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	05/29/2026

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 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 interview and record review, the facility failed to develop a pain care plan for one out of three sampled residents (Resident 1). This failure had the potential to result in Resident 1 not receiving specific care interventions related to Resident 1's pain.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 Unilateral Primary Osteoarthritis of the left hip (a progressive disorder of the joints, caused by a gradual loss of cartilage), left hip artificial joint, and anxiety disorder (a mental health condition defined by intense, excessive, and persistent worry or fear about everyday situations).During a review of Resident 1's physician order, dated 5/18/2026, the physician order indicated to administer Hydrocodone-Acetaminophen (a pain medication) 10-325 milligram (mg, a unit of measurement) one tablet by mouth every four hours as needed for moderate to severe pain.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/24/2026, the MDS indicated Resident 1's cognition (ability to think and process) was intact. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) from staff for toileting hygiene, showering, lower body dressing, sitting to standing, and transfers. The MDS indicated Resident 1 had frequent pain and recently had a hip replacement.During a concurrent interview and record review on 5/29/2026 at 8:48 a.m. with Registered Nurse (RN 1) 1, Resident 1's Care Plan Report, undated, was reviewed. The Care Plan Report did not include a care plan for Resident 1's left hip pain. RN 1 stated there were no care plans for Resident 1's pain. RN 1 stated care plans should be initiated within 3 days of admission. RN 1 stated the care plan was a means of communication for all staff caring for the residents and it was important to have a care plan for everyone to see, follow, and be consistent in the residents' care. During an interview on 5/29/2026 at 9:06 a.m. with Resident 1, Resident 1 stated she had pain in her left hip after having a left hip replacement surgery. During a review of the facility's policy and procedure (P&P), titled Develop-Implement Comprehensive Care Plans, dated 1/2026, the P&P indicated the facility would develop a person-centered comprehensive care within seven days after the completion of the comprehensive assessment. The P&P indicated care plans should describe the residents' needs and preferences and how the facility would assist in meeting those needs and preferences.

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