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	04/11/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49906 Based on interview and record review, the facility failed to manage a resident ' s pain (Resident 1) after the resident complained of pain to the licensed nurse. This failure resulted in Resident 1 experiencing unrelieved pain and had the potential to interfere with activities of daily living (ADLs). Findings: During a review of Resident 1 ' s Admission Record (front page of the chart that contains a summary of basic information about the resident), the admission record indicated the facility admitted Resident 1 on 10/10/2024, with diagnoses including polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), repeated falls, and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 1 had the ability to express ideas and wants and the ability to understand others. The MDS also indicated Resident 1 had no impairment in the upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). During review of Resident 1 ' s Order Summary Report on 12/30/2024, the Order Summary Report indicated an order for Acetaminophen [(APAP) a pain reliever] 500 mg 2 tabs; Give 1000 mg by mouth every 6 hours as needed for severe pain (7/10 - 10/10). During an interview on 4/11/2025 at 8:49 am with Resident 1, Resident 1 stated, he had pain under his left eye after being hit by Resident 2. During a concurrent interview and record review on 4/11/2025 at 3:30 pm with Licensed Vocational Nurse (LVN) 1, Resident1 ' s Medical Administration Record (MAR) dated 4/1/2025-4/30/2025 was reviewed. The MAR indicated, on 4/7/2025, 4/9/2025, and 4/10/2025, Resident 1 reported a pain level of 7/10 (on a scale of 1 - 10, 1 being the least pain and 10 being the worst pain) during a total of four nursing shifts. LVN 1 stated, the MAR also indicated no pain medication was given to Resident 1 after reporting 7/10 pain. LVN 1 stated, Resident 1 ' s pain was documented 7/10 four times on the MAR and no pain medication given to Resident 1 as ordered. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/11/2025 at 4:07 pm with the Director of Nursing (DON), Resident1 ' s MAR dated 4/1/2025-4/30/2025 was reviewed. The DON stated Resident 1 ' s pain of 7/10 was documented four times by the licensed nurses without documentation of pain medication being given to Resident 1. A review of the facility ' s Policy & Procedure (P&P) titled Administering Medications, revised 4/ 2019, the P&P indicated, medications are administered in accordance with prescriber orders. A review of the facility ' s P&P titled Pain-Clinical Protocol, revised 10/2022, the P&P indicated the staff would identify residents who have pain or who are at risk for having pain. The P&P indicated the staff would identify any situations or interventions where an increase in the resident ' s pain may be anticipated, will establish goals of pain treatment, and freedom from pain. Based on interview and record review, the facility failed to manage a resident's pain (Resident 1) after the resident complained of pain to the licensed nurse. This failure resulted in Resident 1 experiencing unrelieved pain and had the potential to interfere with activities of daily living (ADLs). Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the admission record indicated the facility admitted Resident 1 on 10/10/2024, with diagnoses including polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), repeated falls, and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 1 had the ability to express ideas and wants and the ability to understand others. The MDS also indicated Resident 1 had no impairment in the upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). During review of Resident 1's Order Summary Report on 12/30/2024, the Order Summary Report indicated an order for Acetaminophen [(APAP) a pain reliever] 500 mg 2 tabs; Give 1000 mg by mouth every 6 hours as needed for severe pain (7/10 - 10/10). During an interview on 4/11/2025 at 8:49 am with Resident 1, Resident 1 stated, he had pain under his left eye after being hit by Resident 2. During a concurrent interview and record review on 4/11/2025 at 3:30 pm with Licensed Vocational Nurse (LVN) 1, Resident1's Medical Administration Record (MAR) dated 4/1/2025-4/30/2025 was reviewed. The MAR indicated, on 4/7/2025, 4/9/2025, and 4/10/2025, Resident 1 reported a pain level of 7/10 (on a scale of 1 - 10, 1 being the least pain and 10 being the worst pain) during a total of four nursing shifts. LVN 1 stated, the MAR also indicated no pain medication was given to Resident 1 after reporting 7/10 pain. LVN 1 stated, Resident 1's pain was documented 7/10 four times on the MAR and no pain medication given to Resident 1 as ordered. (continued on next page)

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