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	04/25/2025

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

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, interview, and record review, the facility failed to ensure one of one sample residents (Resident 30) had an intravenous (IV- a thin flexible tube inserted into the vein used to draw blood and give treatments) catheter with the date of insertion on it. This deficient practice had the potential for Resident 30's IV site to go unchanged which could lead to an infection. Findings: During an observation on 11/22/2025 at 11:00 a.m. Resident 30 was observed lying in bed with an IV catheter inserted to the left wrist with no date on the outer dressing of the IV. Resident 30 was receiving IV fluids through the IV catheter inserted to the left wrist. During a review of Resident 30's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 30 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included chronic kidney disease (a condition where the kidneys are damaged and can't filter blood as well), hypokalemia (low potassium levels in the blood), hyperlipidemia (high levels of fats in the blood), and vitamin D deficiency (low levels of vitamin D in the blood). During a review of Resident 30's History and Physical (H&P), dated 8/13/2024, the H&P indicated Resident 30 did not have the ability to understand and make medical decisions. During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 30 had severely impaired cognition (ability to learn, reason, remember, understand, and make decisions) and did not have impairments to their upper extremities (related to the arms) and lower extremities (related to the legs). During a review of Resident 30's Progress Notes dated 4/1/2025 at 9:13 p.m., the Progress Notes indicated an order was received to insert a new IV catheter. During an interview on 4/23/2025 at 4:18 p.m. with Registered Nurse (RN) 1, RN 1 stated the RN's are the ones who are responsible for anything related to IV, whether it is giving medication, and inserting and removing the IV, the RN's are also the one who is responsible for any documentation related to the IV as well. (continued on next page)

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up concurrent interview and observation on 4/23/2025 at 4:24 p.m. with RN 1, Resident 30's IV catheter on the left wrist was observed. RN 1 stated there was no date on it and was unsure why there was no date on it. RN 1 stated the IV catheter site should be changed every 7 days if the IV catheter is not in use and changed every 3 days if it is being used for medications. RN 1 stated having the date on the IV catheter would help the next nurses to determine when the IV catheter should be changed to avoid infection. During a review of the facility's policy and procedure (P&P) titled Peripheral IV Cather Insertion, dated 2/2022, the P&P indicated after taping the IV catheter in place, place a label on one side of the catheter, not over the insertion site and include the date of catheter insertion.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 82) had their oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) checked every shift as ordered. This deficient practice had the potential for Resident 82 to be receiving too much or too little oxygen and could lead to difficulty in breathing. Findings: During an observation on 4/22/2025 at 11:13 a.m., Resident 82 was observed in bed and had a nasal cannula (a device that delivers extra oxygen through a tube into your nose) on with oxygen at 2 liters per minute (lpm- flow of oxygen per minute). During a review of Resident 82's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 82 was admitted on [DATE] with diagnoses that included dependence on supplemental oxygen (a medical treatment that provides extra oxygen to a person), cardiomegaly, and myocardial infarction (heart attack). During a review of Resident 82's History and Physical (H&P), dated 12/8/2024, the H&P indicated Resident 82 did not have the ability to make medical decisions. During a review of Resident 82's Minimum Data Set (MDS - a resident assessment tool), dated 2/19/2025, the MDS indicated Resident 82 was not able to be evaluated for their mental status and had impairments to their upper extremity (related to the arms) and no impairments to their lower extremity (related to the legs). The MDS further indicated Resident 82 was receiving oxygen therapy. During a review of Resident 82's Order Summary Report, the Order Summary Report indicated an order was placed on 4/3/2025 to give Resident 82 oxygen at 2 lpm (via nasal cannula every shift to maintain O2 sat at 92% and above and to titrate (adjust and change the amount of a substance) oxygen 2-4 lpm and to call the doctor if the O2 sat is less than 92%. Another order indicated to monitor the O2 sat every shift for the use of oxygen. During a review of Resident 82's O2 Sat levels dated 4/2025, the O2 sat levels indicated the following O2 sat levels were obtained for Resident 82: 4/4/2025 2:57 p.m. - 97.8% room air (without supplemental oxygen) 4/11/2025 5:28 p.m. - 97% via nasal cannula 4/22/2025 10:20 p.m. - 97% via nasal cannula 4/23/2025 1:54 p.m. - 97% via nasal cannula 4/23/2025 5:36 