STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055072	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosecrans Care Center	1140 West Rosecrans Avenue Gardena, CA 90247

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 44294 Based on interview and record review, the facility failed to follow its Administrative Manual titled, Elder/ Dependent Abuse, which indicated to report any allegations of abuse or that results in serious bodily injury, to the State Survey agency, immediately but not later than two hours, for one of three residents (Resident 1). Resident 1 sustained a baseball size (a regulation baseball is 9 to 9.25 inches in circumference) bruise (discolored skin) on her right upper forearm. Resident 1 sustained right upper arm bone fracture (broken bone). This deficient practice delayed the investigation by the California Department of Public Health (CDPH). Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia, contracture of right hand, and aphasia (inability to communicate). During a review of Resident 1 ' s History and Physical (H&P), dated 10/23/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s MDS dated [DATE], the MDS indicated Resident 1 had functional limitation in range of motion, impairment on both upper and lower extremities. The MDS indicated Resident 1 required two or more persons to assist with mobility (including rolling form left to right, sit to lying, lying to sitting position and with transfer from bed to chair, chair to bed and with tub/ shower transfer) and had contractures of muscles in multiple sites. During a review of Resident 1 ' s undated care plan titled, Impaired ability to perform or complete activities of daily living (ADLs) task, the interventions included Resident 1 may be up on geri chair (a specialized, padded recliner chair for patients with limited mobility) for comfort and good body alignment. The interventions also indicated the facility will provide resident a safe environment and emphasize incident and accident precaution as appropriate. However, the care plan did not indicate interventions for 2 or more persons assist as indicated in Resident 1 ' s MDS. (continued on next page)

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s undated care plan, the care plan indicated Resident 1 had contractures on the left and right elbow, right hand, left and right knee, however the interventions did not indicate safety measures to prevent injuries to Resident 1. During a review of Resident 1 ' s undated care plan titled, Potential for bleeding, easily get bruised or skin discoloration due to use of aspirin (blood thinner) and Plavix (blood thinner). One of the interventions indicated to handle resident gently during care and transfer. During a review of the Change in condition (COC) form, dated 2/28/2024 at 2:44 p.m., the COC indicated the CNA 2 notified LVN 1 of Resident 1 ' s right upper arm discoloration. During a review of facility ' s x-ray (a test used to generate images of tissues and structures inside the body) report for Resident 1, dated 2/28/2024, indicated Resident 1 had sustained an acute obliquely (slant) oriented non-displaced (did not move out of alignment) fracture or surgical neck of humerus (upper arm bone). During an interview on 3/26/2024 at 1:27 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 2/28/2024 at 2:40 p.m., Certified Nurse Assistant 1 (CNA1) reported that Resident 1 had a baseball-size (a regulation baseball is 9 to 9.25 inches in circumference) bruise (an injury appearing as an area of discolored skin on the body, caused by a blow or impact) on her right upper arm. LVN 1 stated Resident 1 usually does not develop bruises. LVN 1 stated, Resident 1 probably got hurt when the CNA moved her harshly. LVN 1 stated that it was suspicious for Resident 1 who does not move sustained a bruise on the top of the arm. During an interview with LVN 2 on 3/26/2024 at 2:00 p.m. LVN 2 stated a bruise could be caused by excessive pressure or trauma (injury). LVN 2 stated there was light swelling on Resident 1 ' s arm. LVN 2 stated the incident (bruise) could have been considered as a suspected abuse or neglect because the Resident 1 was quadriplegic and was unable to move her (Resident 1) body and all extremities without assistance. During an interview with Director of Nursing (DON) on 3/26/2024 at 2:35 p.m., the DON stated that he was informed of incident on 2/28/2024 approximately 3:00 pm. by LVN 1. The DON stated facility notified State Survey Agency 2/29/2024 around 3:00 p.m. The DON stated that the injury of unknow origin was not reported within 2 hours as per their policy. The DON stated not reporting abuse in a timely manner could have led to continued injuries and delayed investigation. During a review of the facility ' s Administrative Manual titled, Elder/ Dependent Abuse, dated 11/19/22, the manual indicated to report any allegations of abuse or that results in serious bodily injury, to the State Survey agency, immediately but not later than two hours.

