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	06/05/2026

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care plans were:1. Updated quarterly for three of seven sampled residents (Resident 4, 5, and 25)2. Revised for one of seven sampled residents (Resident 87)These failures had the potential to result in Residents 4, 5, 25, and 87 not receiving the specific and timely care related to their illnesses and diagnoses.Findings: 1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included dysphagia (difficulty swallowing) and dementia (loss of thinking, remembering, and reasoning). During a review of Resident 4's care plan titled, At risk for impaired skin integrity as evidence by easy skin bruising/skin discoloration, skin tears/abrasions including pressure skin injury due to Braden scale score: 18 – at risk, dated 10/22/2025, the care plan indicated the goals were last revised on 10/22/2025. During a review of Resident 4's care plan titled, Resident 4 is at risk for communication problem related to the diagnosis of Dementia, dated 2/10/2026, the care plan indicated the goals were last revised on 2/10/2025. During a review of Resident 4's History & Physical (H&P), dated 4/23/2026, the H&P indicated Resident 4 had the capacity to make medical decisions, but did not have the capacity to make own needs known. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including occlusion (blockage) and stenosis (narrowing) of the left middle cerebral (brain) artery, and atrial fibrillation (irregular heartbeat). During a review of Resident 5's care plan titled, On anticoagulant (blood thinner) therapy (Apixaban related to CVA (cerebral vascular accident) PPX (prophylaxis) dated 3/31/2025, the care plan indicated the goals were last revised on 11/28/2025. During a review of Resident 5's Minimum Data Set (MDS), a tool used to evaluate the health status, functional abilities, and healthcare needs, dated 3/10/2026, the MDS indicated that Resident 5 had a memory problem and daily decision making is moderately impaired, has an active diagnosis of a stroke, and is receiving an anticoagulant medication. During a review of Resident 5's physician order, dated 05/1/2026, the physician order indicated to (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer Apixaban Oral Tablet 2.5 milligram (mg, a unit of measurement), 1 tablet via gastrostomy (stomach) tube two times a day for cerebral vascular accident prophylaxis (stroke prevention). During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 25's diagnoses included neuralgia (pain caused by damaged nerves), neuritis (nerve inflammation), osteoarthritis (arthritis involving flexible tissue), and chronic pain. During a review of Resident 25's physician order dated 02/07/2025, the physician order indicated to administer Baclofen 20mg one tablet by mouth three times a day for neuropathic pain and Diclofenac Sodium topical gel 1% 100 grams to right shoulder every eight hours as needed. During a review of Resident 25's H&P, dated 2/27/2026, the H&P indicated Resident 25 had the capacity to understand and make decisions. During a review of Resident 25's MDS, dated [DATE], the MDS indicated that Resident 25 had a Brief Interview Mental Status score of 15. During a review of Resident 25's Care Plan titled, Chronic Pain related to bone deformities, joint degeneration, muscle spasm, physical mobility as evidenced by decreased ability to perform ADLs (activities of daily living) because of discomfort related to: Diagnosis: Osteoarthritis, dated 7/17/2021, the care plan indicated the goals were last revised on 6/20/2025. During a concurrent interview and record review on 6/4/2025 at 10:06 a.m. with Registered Nurse 1 (RN 1) the care plan for Resident 5, titled, On anticoagulant therapy (Apixaban r/t CVA PPX), dated 3/31/2025 was reviewed. RN 1 stated, the care plan should have been revised three months after 11/26/2025 and by not revising the care plan in three months, the resident could have had an adverse reaction to the anticoagulant therapy. RN 1 stated staff would need to know whether the medication was effective, and if the goal of effectiveness was reached. RN 1 stated blood work would be needed to determine if the resident had an abnormal lab result. RN 1stated if the goals were not revised, it could lead to Resident 5's blood clotting or bleeding and decrease the effectiveness of the anticoagulant treatment. During a concurrent interview and record review on 06/04/2026 at 10:22 a.m., with RN 1, Resident 4's care plan titled, At risk for communication problem related to the diagnosis of Dementia revised on 2/10/2025, and the care plan titled, At risk for impaired skin integrity as evidence by easy skin bruising/skin discoloration, skin tears/abrasions including pressure skin injury due to Braden scale score: 18 – at risk, revised on 10/22/2025, were reviewed. RN 1 stated care plans should be reviewed every three months, and by not reviewing the resident's care plan, the needs of the residents would not be met. RN 1 stated Resident 4's safety could be at risk if the dementia worsens because staff would not be aware if the resident's cognition changed. RN 1 stated staff would not be able to identify if there was a need to change the resident's dementia medication. RN 1 stated that if staff were not meeting the goals of the resident's skin integrity, there was a possibility the skin could heal slowly or worsen, deteriorate