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	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardena Convalescent Center	14819 S. Vermont 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to: 1.Ensure 36 out of 36 narcotic destruction log sheets were signed by the Director of Nursing (DON) and the facility's pharmacist consultant. This deficient practice had the potential to result in narcotic diversion (the illegal transfer of prescription drugs, specifically controlled substances like opioids, from their intended, legal purpose to an unauthorized person or for illegal use).Findings:During a concurrent interview and record review, on 3/11/2026 at 10:32 a.m., with the DON, the DON stated there were 34 individual residents-controlled drug record that she did not sign on 1/30/2026 during drug destruction with RPH. The DON stated all discontinued narcotics were kept in a locked drawer inside of her office. The DON stated if a narcotic was discontinued, a licensed nurse would come to her office, and both (DON and license nurse) would count the remaining medications. The DON stated she would do a monthly narcotic destruction with the pharmacy consultant. The DON stated she and the pharmacy consultant would count the narcotics together to ensure the amount of medication on the bubble pack matched the medication on the narcotic destruction log, then destroy them by placing the medications into destruction bin. The DON stated the process of destroying narcotics medications included two signatures on the Controlled or Antibiotic Drug Record, one from the Registered Pharmacy (RPH) and the DON per State and Federal guidelines. The DON stated the risk of not properly accounting for a narcotic, not being able to validate a narcotic could result in narcotic diversion. A review of the facility policy and procedures (P&P), titled Medication Destruction, revised 1/2025, indicated Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous waste and controlled substances and to include the signature(s) of at least two witnesses including a registered nurse and an authorized licensed pharmacy representative.

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 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** Based on observation, interview, and record review the facility failed to: 1. Label with an opened date and remove expired ipratropium with albuterol (a combination medication used to treat and prevent shortness of breath) inhalation solution for three of three sampled residents (Resident 16, Resident 20, and Resident 72) in Medication cart 1. This deficient practice had the potential to result in prolonged use and loss of strength of the expired inhalation solution and can lead to ineffective treatment of respiratory symptoms for Resident 16, 20 and 72.Findings:During a review of Resident 16's admission Record, the admission Record indicated, Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's diagnoses included pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 16's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Minimum Data Set ([MDS] - a resident assessment tool), dated [DATE], the MDS indicated, Resident 16's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 16 required substantial assistance (helper does more than half the effort) from staff with eating, oral hygiene, and upper body dressing. During a review of Resident 16's Order Summary Report (a document containing active orders), dated [DATE], the Order Summary Report indicated, the physician placed a telephone order on [DATE] for Resident 16 to start on ipratropium with albuterol inhalation solution 3 milliliter ([ml] unit of volume) every 4 hours as needed for dyspnea (shortness of breath). During a review of Resident 20's admission Record, admission Record indicated, Resident 20 was admitted to the facility on [DATE]. Resident 20's diagnoses included pneumonia (an infection/inflammation in the lungs),congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 20's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set ([MDS] - a resident assessment tool), dated [DATE], the MDS indicated, Resident 20 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 20 required set-up assistance (helper assists only prior to or following the activity) from staff with eating and oral hygiene. During a review of Resident 20's Order Summary Report (a document containing active orders), dated [DATE], the Order Summary Report indicated, the physician placed a telephone order on [DATE] for Resident 20 to start on ipratropium with albuterol inhalation solution 3 milliliter ([ml] unit of volume) every 6 hours (12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m.). During a review of Resident 72's admission Record, admission Record indicated, Resident 72 was admitted to the facility on [DATE]. Resident 72's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and atrial fibrillation (irregular heart rate and rhythm). During a review of Resident 72's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 72 had the fluctuating capacity to understand and make decisions. During a review of