| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055072 | A. Building<br>B. Wing | 12/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rosecrans Care Center | 1140 West Rosecrans Avenue<br>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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure privacy during care for three of eight residents (Residents 2, 3, and 4) when certified Nursing Assistants (CNA) 1, CNA 2, and CNA 3 did not fully close the privacy curtains while providing care. This failure had the potential to affect the dignity and self-worth of Residents 2, 3, and 4. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/15/2025 with diagnoses including generalized muscle weakness, difficulty in walking, lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), and morbid obesity (severely overweight). During a review of Resident 2's History and Physical (H&P), dated 9/1/2025, the H&P indicated, Resident 2 had the capacity to make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 8/19/2025, the MDS indicated Resident 2 was understood by staff and was able to understand others. The MDS indicated, Resident 2 required partial to moderate assistance for activities of daily living (ADLs-activities such as bathing, dressing, personal/oral hygiene, and toileting). During an observation on 9/22/2025 at 9:00 a.m. in Resident 's room, Certified Nursing Assistant (CNA) 1 was providing ADLs to Resident 2. The privacy curtain was halfway closed while Resident 1 was being provided with incontinent care. Resident 2's bedside window curtains were open, and the resident was visible from the outside of the window. During an interview on 9/22/2025 at 10:05 a.m. with Resident 2, Resident 2 stated having privacy was important to feeling safe. Resident 2 stated feeling embarrassed if exposed to other residents or staff in the room. During an interview on 9/22/2025 at 12:03 p.m. with CNA 1, CNA 1 stated keeping the curtains closed was important for residents' privacy. CNA 1 stated residents would feel embarrassed if curtains were open while receiving care. b. During a review of Resident 3's admission Record, the admission Record indicated, the facilityadmitted Resident 3 on 3/10/2015 with diagnoses including epilepsy (a long-term chronic disease thatcauses repeated seizures due to abnormal electrical signals produced by damaged brain cells), overactivebladder, dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM-a disordercharacterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's H&P, dated 5/28/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had severe cognitive (ability to think, learn, remember, use judgement, and make decisions) impairment. The MDS indicated Resident 3 required partial to moderate assistance for ADLs. During a concurrent observation and interview on 9/22/2025 at 9:30 a.m. in Resident 3's room, CNA 2 was providing ADLs to Resident 3. The privacy curtain was halfway closed when Resident 3 was being provided with incontinent care. Resident 3 was observed to be naked. CNA 2 stated the curtains must be closed all the way for residents' privacy. c. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 10/4/2023 with diagnoses including epilepsy, generalized muscle weakness, dementia, hemiplegia (total paralysis ofthe arm, leg, and trunk on the same side of the body), hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), and diabetes mellitus.During a review of Resident 4's H&P, dated 1/26/2024, the H&P indicated, Resident 4 did not have the capacity to understand and make decisions.During a review of Resident 4's MDS, dated [DATE] the MDS indicated Resident 4 had severe cognitive impairment. The MDS also indicated Resident 4 required maximum assistance for ADLs. During a concurrent observation and interview on 9/22/2025 at 9:57 a.m. in Resident 4's room, CNA 3 was providing ADLs to Resident 4. Resident 4 was observed with the entire body exposed. The privacy curtain was only halfway closed. CNA 3 was in the process of cleaning Resident 4 while the resident remained naked. CNA 3 stated curtains needed to be closed all the way to provide privacy. During an interview on 9/22/2025 at 12:16 p.m. with CNA 3, CNA 3 stated closing the curtain was important to provide privacy to Residents. CNA 3 stated residents would feel embarrassed, and uncomfortable if privacy were not provided to them.During an interview on 9/22/2025 at 1:05 p.m. with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated providing privacy such as closing the doors, and curtains were important for respect and dignity purposes. LVN 1 stated residents would feel embarrassed if they were exposed during care. During an interview on 9/22/2025 at 2:45 p.m. with Registered Nurse (RN) 1, RN 1 stated to ensure residents' privacy, staff are expected to knock before entering, introduce themselves, close privacy curtains, and explain the procedures to be performed. RN 1 stated failing to close curtains before |