and become infected, leading to sepsis. During a concurrent interview and record review on 06/04/2026 at 10:36 a.m., with RN 1, Resident 25's care plan titled, Chronic Pain related to bone deformities, joint degeneration, muscle spasm, physical mobility as evidenced by decreased ability to perform ADLs because of discomfort related to: Diagnosis: Osteoarthritis, dated 6/20/2025, was reviewed. RN 1 stated the care plan should have (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been revised three months after 6/20/2025. RN 1 stated by not revising the care plan in three months, staff would not know if the pain for Resident 25 was resolving, ongoing, and if the resident was tolerating the pain medication ordered. RN 1 stated the resident could be uncomfortable and complain of pain if the medication was not effective. 2. During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 87's diagnosis included encephalopathy (any diffuse disease or damage that alters brain structure or function), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and tinea unguium (a contagious fungal infection that affects the fingernails and toenails), During a review of Resident 87's physician orders dated 8/23/2025, the physician orders indicated Resident 87 was to have podiatry every two months and as needed. During a review of Resident 87's MDS, dated [DATE], the MDS indicated Resident 87's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 87 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff for toilet hygiene, showering, and dressing. The MDS indicated Resident 87 was at risk for pressure ulcers (localized damage to the skin and/or underlying tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During a review of Resident 87's progress notes, dated 5/27/2026, the progress notes indicated Resident 87 refused to be seen by the podiatrist. During a concurrent interview and record review on 6/4/2024 at 12:25 p.m. with Registered Nurse (RN) 1, Resident 87's progress note, dated 5/27/2026, was reviewed. The progress note indicated Resident 87 refused to be seen by the podiatrist. RN 1 stated Resident 87 had refused to be seen by the podiatrist. RN 1 stated Resident 87's care plan of non-compliance was not revised. RN 1 stated the non-complaint care plan should have included interventions such as education of risk and benefits, and monitoring of the resident's feet. RN 1 stated the revised care plan should include behavior reinforcement to encourage Resident 87 to be compliant and an updated care plan with new approaches to assist Resident 87 with a successful outcome of care. During a review of facility's P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated the interdisciplinary team would review and update the care plan at least quarterly, in conjunction with the required quarterly MDS assessment. The P&P indicated the comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. The P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to date food items in the pantry, refrigerator and freezer, and did not securely store prepared raw fish in flat tray.These deficient practices had the potential to cause food-borne illness for all residents.Findings:During an observation on 6/2/2026 at 9:00 a.m. in pantry number one in the kitchen, a box of 100 tea bags and a box containing Nestle rich chocolate individualized bags did not have a use by date.During an observation on 6/2/2026 at 9:30 a.m. in freezer number one in the kitchen, one package of frozen chocolate chip cookies did not have a use by date.During an interview on 6/2/2026 at 9:35 a.m. with the Dietary Supervisor (DS), the DS stated the two boxed items in the pantry and the frozen package of cookies in the freezer did not have a use by date. The DS stated labeling dried and frozen packages with a use by date was essential to ensure food was stored safely and to prevent contamination, spoilage, and foodborne illness.During an observation on 6/4/2026 at 11:11 a.m. in the kitchen, four flat baking trays containing ten raw fish in yellow liquid were left uncovered and unattended on a three-tier cart. During an interview on 6/4/2026 at 11:13 a.m. with the DS, the DS stated the raw fish had been left uncovered and unattended. The DS stated she could not specify how long the fish remained uncovered. The DS stated leaving raw fish left uncovered on a baking tray exposed the fish to contamination from dust, debris, or airborne particles, and increased the risk of cross-contamination if juices drip or splash onto nearby ready-to-eat foods. The DS stated the tray should have been labeled with the date and time to ensure the fish was used within safe timeframes.During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated 11/2022, the P&P indicated the facility required staff to handle and store dry foods in a manner that maintained the integrity of the packaging until the items are ready to use. The P&P indicated staff to label and date dry food items with a use by date and to rotate foods using a first in-first out system. During a review of the facility's P&P titled, Food Preparation and Service, dated 11/2022, the P&P indicated cross-contamination could occur when raw food touched or dripped onto cooked or ready-to-eat foods. The P&P indicated staff would track the amount of time potentially hazardous food/temperature control for safety (PHF/TCS, foods that require strict temperature controls to prevent the growth of bacteria and toxins) foods were held out of temperature control and discard the foods accordingly.