Resident 72's Order Summary Report (a document containing active orders), dated [DATE], the Order Summary Report indicated, the physician placed a telephone order on [DATE] for Resident 72 to start on ipratropium with albuterol (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inhalation solution 3 milliliter ([ml] unit of volume) every 4 hours for COPD. During a concurrent observation and interview on [DATE] at 9:56 a.m., with Licensed Vocational Nurse 1 (LVN 1), of the medication cart 1, found three opened ipratropium with albuterol combination inhalation foil pack stored at room temperature. LVN 1 stated Residents 16, 20, and 72 have one opened ipratropium with albuterol combination inhalation foil pack with no label with an opened date. LVN 1 stated Resident 16's one opened ipratropium with albuterol combination inhalation foil pack indicated a pharmacy fill date of [DATE]. LVN 1 stated Resident 20's one opened ipratropium with albuterol combination inhalation foil pack indicated a pharmacy fill date of [DATE]. LVN 1 stated Resident 72's one opened ipratropium with albuterol combination inhalation foil pack indicated a pharmacy fill date of [DATE]. LVN 1 stated all medications should be labeled with an open date so the facility staff would know the expiration date. LVN 1 stated giving expired ipratropium with albuterol combination inhalation solution to Residents 16, 20, and 72 would no longer be effective in treating their respiratory symptoms. LVN 1 stated she will discard immediately the three opened ipratropium with albuterol combination inhalation foil pack.During an interview on [DATE] at 12:11 p.m., with the Director of Nursing (DON), the DON stated it is important to label all medications with an open date so the facility staff would know the life span of the medication (the period during which it remains safe and effective for use, provided it is stored properly). The DON stated giving expired medication would have a possibility of adverse reaction (an unintended effect of a medication that is harmful or unpleasant) to residents.During a review of the manufacturer's product storage and labeling, opened foil packs of ipratropium with albuterol inhalation solutions should be stored at room temperature between 36 and 77 degrees Fahrenheit and used or discarded within two weeks of opening the foil cover.During a review of the facility's policy and procedure (P&P), titled, Labeling of Biologicals and Storage of Biologicals, dated 1/2025, the P&P indicated Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to:1. Ensure food items stored in the kitchen walk in refrigerator were maintained in a safe and sanitary manner by allowing expired hot dog buns and corn tortillas to remain stored and available for use. This deficient practice had the potential to result in residents being served expired food products.During a concurrent observation and interview on 3/10/2026 at 8:40 a.m. with the [NAME] in the kitchen walk in refrigerator observed was an opened bag of [NAME] brand corn tortillas 80 count with an expiration date of 12/21/2025 and 5 bags of [NAME] Deli 16 count hot dog buns with 3 with expiration dates of 1/31/2026 and 2 with expiration dates 2/2/2026. The [NAME] stated the hot dog buns and tortillas should not be in the refrigerated stored with other food they should be thrown out. During an Interview on 3/10/26 at 11:09 a.m. with the Dietary Services Supervisor (DSS), the DSS stated having the expired food could expose residents to foodborne illness and make residents sick. The DSS stated the expired food should not have been in the kitchen. During a review of the facility's policy and procedure (P&P), title, Food Receiving and Storage revised January 2026, the P&P indicated, monitoring refrigerated food, including but not limited to leftovers, so it is used by its used-by date or discarded.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Ensure the call light (a device used by a resident to signal his or her need for assistance from a staff) was within reach for one of 17 sampled residents (Resident 39).This failure had the potential for increased risk of falls, delayed response to emergencies, and unmet basic needs for Resident 39. Findings:During a review of Resident 39's admission Record, the admission Record indicated, Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 39's diagnoses included dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 39's History and Physical (H&P), dated 8/30/2025, the H&P indicated, Resident 39 did not have the capacity to understand and make decisions.During a review of Resident 39's Minimum Data Set Assessment ([MDS] - a resident assessment tool), dated 12/10/2025, the MDS indicated, Resident 39's cognitive (ability to think and reason) skills for daily decision were severely impaired (never/rarely made decisions). The MDS indicated, Resident 39 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of Resident 39's care plan, titled Alteration with Activities of Daily Living ([ADL] - a basic skill needed to carry out tasks of everyday life), revised 1/12/2026, the care plan intervention included