for constant screaming and the doctor should had been notified of Resident 25's behaviors. During a concurrent interview and record review, on 1/22/2026 at 12:23 p.m., with RN 2, RN 2 stated the meaning of A&O x3 meant a resident understood and could say their name, date, time and place. RN 2 stated when a resident's cognitive skills were severely impaired, it meant a resident was incoherent and would not be understood. RN 2 stated Resident 25 was A&O x0 (a medical notation indicating that a patient is awake and alert, but not oriented to any of the standard, tested cognitive categories). RN 2 stated nursing progress notes indicated Resident 25 was A&O x3 which was inaccurate. RN 2 stated the risk of documenting inaccurate resident information could negatively affect a resident's treatment and plan of care. During a review of the facility's policy and procedures (P&P), titled Completion & Correction, revised 1/1/2012, the P&P indicated, The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation.		