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the physician for one of five sampled residents (Resident 2) was notified when Resident 2 had redness and exudate (a fluid that leaks out onto skin surface in response to inflammation, injury, or infection) at the insertion site of the perma-catheter (a long, flexible tube inserted into a large vein and threaded near the heart).This deficient practice had the potential to delay medical evaluation and treatment.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnosis included stage three pressure ulcer (full thickness loss of skin. Dead and black tissue may be visible), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and end stage renal disease (the final, permanent stage when the kidneys can no longer filter wase and fluid s from the blood to sustain life).During a review of Resident 2's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 2 did not have the capacity to understand and make medical decisions.During a review of Resident 2's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 2's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 2 was dependent (helper does all of the effort to complete the activity) on staff for toilet hygiene, showering, and dressing. The MDS indicated Resident 2 was at risk for pressure ulcers (localized damage to the skin and/or underlying tissue loss with exposed muscle, tendon, ligament, cartilage, or bone).During an observation on 6/3/2026 at 3:34 p.m., in Resident 2's room, Resident 2 had a right chest perma-catheter double lumen (the hollow, tubular channel inside an intravenous [IV] catheter) with redness and exudate (a fluid that leaks out onto skin surface in response to inflammation, injury, or infection) to the surrounding skin at the insertion site and the lumen had blood in the tubing.During a concurrent interview and picture record review on 6/4/2026 at 12:10 p.m., with Registered Nurse (RN) 1, the picture of the perma-catheter, dated 6/3/2026, was reviewed. The picture indicated Resident 2 had a right chest perma-catheter double lumen with redness and exudate to the surrounding skin at the insertion site. RN 1 stated Resident 2 had redness and exudate surrounding the insertion site. RN 1 stated this was considered a change in condition and the physician should have been notified. RN 1 stated the physician should have been notified to make sure the perma-catheter was properly in place. RN 1 stated it was important to notify the physician in a timely manner to prevent worsening of the redness and exudate of the insertion site.During a concurrent interview and picture record review on 6/5/2026 at 10:05 a.m. with Infection Preventionist (IP) Nurse, the picture of the perma-catheter, dated 6/3/2026, was reviewed. The IP Nurse stated the licensed staff were to monitor the perma-catheter every shift. The IP Nurse there was no documentation of redness, exudate, or blood in the perma-catheter lumen. The IP Nurse stated these issues were reportable to the physician. The IP Nurse stated these issues had the potential for Resident 2 to become septic (a life-threatening blood infection).During a facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated staff would promptly notify the attending physician of changes in the resident's medical condition. The P&P indicated prior to notifying the physician, the nurse was to do a detailed Situation, Background, Assessment, Recommendation (SBAR, a standardized, structured communication framework used in healthcare to quickly and accurately shared critical patient information) communication form.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review ([PASRR] - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was accurate for one of five sampled residents (Resident 107).This deficient practice had the potential to result in an inaccurate identification of specialized mental health service needs.Findings:During a review of Resident 107's admission Record, the admission Record indicated Resident 107 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a severe, chronic mental health condition where a patient experiences a loss of touch with reality), dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 107's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 107 did not have the capacity to make medical decisions.During a review of Resident 107's Minimum Data Sheet (MDS, a resident assessment tool), dated 4/17/2026, the MDS indicated Resident 107's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 107 required partial assistance (helper does less than half the effort for lifts /support) on staff for toilet hygiene, showering, and dressing. The MDS indicated Resident 107 was taking antipsychotic medication (drugs used to treat symptoms of psychosis).During a review of Resident 107's physician order, dated 7/18/2024, the physician order indicated to administer Abilify (used to treat mental health conditions) 15 milligrams ([mg] -unit of measurement) one tablet by mouth one time a day for schizophrenia.During a review of Resident 107's PASRR, dated 7/24/2024, the PASRR indicated Resident 107 was not diagnosed with any serious mental illness and was not prescribed psychotropic medications.During a concurrent interview and record review on 6/3/2026 at 1:52 p.m., with the Business Administrator, Resident 107's