to maintain call light within easy reach and answer promptly.During a concurrent observation and interview on 3/10/2026 at 9:45 a.m., with the Infection Preventionist Nurse (IPN) in Resident 39's room, the IPN stated Resident 39's touch pad call light was under her pillows and Resident 39 could not reach her touch pad call light (specialized call light in the form of a pad). The IPN stated call light should be in the residents reach to allow resident to call for help and assistance.During an interview on 3/12/2026 at 12:07 p.m., with the Director of Nursing (DON), the DON stated all staff are responsible in monitoring resident's call light. The DON stated resident's call light should be within their reach at all times so the facility staff could anticipate the needs of the residents. The DON stated the purpose of the call light was to ensure residents can call for help especially during emergency.During a review of the facility's policy and procedure (P&P) titled, Resident Call System, dated 1/2025, the P&P indicated, Resident call system shall be accessible to residents while in their bed.During a review of the facility's P&P titled, Reasonable Accommodations of Needs-Preferences, dated 1/2026, the P&P indicated, Each resident shall have access to the resident call system within reach.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to:1.Ensure personal information of residents was protected by not throwing the protected information (PHI - any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) in the trash can without shredding.This failure had the potential to violate residents rights and privacy.During an observation on 3/12/2026 at 1:45 p.m. observed meal tickets in the trash by the dishwashing machine area. The meal tickets contained resident names, room numbers and diet types, texture level, liquid consistency level and likes and dislikes.During an interview on 3/12/2026 at 1:50 p.m. with the Dietary Aide (DA) the DA stated the meal cards have patient information names, diet type, and room number and I should not have been thrown in the trash they should have been shredded or given to the supervisor.During an interview on 3/12/2026 at 1:50 p.m. with the Dietary Service Supervisor (DSS) the DSS stated I have staff put the meal tickets on the side and I take the meal tickets and have them shredded. The meal tickets contain resident names, diet and room numbers, which is all protected information. This information should not be discarded in the trash personal privacy information should not be thrown in the trash can, that could expose resident's personal information.During a review of the facility policy and procedure (P&P) titled, Privacy and Confidentiality dated 1/2025 the P&P indicated the resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure the quarterly (every 3 months) Minimum Data Set Assessment ([MDS] - a resident assessment tool) for one of one sampled resident (Resident 2) was completed within the required timeframe. This deficient practice could potentially affect the care services of Resident 2.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 4's diagnoses included congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), atrial fibrillation (irregular heart rate and rhythm), and hypertension ([HTN] - high blood pressure).During a review of Resident 2's History and Physical (H&P), dated 9/11/2025, the H&P indicated, Resident 2 lacks the capacity to make medical decisions.During a concurrent interview and record review on 3/11/2026 at 12:57 p.m., with the Minimum Data Set Nurse (MDSN), Resident 2's quarterly MDS assessment, dated 2/20/2026, was reviewed. The MDSN stated Resident 2's quarterly MDS assessment was not completed yet. The MDSN stated Resident 2's quarterly MDS assessment should have been completed on 3/6/2026 which is 14 days from 2/20/2026. The MDSN stated all MDS assessment should be completed in a timely manner in order to capture the unnecessary changes of resident's condition. The MDSN stated late completion of MDS assessment would affect the plan of care of the resident.During an interview on 3/12/2026 at 12:15 p.m., with the Director of Nursing (DON), the DON stated MDS assessment should be completed within 14 days from the Assessment Reference Date ([ARD] - the specific date used as the endpoint of the observation period when assessing resident's condition). The DON stated by not completing the MDS in a timely manner, the resident's assessment will not be updated and there is a possibility that the care of the resident would not be met.During a review of the facility's policy and procedure (P&P), titled, Resident Assessment, dated 1/2026, the P&P indicated The facility shall complete MDS assessments within required federal timeframes.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure the Minimum Data Set ([MDS] - a resident assessment tool) was completed accurately for one of 17 sampled residents (Resident 2). This deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Resident 2.