p.m. - 97.8% via nasal cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/2024 at 1:40 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 82's Order Summary Report, and O2 sat levels were reviewed. LVN 1 stated Resident 82 required oxygen and is currently on 2lpm via nasal cannula and does well on it. LVN 1 reviewed Resident 82's Order Summary Report and stated Resident 82 needed to have O2 sat levels checked every shift. LVN 1 reviewed the O2 sat levels for the month of April and stated Resident 82's O2 sat level was not being checked every shift and there have been many days in April where her O2 sat level was not checked at all. LVN 1 stated if the nurses are not monitoring every shift they would not know what the residents O2 sat level was and would not know if further interventions are needed or they need to increase her oxygen. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, dated 10/2010, the P&P indicated while the resident is receiving oxygen therapy, assess for vital signs, and oxygen saturation if applicable.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to monitor for signs and symptoms of bleeding and bruising related to the use of aspirin (a medication used to prevent blood clots) and Eliquis (a medication used to prevent blood clots) between 4/1/25 and 4/24/25 in one of five residents sampled for unnecessary medications (Resident 82). The deficient practice of failing to monitor for signs and symptoms of bleeding during aspirin and Eliquis therapy increased the risk that Resident 82 could have experienced adverse effects (unwanted and dangerous side effects of medication) such as bleeding and bruising leading to medical complications requiring hospitalization . Findings: During a review of Resident 82's Admission Record (a record containing diagnostic and demographic resident information), dated 4/24/25, indicated he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and muscle weakness in the right side following a stroke). During a review of Resident 82's History and Physical (H&P - a record of a comprehensive physician's assessment) dated 12/8/24, indicated Resident 82 lacked the capacity to make medical decisions. During a review of Resident 82's Order Summary Report (a summary of all current physician orders), dated 4/24/25, indicated Resident 82's attending physician prescribed: 1. Aspirin 81 milligrams (mg - a unit of measure for mass) via gastrostomy tube (g-tube - a tube surgically inserted into the stomach for administration of nutrition and medication) one time a day for CVA (stroke) prophylaxis (prevention) on 2/27/25. 2. Eliquis 2.5 mg via g-tube two times a day for CVA prophylaxis on 12/23/24. During a review of Resident 82's available Care Plans (a resident-centered plan of care developed to address a resident's unique health care needs), revised 3/31/25, indicated Resident 82 was at high risk of bleeding, bruising, and skin discoloration due to her use of aspirin and Eliquis and facility staff should monitor for and document any signs of bleeding (unexplained bruising, nosebleeds, bleeding gums, signs of gastrointestinal bleeding, etc .) every shift. During a review of Resident 82's Medication Administration Record (MAR - a monthly record of medications administered and monitoring documented for a resident) for April 2025 indicated facility staff failed to monitor for signs and symptoms or bleeding and bruising as potential adverse effects of her therapy with aspirin and Eliquis between 4/1/25 and 4/24/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/25 at 9:25 AM with the Director of Nursing (DON), the DON stated the facility failed to actively monitor Resident 82 for adverse effects related to the use of apixaban and aspirin. The DON stated because this resident has both apixaban and aspirin therapy as well as care plans for past incidences related to bleeding, it is important to monitor on an ongoing basis for signs and symptoms of bleeding and bruising so that action could be taken swiftly if any is noted. The DON stated failing to monitor this resident's anticoagulant therapy for signs of bleeding and bruising increased the risk that Resident 82 could have complications from bleeding or bruising that were not addressed promptly possibly leading to hospitalization . During a review of the facility's policy and procedure (P&P) Anticoagulation - Clinical Protocol, revised November 2018, the P&P indicated The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review the facility failed to: 1. Label one opened vial of latanoprost (a medication used to treat eye conditions) eye drops with an open date affecting Resident 16 in one of two inspected medication carts (East Medication Cart). 2. Store lorazepam oral solution (a medication used to treat mental illness) in the refrigerator per the manufacturer's requirements affecting resident 410 in one of two inspected medication carts (East Medication Cart). 3. Store gabapentin oral solution (a medication used to treat nerve pain) in the refrigerator per the manufacturer's requirements affecting resident 410 in one of two inspected medication carts (East Medication Cart). 