PASRR, dated 7/24/2024, was reviewed. The PASRR indicated Resident 107 was not diagnosed with any serious mental illness and was not prescribed psychotropic medications. The Business Administrator stated Resident 107 had schizophrenia and was administered psychotropic medication. The Business Administrator stated the PASRR was not accurate. The Business Administrator stated this placed Resident 107 at risk for not adequately identifying cognitive behavior and medication usage which can result in inappropriate care planning and unmet mental health needs.During a review of facility's policy and procedure (P&P) titled, Preadmission Screening & Resident Review (PASRR), dated 11/2023, the P&P indicated the facility would confirm the PASRR process was completed by the General Acute Care Hospitals (GACHs) by accepting and reviewing the PASRR. The P&P indicated when a resident was newly admitted to the facility after a hospital stay, facility staff would review the hospital completed PASRR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered language and communication care plan for one of five sampled residents (Resident 45).This deficient practice had the potential to result in Resident 45 having a communication barrier with staff.Findings:During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and chronic kidney disease stage 5 (kidneys have lost almost all of their ability to filter waste, extra water, and toxins from the blood).During a review of Resident 45's History and Physical (H&P) dated 6/2/2026, the H&P indicated Resident 45 had the mental capacity to understand but lacked the capacity to make medical decisions.During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 45 was able to understand and be understood by others. The MDS indicated Resident 45's cognition (ability to think and process) was intact. The MDS indicated Resident 45 required substantial assistance (helper does more than half the effort) from staff for activities of daily living and mobility. During a review of Resident 45's care plan, titled Resident 45 was an Armenian speaking resident., dated 5/20/2026, the care plan intervention included to provide staff and volunteers to interpret in native language and a communication board as needed for effective communication.During an observation and interview on 6/2/2026 at 10:35 a.m. with the Director of Staff Development (DSD), Resident 45's room did not have a communication board. The DSD stated she did not know if Resident 45 spoke or understood English. The DSD stated a communication board was not placed in the resident's room. The DSD stated she did not know what resources staff should use to communicate with Resident 45.During a concurrent interview and record review on 6/3/2026 at 10:53 a.m. with Registered Nurse (RN) 1, Resident 45's care plans were reviewed. RN 1 stated Resident 45's care plan did not include measurable objectives, individualized care and interventions, or timeframes based on the resident's assessed needs and preferences. RN 1 stated without measurable goals and timeframes, the facility could not demonstrate staff implemented interventions, understood expectations, reduced communication barriers, or evaluated outcomes.During an interview on 6/4/2026 at 9:06 a.m. with Resident 45 using an interpreter, Resident 45 stated she has never seen the communication board before and her husband was her sole interpreter.During a record review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated the care plan must describe the services provided or arranged by the facility, ensure these services were delivered by qualified personnel, and reflect culturally competent, and trauma informed practices.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 2) had the correct low air loss mattress (LALM, a specialized mattress support surface used to prevent and treat pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) setting.This deficient practice had the potential for Resident 2 to develop pressure ulcers. Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included stage three pressure ulcer (full thickness loss of skin. Dead and black tissue may be visible), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and end stage renal disease (the final, permanent stage when the kidneys can no longer filter waste and fluids from the blood to sustain life).During a review of Resident 2's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 2's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 2 was dependent (helper does all of the effort to complete the activity) on staff for toilet hygiene, showering, and dressing. The MDS indicated Resident 2 was at risk for pressure ulcers.During a review of Resident 2's physician order, dated 3/24/2026, the physician order indicated to have a LALM for wound management (the ongoing clinical process of assessing, treating, and monitoring wounds to promote optimal healing and prevent infection).During an observation on 6/3/2026 at 3:34 p.m., in Resident 2's room, Resident 2's LALM setting was set at 200 pounds (lbs., a unit of weight)During a concurrent interview and record review on 6/4/2026 at 3:43 p.m., with Licensed Vocational Nurse (LVN) 5, Resident 2's Vital Sign Summary, dated 5/11/2026, was reviewed. The Vital Sign Summary indicated Resident 2 weighed 169 lbs. LVN 5 stated Resident 2 weighed 169 lbs. and the LALM was set at 200 lbs.During an interview on 6/4/2026 at 11:45 