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 4's diagnoses included congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), atrial fibrillation (irregular heart rate and rhythm), and hypertension ([HTN] - high blood pressure).During a review of Resident 2's History and Physical (H&P), dated 9/11/2025, the H&P indicated, Resident 2 lacks the capacity to make medical decisions.During a review of Resident 2's MDS assessment, dated 11/21/2025, the MDS assessment indicated, Resident 2's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 2 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, lower body dressing, and personal hygiene.During a review of Resident 2's Joint Mobility Assessment ([JMA] - brief assessment of a resident's range of motion in each joint of both arms and legs), dated 8/29/2025, 9/9/2025, 12/15/2025, and 2/20/2026, were reviewed. The JMA indicated, Resident 2 had no impairment on upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot).During a concurrent interview and record review on 3/11/2026 at 1:04 p.m., with the Minimum Data Set Nurse (MDSN), Resident 2's MDS assessment, dated 11/21/2025, was reviewed. The MDSN stated Resident 2's MDS assessment was completed inaccurately. The MDSN stated there was a wrong entry on MDS section GG0115 (Functional Limitation in Range of Motion ([ROM] - full movement potential of a joint]). The MDSN stated MDS section GG0115 ([B] - lower extremity (hip, knee, ankle, foot) should be coded as 0 (no impairment) not 1 (impairment on one side) because Resident 2 had no functional limitation in range of motion on lower extremities. The MDSN stated the facility transmitted an inaccurate information of Resident 2's actual condition to the CMS. The MDSN stated inaccuracy of MDS assessment would affect facility's quality measures (standardized, data-driven metrics derived from CMS-mandated resident assessments to monitor care quality in nursing homes).During an interview on 3/12/2026 at 8:46 a.m., with the Director of Rehabilitation (DOR), the DOR stated Resident 2 had no contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) and had no limitation in range of motion on upper and lower extremities that impairs her Activities of Daily Living ([ADL's] - activities such as bathing, dressing and toileting a person performs daily) function. The DOR stated Resident 2 had no change on ROM since she was admitted to the facility. The DOR stated Resident 2's MDS assessment on functional limitation in range of motion on lower extremity dated 11/21/2025 was not completed accuratelyDuring an interview on 3/12/2026 at 12:12 p.m., with the Director of Nursing (DON), the DON stated it is important to complete MDS assessment accurately in order to provide the needs of the resident.During a review of the facility's policy and procedure (P&P), titled, Resident Assessment, dated 1/2026, the P&P indicated Initially and periodically, the facility conducts a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.During a review of the facility's P&P, titled Accuracy of Assessments, dated 1/2026, the P&P indicated, The facility shall maintain supporting source documentation used to substantiate all MDS coding in the resident's medical records.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary care and services in accordance with professional standards of practice for one of one sampled resident (Resident 3) by failing to: 1. Obtain a medical order clearance for tooth extraction (removal of a tooth) for Resident 3 as recommended by the dentist. This deficient practice had the potential to put Resident 3 at risk for oral infection, pain, and weight loss.Findings:During a review of Resident 3's admission Record, the admission Record indicated, Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's History and Physical (H&P), dated 1/21/2026, the H&P indicated, Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set ([MDS] - a resident assessment tool) assessment, dated 1/26/2026, the MDS assessment indicated, Resident 3 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 3 required substantial assistance (helper does more than half the effort) from staff with eating and oral hygiene.During an interview on 3/10/2026 at 9:54 a.m., with Resident 3, Resident 3 stated she needed a surgery to remove her broken teeth. Resident 3 stated her broken teeth bothers her and she was not able to chew the food properly. Resident 3 stated she's still waiting for the dentist to come to remove her broken teeth.During a concurrent interview and record review on 3/11/2026 at 2:15 p.m., with the Social Service Director (SSD), Dental Visit Summary, dated 12/10/2025, was reviewed. The SSD stated the Dental Visit Summary indicated, Resident 3 had periodic oral evaluation (routine dental examination) and the dentist recommended to obtain medical order. The SSD stated she was not aware of the dentist recommendation, and she does not know what kind medical order the dentist was referring to.During an interview on 3/11/2026 at 2:23 p.m., with Registered Nurse 1 (RN 1), RN 1 stated she did not check the Dental Visit Summary, and she was not aware of the dentist recommendation to obtain medical order for Resident 3.During a concurrent interview