

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2025
NAME OF PROVIDER OR SUPPLIER Rosecrans Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify one of four sampled residents (Resident 1), at least 30 days prior to the resident's discharge plan on 7/19/2025, as indicated in the facility's policy and procedure (P&P) titled, Transfer and Discharge Notice. This deficient practice resulted in Resident 1 not being aware of the discharge plans and had the potential to affect the resident's highest practicable physical, mental and psychosocial well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including muscle weakness, abnormalities of gait and mobility (deviations from the typical manner of walking) and atrial fibrillation (irregular heartbeat.) During a review of Resident 1's History and Physical (H&P) dated 6/26/2025, the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/30/2025, the MDS indicated Resident 1 had intact cognition. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 1's progress notes dated 7/21/2025, the progress notes did not indicate an Interdisciplinary Team (IDT) group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) meeting was conducted prior to Resident 1's planned discharge on [DATE]. During a review of Resident 1's undated Notice of Medicare Non-Coverage (NOMNC, a form that Medicare providers are required to give to beneficiaries when their Medicare-covered services are ending), the NOMNC indicated the Medicare coverage of current skilled nursing services would end on 7/21/2025. During an interview on 7/18/2025 at 2:45 p.m. with Resident 1, Resident 1 stated the Rehabilitation Director (RD) did not inform him that he had reached his goals in therapy. Resident 1 stated on 7/18/2025 before lunch time, the Business office representative (BO) came to his room and was asked to sign a document. Resident 1 stated the BO representative told Resident 1 that he will be discharged [DATE] and the resident's Medicare benefits will not be used. Resident 1 stated the Social Services Department (SSD) also came to his room on 7/18/2025 and told him that he will be discharged [DATE]. Resident 1 stated the facility did not talk to him in advance or informed him about any discharge plans. Resident 1 stated he applied an appeal to Livanta (a Medicare-contracted Quality Improvement Organization that provides help, support and resources for Medicare beneficiaries) on 7/18/2025. During an interview on 7/18/2025 at 3:43 p.m. with the BO representative, the BO representative stated the NOMNC should be given to residents 72 hours before the discharge date. The BO representative stated Resident 1's last day of Medicare coverage was 7/21/2025. The BO representative stated she went to Resident 1's room on 7/17/2025 but Resident 1 was not in the room. The BO representative stated she did not go back to Resident 1's room to look for him. The BO representative stated she went back to Resident 1's room on 7/18/2025 and asked Resident 1 to sign the NOMNC, but Resident 1 refused to sign. The BO representative stated the facility did not conduct an IDT meeting before Resident 1's discharge date of 7/19/2025. During an interview on 7/21/2025 at 11:37 a.m. with the RD, the RD stated he (RD) could not remember the facility conducted an IDT meeting for Resident 1's discharge. The RD stated the rehabilitation department should inform the residents when therapies are about to end and provide recommendations for home services as part of discharge planning. The RD stated Resident 1 should be informed about discharge planning before asking him to sign any papers. During an interview on 7/21/2025 at 11:45 a.m. with SSD, the SSD stated the facility did not conduct an IDT meeting prior to Resident 1's planned discharge on [DATE]. The SSD stated on 7/18/2025 at 11:00 a.m., Resident 1's doctor gave a discharge order for Resident 1. The SSD stated she went to Resident 1's room and told Resident 1 about the discharge order, but Resident 1 refused to talk about discharge plans. The SSD stated it was important to schedule IDT meetings when a resident is ready to be discharged to discuss the plan of care and discharge needs. The SSD stated the facility should have given Resident 1 the discharge notice prior to 7/18/2025. During a concurrent interview and record review on 7/21/2025 at 3:55 p.m. with the Director of Nursing (DON), Resident 1's progress notes for 7/2025 were reviewed. The DON stated the progress notes did not indicate SSD scheduled an IDT meeting with Resident 1. The DON stated on 7/16/2025, he asked the SSD to schedule an IDT meeting for Resident 1. The DON stated conducting discharge IDT meetings with residents is very important so the residents will be aware of all discharge plans, and whatever the resident would need will be ready providing residents safe discharge. During a review of</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Residents 2), was not trapped in Resident 1's room on 7/15/2025 at 4:00 a.m. This failure had the potential to cause resident to resident altercation and resident injuries, leading to hospitalization.1). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including muscle weakness, abnormalities of gait and mobility (deviations from the typical manner of walking,) and Atrial Fibrillation (irregular heartbeat.)During a review of Resident 1's H&P dated 6/26/2025, the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions.During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had intact cognition. The MDS indicated Resident 1 required supervision or touching assistance with ADLs such as dressing, toilet use, personal hygiene, transfer and mobility.During a review of Resident 1's progress notes dated 7/17/2025, timed 3:44 p.m. the progress notes indicated Resident 1 filed a grievance report to Social Services (SS) that a female resident on a wheelchair, went to his room at 4:00 a.m. on 7/15/2025.During an interview on 7/18/2025 at 2:45 p.m. with Resident 1, Resident 1 stated on 7/15/2025 around 4 a.m., he heard his roommate moaning while furniture moving. Resident 1 stated he heard the moaning again and went to the nurses' station. Resident 1 stated Licensed Vocational Nurses (LVN) 2, came to the room, and saw Resident 2 in her wheelchair trapped between Resident 1's roommate's beds and the curtains. Resident 1 stated LVN 2 stated Resident 2 likes to move around in her wheelchair and make the wrong turn. Resident 1 stated he did not want anybody to appear in his room and needed his privacy. 2). During a review of Resident 2's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) dementia (a progressive state of decline in mental abilities) and anxiety disorder (mental conditions characterized by excessive fear of or apprehension about real or perceived threats).During a review of Resident 2's History and Physical (H&P) dated 4/4/2025, the H&P indicated Resident 1 had the mental capacity to make needs known but cannot make medical decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 6/21/2025, the MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 was dependent on staff with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene. The MDS indicated Resident 2 required substantial to maximal assistance with transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side.) During a review of Resident 2's care plan titled anti-anxiety medication Buspirone care plan, dated 1/8/2025, one of the interventions indicated to monitor/record occurrence of target behavior symptoms like pacing (walking back and forth), wandering and to document per facility protocol.During a review of Resident 1's Medication Administration Record (MAR) dated 7/21/2025 timed 3:55 p.m., the MAR did not indicate Resident 2's wandering behavior was monitored or documented on 7/15/2025 11:00 p.m. to 7:00 a. m. shift.During an interview on 7/21/2025 at 12:45 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 2 was confused, and likes to go around and follow staff. CNA 2 stated staff are aware of Resident 2's wandering behavior and should have monitored Resident 2 on 7/15/2025 around 4 a.m. and redirect when needed, because it can make other residents agitated and can cause conflict between residents and can lead to abuse. CNA 2 stated it was important to check and supervise the residents because at nighttime they get so confused. During a concurrent interview and record review on 7/21/2025 at 3:55 p.m. with the Director of Nursing (DON), the MAR for 7/15/2025 was reviewed. The DON stated Resident 2's MAR did not indicate Resident 2's wandering behaviors were monitored. The DON stated that when residents are not monitored, it can cause altercations between residents leading to resident-to-resident abuse and invading the other resident's privacy. During a review of the facility's policy and procedures (P&P) titled, Wandering, Unsafe Resident, dated 12/2008, the P&P indicated staff should identify residents who are at risk for harm because of unsafe wandering. The P&P indicated staff should institute a detailed monitoring plan, as indicated for residents who are assessed for unsafe behavior.During a review of the facility's P&P titled, Safety and Supervision of Residents, dated 12/2007, the P&P indicated resident supervision is a core component of the systems approach to safety. The P&P indicated the type and frequency of resident's supervision is determined by the individual resident's assessed needs</p>		