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 2 weighed 160 lbs. and the LALM was set at 200 lbs. RN 1 stated the LALM had the incorrect settings. RN 1 stated the setting should be set at 160 lbs., which was closer to Resident 2's weight (169 lbs.). RN 1 stated the LALM was part of skin management (an approach to maintain, improve, and treat the skin's health and appearance) and to sustain the resident skin integrity (the overall health, strength, and completeness of the skin). RN 1 stated the incorrect LALM could cause worsening of pressure ulcers and slow down the healing process.During a review of the facility's policy and procedures (P&P) titled, Support Surface Guidelines, the P&P indicated any individual at risk for developing pressure ulcers should be placed on a redistribution support surface and settings for static air, alternating air, or air-loss must follow manufacturer's recommendations.During a review of manufacturer operational manual titled, Proactive Medical Products, unknown date, the operational manual indicated the LALM was intended to prevent and treat all pressure ulcer stages. The operational manual indicated to adjust the air mattress according to the resident's weight or the suggestion from a health care professional.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven residents (Resident 70) had an identification (ID) band on their wrist or ankle.This failure had the potential to result in Resident 70 not being properly identified for medical care and procedures.Findings:During a review of Resident 70's admission Record, the admission Record indicated Resident 70 was admitted to the facility on [DATE] with diagnoses including encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function), dementia (loss of thinking, remembering, and reasoning), and muscle weakness.During a review of Resident 70's History & Physical (H&P), dated 6/24/2025, the H&P indicated Resident 70 did not have the capacity to understand and make decisions.During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 70's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 70 used a manual wheelchair.During a review of Resident 70's care plan titled, Resident 70 is an elopement (the act of leaving a facility unsupervised and without prior authorization) risk/wanderer related to history of attempts to leave facility unattended, Impaired safety awareness, dated 12/28/2021, the care plan indicated a goal was to maintain Resident 70's safety.During an observation on 06/02/2026 at 11:06 a.m., Resident 70 was in the hallway in a wheelchair without an ID band. During a concurrent observation and interview on 06/02/2026 at 11:13 a.m. with Certified Nursing Assistant (CNA 2), CNA 2 checked Resident 70's wrists and ankles and stated Resident 70 was not wearing an ID band. CNA 2 stated Resident 70 would keep taking off the ID band. CNA 2 stated the facility's policy was that the residents should wear an ID band. During an interview on 6/2/2026 at 11:19 a.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated if there was no ID band, nurses could not check the resident's ID band to verify they were giving the correct resident their medications. LVN 3 stated the facility's policy was that the residents should wear an ID band.During an interview on 6/5/2026 at 9:05 a.m. with the Registered Nurse 1 (RN 1), RN 1 stated all residents had to have an ID band for their safety. RN 1 stated the ID band was used to identify residents when receiving medications and other treatments. RN 1 stated Resident 70 could be at risk of receiving the wrong medications if she was not properly identified. RN 1 stated if Resident 70 were to elope from the facility without an ID band, there would be no way to identify the resident. RN 1 stated it could take a long time to locate the resident, which could lead to the resident being afraid and lost in an unfamiliar environment.During a review of the facility's policy and procedure (P&P) titled, Resident Identification System, dated 12/2007, the P&P indicated a resident identification system was used to help facility personnel provide medical and nursing care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide transportation to a dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) clinic for one of five residents (Resident 17).This deficient practice had the potential to result in dangerous buildup of toxins in the body and fluid overload (the body retains too much sodium and water).Findings: During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD, the final most severe stage of chronic kidney disease), anxiety disorder (excessive fear or worry in everyday situations), and dependence on renal dialysis.During a review of Resident 17's History & Physical (H&P) dated 5/4/2026, the H&P indicated Resident 17 had fluctuating capacity to understand and make decisions and was able to make decisions for daily activities. During a review of Resident 17's Minimum Data Set (MDS-a resident assessment tool), dated 5/10/2026, the MDS indicated Resident 17 was able to express ideas and wants and was able to understand others. The MDS indicated Resident 17's cognition (ability to think and process) was intact. The MDS indicated Resident 17 was dependent (helper does all of the effort) on staff for eating, oral and personal hygiene and dressing his upper and lower body.During a review of General Acute Care Hospital (GACH) 1 document, undated, the document