4. Label one open fluticasone/salmeterol inhaler (a medication used to treat breathing problems) with an open date affecting Resident 411 in one of two inspected medication carts (East Medication Cart). 5. Label one open Lantus insulin pen (a medication used to treat high blood sugar) with an open date affecting Resident 94 in one of two inspected medication carts (East Medication Cart). The deficient practices of failing to store or label medications per the manufacturers' requirements increased the risk that Residents 16, 94, 410, and 411 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 11:39 AM of East Medication Cart with the Licensed Vocational Nurse (LVN 5), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One bottle of lorazepam oral solution for Resident 410 was found stored at room temperature. According to the product labeling, lorazepam oral solution should be stored in the refrigerator. 1. One opened Lantus insulin pen for Resident 94 was found without a labeled open date. According to the product labeling, opened Lantus insulin pens should be used or discarded within 28 days of opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One opened vial of latanoprost eye drops for Resident 16 were found without a labeled open date. According to the product labeling, opened vials of latanoprost eye drops should be used or discarded withing six weeks of opening. 1. One opened fluticasone/salmeterol inhaler for Resident 411 was found without a labeled open date. According to the product labeling, fluticasone/salmeterol inhalers should be used or discarded once removed from the protective foil pouch. 1. One bottle of gabapentin oral solution for Resident 410 was found stored at room temperature. According to the product labeling, gabapentin oral solution should be stored in the refrigerator. During a concurrent interview, LVN 5 stated the lorazepam oral solution and the gabapentin oral solution for Resident 410 should be stored in the refrigerator but is stored at room temperature. LVN 5 stated she does not know how long the lorazepam was stored at room temperature but gave a dose of the gabapentin to Resident 410 this morning. LVN 5 stated she failed to return the gabapentin solution to the refrigerator immediately after giving the medication as required. LVN 5 stated giving Resident 410 gabapentin and lorazepam solution which has not been refrigerated could cause the medication not to work as well possibly causing medical complications. LVN 5 stated the Lantus for Resident 94 is opened but not labeled with an open date. LVN 5 stated, when Lantus is opened, it expires 28 days after opening and without an open date, there is a risk that it could continue to be used after it expires. LVN 5 stated Lantus is used to control blood sugar and giving expired insulin to Resident 94 could cause medical complications due to poorly controlled blood sugar. LVN 5 stated the latanoprost for Resident 16 was opened but not labeled with an open date. LVN 5 stated this increased the risk that it could be given to Resident 16 after it expired possibly causing her glaucoma to worsen and negatively affect her sight. LVN 5 stated the inhaler for Resident 411 is opened but not labeled with an open date. LVN 5 stated fluticasone/salmeterol is used to treat or prevent breathing conditions and giving it after it expires could cause Resident 411 to have increased difficulty breathing possibly resulting in hospitalization or death. During a review of the facility's policy and procedure (P&P) Medication Labeling and Storage, revised February 2023, the P&P indicated The facility stores all medication and biologicals in locked compartments under proper temperature, humidity, and light controls . Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured locations . The medication label includes . expiration date, when applicable .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure residents in Rooms 6, 7, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 29 had at least 80 square feet ([sqft]- a unit of measure) of living space. This deficient practice had the potential to result in residents not being able to move around freely or store personal items. This also had the potential for staff having difficulty providing care due to a lack of space. Findings: During an observation on 4/22/2025 at 10:51 a.m., Toom 26 was noted to contain four beds. During a review of the Client Accommodation Analysis, dated 4/22/2025, the analysis indicated the facility had the following room measurements: Room # # of beds Floor square footage 6 1 90 7 4 270 14 2 150 15 2 150 16 2 150 18 2 150 19 2 150 20 2 150 21 2 150 22 2 150 23 2 150 24 2 150 25 2 150 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	26 4 285 27 2 150 28 2 150 29 2 150 During a review of the Room Variance Waiver request letter, dated 4/23/2025, the letter indicated Rooms 6, 7, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 29 fall short of the minimum square footage requirement. During an interview on 4/25/2025 at 12:00 p.m. with the Administrator (Adm), the Adm stated there has not been complaints from residents who reside in the smaller rooms. The Adm stated staff ensure residents have ample room to maneuver wheelchairs. The Adm stated due to the smaller room size, staff can potentially have issues providing care.