STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056019	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardena Convalescent Center	14819 S. Vermont 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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of four residents (Resident 1), was provided with a safe and hazard-free environment while providing care. This deficient practice had the potential to cause severe injuries to Resident 1 including hospitalization and death.Findings: During a concurrent observation and interview on 7/9/2025 at 12:30 p.m. with Resident 1, in Resident 1's room, Resident 1's right upper cheek was observed slightly swollen and purple in color and the right elbow had a dime size abrasion (scratch). Resident 1 was unable to move right upper and lower extremity. Resident 1's speech was slurred but Resident was able to communicate with simple words. Resident 1 stated she fell in the facility while the nurse was in the room and was sent to the hospital. During a review of Resident 1'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 hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarct affecting right dominant side ([stroke], loss of blood flow to a part of the brain), muscle wasting and atrophy (loss of muscle mass and strength,) and abnormalities of gait and mobility (any deviation from a typical walking pattern or the ability to move easily and freely in the environment). During a review of Resident 1's History and Physical (H&P) dated 6/24/2025, the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/26/2025, the MDS indicated Resident 1 was dependent with staff with activities of daily living (ADL) such as dressing, toilet use, personal hygiene, 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 1's Change of Condition (COC), dated 7/4/2025, timed 6:20 a.m., the COC indicated Resident 1 was in bed while Certified Nurse Assistant (CNA) 2 was providing ADL care. The COC indicated while CNA 2 was doing peri-care to Resident 1, Resident 1's weight shifted (move or cause to move from one place to another) when Resident 1 was turned to one side which contributed to Resident 1's fall from the bed to the floor. The COC indicated Licensed Vocational Nurses (LVN) 1 went to Resident 1's room and found Resident 1 on the floor in a side-lying position (side unspecified) supported by CNA 2. The COC indicated Resident 1 needed maximum assistance with baseline and dependent on transfers. The COC indicated Resident 1 was assisted by nurses (unspecified) back to bed. The COC indicated Resident 1 had an abrasion on the right elbow, and a periorbital (the area around the eye socket) swelling with purple discoloration on the right eye. During a review of Resident 1's care plan titled, Alteration with ADL functions, dated 7/8/2025, the care plan indicated Resident 1 was dependent with staff's assistance. The interventions indicated maintaining a safe and hazard free environment. The interventions did not specify the type of assistance staff needed to provide Resident 1 while providing ADL care. During an interview on 7/9/2025 at 12:30 p.m. with CNA 1, CNA 1 stated when CNAs are changing the residents, we need to make sure when residents are turned to the side, the residents are able keep that position, otherwise the CNA should find help from another nurse. CNA 1 stated Resident 1 was usually able to stay on her side when turned. CNA 1 stated we need to make sure Resident 1 understood to be still until the CNA is done cleaning her (Resident 1). CNA 1 stated it is the nurse's responsibility to provide residents' safety and prevent any falls. During an interview on 7/9/2025 at 3:31 p.m. with LVN 1, LVN 1 stated Resident 1 was totally dependent on staff with ADL care, turning and repositioning. LVN 1 stated Resident 1 can be assisted by one person, but nurses need to make sure that Resident 1 is at the center of the bed before being turned. LVN 1 stated if a resident is at the edge of the bed when turned, the resident could fall. LVN 1 stated nurses should prioritize residents' safety first, or request assistance. During a concurrent interview and record revied on 7/9/2025 at 4:44 p.m. with LVN 2, LVN 2 stated Resident 1 was paralyzed on her right side. LVN 2 stated Resident 1 was totally dependent on staff for mobility and hygiene care. LVN 2 stated Resident 1 was not able to turn by herself, and the nurses should have taken precautions when Resident 1 was repositioned. LVN 2 stated Resident 1 should not be at the edge of the bed when turned so the resident does not fall. LVN 2 stated staff need to maintain a safe environment for the residents. LVN 2 stated Resident 1's care plan should have specified the number of staff needed when providing ADL care. LVN 2 stated if nurses failed to personalize a resident's care plan, it would place the residents at risk for falls and injuries. During an interview on 7/9/2025 at 5:06 p.m. with the Director of Nursing (DON), the DON stated Resident 1 fell from the bed on 7/4/2025 while receiving care from CNA 1