indicated GACH 1 arranged round trip transportation for Resident 17 from the facility to dialysis from 5/5/2026 to 5/30/2026.During a review of Resident 17's physician's order, dated 5/15/2026, the physician's order indicated Resident 17 was to be transported to dialysis weekly on Tuesday, Thursday, and Saturday.During a review of Resident 17's care plan titled, Resident 17 needs dialysis related to ESRD, dated 5/29/2026, the care plan intervention indicated Resident 17 was scheduled for dialysis on Tuesday, Thursday, and Saturday.During an interview on 6/2/2026 at 3:45 p.m. with Resident 17 in his room, Resident 17 stated he should be at dialysis right now, but he did not have a ride. Resident 17 stated on Saturday, the transportation driver who took him to dialysis told him the contract ended.During an interview on 6/3/2026 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated social services was aware Resident 17 did not have transportation to dialysis. LVN 4 stated missing dialysis could cause toxic buildup and fluid overload in the body.During an interview on 6/3/2026 at 12:43 p.m. with the Social Services Director (SSD), the SSD stated she usually scheduled transportation after nurses input appointments. The SSD stated the GACH Resident 17 transferred from covered the first 30 days of transportation. The SSD stated the facility should have worked on Resident 17's dialysis transportation before the first 30 days ended to ensure he did not miss his appointment.During a review of the facility's Policy & Procedure (P&P) titled End-Stage Renal Disease, Care of a Resident with dated 9/2010, the P&P indicated residents with ESRD will be cared for according to currently recognized standards of care.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Social Services Director (SSD) planned for transportation to dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) for one of five residents (Resident 17).This deficient practice resulted in Resident 17 missing one dialysis treatment.Findings: During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD, the final most severe stage of chronic kidney disease), anxiety disorder (excessive fear or worry in everyday situations), and dependence on renal dialysis.During a review of Resident 17's Minimum Data Set (MDS-a resident assessment tool), dated 5/10/2026, the MDS indicated Resident 17 was able to express ideas and wants and was able to understand others. The MDS indicated Resident 17's cognition (ability to think and process) was . The MDS indicated Resident 17 was dependent (helper does all of the effort) on staff for eating, oral and personal hygiene and dressing his upper and lower body.During a review of Resident 17's History & Physical (H&P) dated 5/4/2026, the H&P indicated Resident 17 had fluctuating capacity to understand and make decisions and was able to make decisions for daily activities. During a review of General Acute Care Hospital (GACH) 1 document, undated, the document indicated GACH 1 arranged round trip transportation for Resident 17 from the facility to dialysis from 5/5/2026 to 5/30/2026.During a review of Resident 17's physician's order, dated 5/15/2026, the physician's order indicated Resident 17 was to be transported to dialysis weekly on Tuesday, Thursday, and Saturday.During a review of Resident 17's care plan titled, Resident 17 needs dialysis related to ESRD, dated 5/29/2026, the care plan intervention indicated Resident 17 was scheduled for dialysis on Tuesday, Thursday, and Saturday.During an interview on 6/2/2026 at 3:45 p.m. with Resident 17, Resident 17 stated he should be at dialysis right now, but he did not have a ride. Resident 17 stated on Saturday, the transportation driver who took him to dialysis told him the contract ended.During an interview on 6/3/2026 at 12:43 p.m. with the Social Services Director (SSD), the SSD stated she usually scheduled transportation after nurses input appointments. The SSD stated the GACH Resident 17 transferred from covered the first 30 days of transportation. The SSD stated Resident 17's insurance did not cover transportation, and the facility should have worked on Resident 17's dialysis transportation before the first 30 days ended to ensure he did not miss his appointment. The SSD said the business office was handling the insurance problem. The SSD stated if the resident missed dialysis, the resident could experience fluid overload. During an interview on 6/3/2026 at 12:57 p.m. with the Business Office Manager (BA), the BA stated Resident 17 needed to be switched from traditional Medi-Cal (a system where the state pays providers directly for services) to a Medi-Cal Managed Care (the state assigns residents to a private plan) for transportation to be covered. The BA stated the facility started the process when Resident 17 arrived and expected it to be done by June 1st when GACH 1's arranged transportation ended. The BA stated the facility would cover Resident 17's transportation to dialysis until the insurance pays for it.During a review of the facility's Policy & Procedure (P&P) titled Transportation, Social Services dated 12/2008, the P&P indicated social services will help the resident obtain transportation.During a review of the facility's Director of Social Services (SSD) job description revised August 2024, the job description indicated the SSD was to assist in arranging transportation to other facilities when necessary.