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	02/25/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on observation, interview, and record review, the facility failed to ensure wound dressings for two of three sampled residents (Resident 1) were labeled with the nurse's initials, time, and date. This failure had the potential to result in wound dressings not being changed, resulting in wound infections and delayed wound healing. Findings: 1.During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 1's diagnoses included stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral (lower back) region, quadriplegia (paralysis from the neck down, including legs, and arms due to severe physical disability or frailty), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 1 had severe cognitive (thought process) impairment. The MDS indicated Resident 1 was dependent (staff does all the effort) for toileting and bathing; Resident 1 required moderate assistance (staff does less than half the effort) for personal hygiene. The MDS also indicated Resident 1 had one unhealed stage 4 pressure ulcer and was at risk of developing pressure ulcers. During a review of Resident 1's History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 1 had fluctuating ability to understand and make medical decisions. During an observation on 2/24/2025 at 1:15 p.m., Resident 1's left forearm dressing and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) dressing were not labeled. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During on a concurrent observation and interview on 2/25/2025 at 9:55 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated, Resident 1's left forearm dressing, Sacro coccyx (area at the base of the spine) dressing, and gastrostomy dressing were not labelled with the date and time of the dressing change and initials of the nurse who performed the dressing application. LVN 1 stated she did not label dressings with her initial, time and date when performing wound care dressing changes. LVN 1 also stated, she was not sure of the facility's policy on labeling wound care dressings. 2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 2 diagnoses included stage 4 pressure ulcer of the sacral region and malnutrition (a condition when the body does not receive enough protein or calories to function properly). During a review of Resident 2's H&P, dated 3/31/2024, the H&P indicated Resident 2 did not have the ability to understand or make medical decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 did not speak and sometimes understood others. The MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 was dependent on staff for toileting, bathing, and personal hygiene. The MDS also indicated Resident 2 had one unhealed stage 4 pressure ulcer and was at risk of developing pressure ulcers. During an observation on 2/24/2025 at 2:00 p.m., Resident 2's Sacro coccyx wound dressing and gastrostomy dressing were not labelled. During a concurrent observation and interview on 2/25/2025 at 10:45 a.m. with LVN 2, LVN 2 stated, Resident 2's Sacro coccyx wound dressing and gastrostomy tube dressing were not labelled with the nurse's initials or the time and date the dressings were changed. LVN 2 stated she did not label any dressings with their initials or the time and date of the dressing change procedure. During an interview on 2/25/2025 at 2:35 p.m. with LVN 4, LVN 4 stated wound dressings should be labelled with the nurse's initials and the time and date of the dressing change. During a concurrent interview and record review on 2/25/2025 at 3:45 p.m. with the Director of Nursing (DON), the facility's P&P titled Wound Care, dated 2001, was reviewed. The DON stated the policy indicated wound dressings must be labelled with initials, time, and date of the dressing change. The DON stated the policy was not followed. A review of the facility's P&P titled Wound Care, dated 2001, the P&P indicated wound dressing tape would be marked with the nurse's initials, time, and date. The P&P indicated the purpose of this practice was to provide guidelines for care to promote wound healing.