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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 0689 Level of Harm - 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** 44294 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was free from injury, by failing to provide two or more staff supervision when providing care with activities of daily living (eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) as indicated in Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 1/1/2024. The MDS indicated two or more persons will assist Resident 1 with mobility (rolling from left to right, sit to lying, lying to sitting position and with transfer from bed to chair, chair to bed and with tub/ shower transfer), toileting hygiene, shower, and personal hygiene. This failure resulted in Resident 1 sustaining a right upper arm fracture (broken bone) which required hospitalization at a general acute care hospital (GACH) for evaluation and treatment. Findings: A review of Resident 1 ' s Admission Record, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included quadriplegia (inability to move all parts of the body below the neck), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right hand, and aphasia (a disorder that results from damage to portions of the brain that are responsible for language). A review of Resident 1 ' s History and Physical (H&P), dated 10/23/2023, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1 ' s MDS dated [DATE], indicated Resident 1 had functional limitation in range of motion, impairment on both upper and lower extremities. The MDS indicated Resident 1 required two or more persons to assist with mobility, toileting hygiene, shower, and personal hygiene. The MDS indicated Resident 1 had contractures of muscles in multiple sites (on the left and right elbow, right hand, left and right knee). A review of Resident 1 ' s undated care plan titled, Impaired ability to perform or complete activities of daily living (ADLs) task, indicated Resident 1 may be up on geri chair (a specialized, padded recliner chair for patients with limited mobility) for comfort and good body alignment. The interventions also indicated the facility will provide Resident 1, a safe environment and emphasize incident and accident precautions as appropriate. The care plan did not indicate interventions for 2 or more persons assist as indicated in Resident 1 ' s MDS. A review of Resident 1 ' s undated care plan titled the resident has impaired physical mobility due to contractures on the right elbow, the goal indicated Resident 1 will remain free of injuries or complications related to contractures. One of the interventions indicated staff will anticipate and meet Resident 1 ' s needs. The interventions did not indicate safety measures to prevent injuries. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s undated care plan titled, Potential for bleeding, easily get bruised or skin discoloration due to use of aspirin (blood thinner) and Plavix (blood thinner), indicated staff should handle resident gently during care and transfer. A review of Resident 1 ' s Change in condition (COC) form, dated 2/28/2024 at 2:44 p.m., indicated the Certified Nurse Assistant 2 (CNA 2) notified Licensed Vocational Nurse 1 (LVN 1) of Resident 1 ' s right upper arm discoloration. The COC indicated LVN 1 assessed Resident 1 ' s skin and the resident ' s skin was intact with no signs of redness, bleeding, swelling or discoloration. The COC indicated Resident 1 was not in pain. A review of Resident 1 ' s, x-ray (process of taking pictures of tissues and structures inside the body for diagnosis and treatment) report from the facility, dated 2/28/2024, indicated Resident 1 had an acute obliquely (slant) oriented non-displaced (did not move out of alignment) fracture or surgical neck of humerus (upper arm bone). A review of Resident 1 ' s GACH emergency room (ER) notes dated 2/29/2024, indicated Resident 1 presented at ER for evaluation of right upper arm proximal (near) humerus fracture. The ER notes indicated Resident 1 ' s right upper arm was swollen. The notes also indicated Resident 1 ' s x-ray indicated the resident had a nondisplaced proximal humerus fracture with associated soft tissue swelling. A review of Resident 1 ' s GACH discharge summary dated 3/1/2024, indicated Resident 1 was discharged back to the facility with a with a sling (a device to immobilize fractured bones). During an interview on 3/26/2024 at 1:27 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 2/28/2024 at 2:40 p.m., CNA2 reported (to LVN1)that Resident 1 had a baseball-size (a regulation baseball is 9 to 9.25 inches in circumference) bruise (skin discoloration caused by a blow or impact) on her right upper arm. LVN 1 stated Resident 1 did not usually develop bruises. LVN 1 stated, Resident 1 probably got hurt when the CNA moved her harshly. LVN 1 stated it was suspicious for Resident 1 who did not move, to sustain a bruise on top of the arm. During an interview with LVN 2 on 3/26/2024 at 2:00 p.m., LVN 2 stated a bruise on a resident ' s skin, could be caused by excessive pressure or trauma (injury). LVN 2 stated there was light swelling on Resident 1 ' s arm. Resident 1 was quadriplegic and unable to move her body and all extremities without assistance. During an interview with CNA 1 (CNA assigned to Resident 1 on 2/28/2024 7a.m. to 3p.m. shift) on 4/2/2024 at 12:16 p.m., CNA 1 stated on 2/28/2024, she (CNA1) provided Resident 1 morning bed bath alone. CNA 1 stated, she (CNA1) noticed Resident 1 had discoloration on the right arm and Resident 1 seemed to be in pain. CNA 1 stated, she reported the discoloration to LVN 1. CNA 1 stated she had always performed Resident 1 ' s activities of daily living ([ADLs] such as bathing and dressing) alone, and without asking for any staff ' s assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review with Director of Nursing (DON) on 4/2/2024 at 12:41 p.m., Resident 1 ' s MDS dated [DATE], was reviewed. The DON stated according to MDS, Resident 1 required two persons assist with ADLs and bed mobility. The DON stated she was not aware CNAs were performing daily bed baths and resident transfers, turning and repositioning on Resident 1without assistance. The DON stated all total care residents, or residents ' dependent on staff for ADLs, were supposed to be assisted by two staff members to prevent injuries. The DON stated if she had known that CNAs were performing care on Resident 1 without the second person ' s assistance, facility would have identified the possibility of this causing an injury. A review of the facility ' s policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 7/2017, indicated the resident ' s safety, supervision, and assistance to prevent accidents were facility-wide priorities. The P&P indicated; employees shall be trained on potential accident hazards to prevent avoidable accidents. The P&P also indicated, the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P also indicated, due to their complexity and scope, certain resident risk factors and environmental hazards were addressed in dedicated policies and procedures, that included bed safety, safe lifting, and movement of residents. A review of the facility ' s P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, indicated the care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The P&P indicated care plan interventions will address the underlying source of the problem area. During a review of the facility ' s P&P titled, Activities of Daily Living (ADLs), Supporting dated 3/2018, the P&P indicated residents will be provided appropriate care and services in accordance with the plan of care.