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a licensed pharmacist conducted a monthly Medication Regimen Review (MMR) for one of five sampled residents (Resident 10).This failure had the potential to result in Resident 10 receiving unnecessary medication and could lead to adverse side effects.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 50 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychotic disorder (mental health condition where a person strongly believes things that are not true, even when there is clear evidence showing otherwise) with delusions (false beliefs).During a review of Resident 10's History and Physical (H&P) dated 1/21/2026, the H&P indicated Resident 10 lacked the capacity to make medical decisions.During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 10's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 10 required supervision (helper provided verbal cues or contact guard assistance) from staff for oral hygiene and mobility. During a concurrent interview and record review on 5/21/26 at 9:28 a.m. with Registered Nurse (RN 1), Resident 10's medical record was reviewed. RN 1 stated the consultant pharmacist did not complete a monthly MMR in January, February, March, April, or May 2026 for Resident 10's psychotropic medications (a medicine that affects how the brain works and can change a resident's mood, thoughts, feelings, or behavior) of Depakote (medication for mood disorder) 125 milligram (mg, unit of measurement), and Risperidone (medication for psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality] insomnia and depression) 0.5 mg. RN 1 stated the consultant pharmacist must review Resident 10's antipsychotic medications to ensure a gradual dosage reduction (GDR) was considered, verify the medication dosage remained therapeutic (having a healing effect), and monitor the resident's behavior and laboratory values for effectiveness.During a record review of the facility's policy and procedure (P&P) titled, Medication Therapy, dated 4/2007, the P&P indicated the consultant pharmacist would review each resident's medication regimen monthly, upon staff or practitioner request, or when a clinically significant adverse consequence was confirmed or suspected. The P&P indicated the medical director and consultant pharmacist would collaborate with the practitioners and staff to address issues related to medication prescribing and monitoring.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the cultural and ethnic needs of food choices were identified for one of five sampled residents (Resident 107).This deficient practice placed Resident 107 at risk for being dissatisfied with meals.Findings:During a review of Resident 107's admission Record, the admission Record indicated Resident 107 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a severe, chronic mental health condition where a patient experiences a loss of touch with reality), dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 107's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 107 did not have the capacity to make medical decisions.During a review of Resident 107's Minimum Data Sheet (MDS, a resident assessment tool), dated 4/17/2026, the MDS indicated Resident 107's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 107 was independent from staff for eating.During a review of Resident 107's care plan titled, Nutrition and Hydration deficit on Therapeutic Diet, dated 9/11/2025, the care plan intervention indicated to adhere to food preferences within diet order.During a review of Resident 107's physician orders, dated 9/10/2025, the physician orders indicated Resident 107 was on a no added salt, low sugar regular (level 7, the highest and least restrictive food texture for safe eating) diet.During a review of Resident 107's, Dietary Quarterly Assessment, dated 4/17/2026, the Dietary Quarterly Assessment indicated Resident 107 had no food preferences.During a concurrent observation and interview on 6/3/2026 at 11:11 a.m., with Resident 107 in Resident 107's room, the menu and alternative food selection were not in her room. Resident 107 stated she would like to have food choices of her culture. Resident 107 stated she had told the staff she had preferred foods from her culture. Resident 107 stated there was no menu provided for alternative food choices and was not aware the alternative food choices were on the wall near the kitchen. Resident 107 stated she would like to have alternative food choices menu in her room and along with food choices from her culture.During an interview on 6/3/2026 at 1:05 p.m. with the Dietary Supervisor (DS), the DS stated there were no menus in Resident 107's room. The DS stated residents with level 7 diets would be eligible to have the menus in the room to select the diet alternatives. The DS stated Resident 107 had a level 7 diet and was qualified to have the menu in her room. The DS stated having food preferences for the residents helps them to thrive and feel good about themselves.During a concurrent interview and record review on 6/3/2026 at 1:12 p.m., with DS, Resident 107's, Dietary Quarterly Assessment, dated 4/17/2026, the Dietary Quarterly Assessment indicated Resident 107 had no food preferences. The DS stated staff had not reported to her about Resident 107's request for food from her culture. The DS stated she did random rounds with Resident 107 but could not produce documentation of their interaction about random rounds. The DS stated Resident 107's culture food preferences were essential so she could enjoy her meals.During a review of facility's policy and procedure (P&P) titled, Resident Food Preferences, unknown date, the P&P indicated food preferences will be assessed. The P&P indicated staff will interview the resident directly to determine current food preferences based on history and life patterns. The P&P indicated nursing staff will document the resident's food and eating preferences in the care plan. The P&P indicated if the resident was unhappy with his or her diet, the staff will create a care plan that the resident was satisfied with.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Infection Preventionist attended the February 2026 and May 2026 Quality Assurance and Performance Improvement (QAPI, a data driven proactive approach to improvement used to ensure services are meeting quality standards) meetings.This failure resulted in the facility not meeting the minimum required members for the monthly committee meeting.Findings:During a record review of the Monthly QAPI Meeting attendance sheets dated 2/20/2026 and 5/22/2026, the QAPI Meeting attendance sheets indicated there was no signature for the infection preventionist (IP).During a concurrent interview and record review on 6/5/2026 at 11:06 a.m. with the Administrator (ADM) and the Director of Nursing (DON), in the DON's office, the QAPI meeting attendance sheets for the 2/20/2026 and 5/22/2026 meetings were reviewed. The attendance sheets indicated there was no signature for the IP. The ADM stated the IP did not attend the meetings on 2/20/2026 and 5/22/2026. The ADM stated the minimum staff in attendance for QAPI meetings were the ADM, DON, IP and three other members. The ADM stated if the IP was not in the meetings, the IP would not be able to address infection control issues or clarify infection control information, concerns, and questions from the team.During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI), dated 2/2020, the P&P indicated the administrator was responsible for assuring that this facility's QAPI program complied with federal, state, and local regulatory agency requirements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the perma-catheter (a long, flexible tube inserted into a large vein and threaded near the heart) was maintained in a clean and sanitary manner for one of five sampled residents (Resident 2).This deficient practice had the potential for Resident 2 to develop an infection.Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included stage three pressure ulcer (full thickness loss of skin. Dead and black tissue may be visible), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and end stage renal disease (the final, permanent stage when the kidneys can no longer filter wase and fluid s from the blood to sustain life).During a review of Resident 2's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 2 did not have the capacity to understand and make medical decisions.During a review of Resident 2's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 2's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 2 was dependent (helper does all of the effort to complete the activity) on staff for toilet hygiene, showering, and dressing. The MDS indicated Resident 2 was at risk for pressure ulcers (localized damage to the skin and/or underlying tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). The MDS indicated Resident was receiving hemodialysis (a treatment to cleanse the blood of wasted and extra fluids artificially through a machine when the kidney (s) have failed).During a review of Resident 2's physician order, dated 3/17/2026, the physician order indicated to monitor right chest perma-catheter dialysis access site for any redness, swelling, bleeding, drainage, and pain. The order indicated to apply pressure on dialysis site if bleeding was noted and notify the physician.During an observation on 6/3/2026 at 3:34 p.m., in Resident 2's room, Resident 2 had redness and exudate (a fluid that leaks out onto skin surface in response to inflammation, injury, or infection) on the skin around the right chest perma-catheter double lumen (the hollow, tubular channel inside an intravenous [IV] catheter) and the lumen had blood in the tubing.During a concurrent interview and picture record review on 6/5/2026 at 10:05 a.m. with the Infection Preventionist (IP), the picture of the perma-catheter, dated 6/3/2026 was reviewed. Resident 2 had a right chest perma-catheter double lumen with redness and exudate to the surrounding skin at the insertion site. The IP stated staff were to monitor the perma-catheter every shift but there was no documentation of the redness or exudate around the perma-catheter. The IP stated the redness and exudate had the potential to cause the resident to become septic (a life-threatening blood infection).During a review of facility's policy and procedure (P&P) titled, Central Venous Catheter Care: Permacath for Hemodialysis, undated, the P&P indicated it was the policy of the facility ensure that residents with a central venous catheter would receive safe, sanitary, and appropriate catheter care to prevent infection. The P&P indicated to promote compliance with infection prevention standards and resident safety requirements. The P&P indicated to assess catheter site for redness, swelling, drainage, warmth, tenderness, or odor.