and record review on 3/11/2026 at 2:34 p.m., with the Director of Nursing (DON), Resident 3's Dental Notes, dated 12/10/2025, was reviewed. The DON stated the Dental Notes indicated, the dentist recommended to obtain a medical order clearance for Resident 3 for tooth extraction. The DON stated there was no documentation by facility staff indicating Resident 3's physician was notified and obtained a medical order clearance for tooth extraction. The DON stated any recommendations by the dentist should be addressed promptly to prevent delay of care and treatment. The DON stated it is important for Resident 3 to have tooth extraction to minimize oral infection, discomfort, and pain that would diminish her quality of life.During a review of the facility's policy and procedure (P&P), titled, Quality of Care, dated 1/2025, the P&P indicated The interdisciplinary team (IDT) shall provide the necessary care or services to improve and/or attain the resident's highest practicable physical, mental, and/or psychosocial well-being.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation interview and record review the facility failed to: 1. Ensure one of two sampled residents (Resident 36), assessed as being at risk for elopement (leaving the facility without permission) wore a ROAM Alert device (an electronic safety device worn by a resident that triggers an alarm if the resident attempts to exit the building) ordered by the physician to notify staff of potential elopement. This failure had the potential to allow a resident to leave the facility unsupervised and without staff awareness, placing the resident at risk of harm or injury.During a review of Resident 36's admission Record (face sheet), the face sheet indicated the facility admitted Resident 36 on 7/31/2023 with diagnoses including homelessness, syncope and collapse (a temporary loss of consciousness caused by a sudden decrease in blood flow to the brain resulting in fainting) and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool) dated 2/6/2026, the MDS indicated Resident 36's was independent (decisions consistent/ reasonable) in cognitive (ability to think and reason) skills of daily decision making. The MDS indicated Resident 36 was independent in functional abilities including eating and upper body dressing and required the minimal assist from one staff for personal hygiene showering and oral hygiene. An elopement risk note dated 2/6/2026 indicated an elopement risk score value of 1 or higher indicated the resident was an elopement risk. Resident 36 risk elopement score was documented as 4. During a review of Resident 36's History and Physical (H&P) dated 2/23/2025, the H&P indicated Resident 36 had fluctuating capacity to understand and make decisions.During a review of the physician orders dated 3/2/2026 the physician orders indicated ROAM Alert to left wrist elopement risk dated 10/7/2024, and ROAM Alert monitor function right wrist every shift dated 11/28/2025.During a review of the plan of care dated 12/3/2023, the plan of care for elopement risk due to Resident 36 constantly seeking behavior, episodes of packing belongings. The intervention dated 5/9/2024 for the problem was for Resident 36 to wear the Roam alert device on the left wrist due to elopement risk.During observations on 3/10/2026, 3/11/2026 and 3/12/2026 at 8:00 a.m. 11:00 a.m. 2:00 p.m. and 4:00 p.m. Resident 36 was observed without a ROAM Alert device on his wrist.During an interview on 3/12/2026 at 9:43 a.m. with the Director of Nurses (DON), the DON stated the resident being without a ROAM Alert device put Resident 36 at an increased safety risk stating Resident 36 could easily elope without staff knowing and put Resident 36 at risk for injury or harm.During a review of the facility's policy and procedure (P&P) titled, Free of Accident Hazards/Supervision/Devices dated January 2025, the P&P indicated, avoidable accident: when an accident occurred because the facility failed to implement interventions including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk.if not reduce the risk of an accident monitor the effectiveness of the interventions and modify the care plan as necessary in accordance with current professional standards of practice.

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	03/13/2026

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 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: 1. Ensure one of one sampled resident (Resident 39) who has a Peripherally Inserted Central Catheter ([PICC] - a thin flexible tube that is inserted into a vein in the upper arm above the right side of the heart, used to give intravenous fluids, blood transfusions, and medications) was placed on Enhanced Barrier Precaution ([EBP] - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). This failure had the potential to increase the risk of infection and cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) among residents and staff.Findings:During a review of Resident 39's admission Record, the admission Record indicated, Resident 39 was admitted to the facility on [DATE]. Resident 39's diagnoses included pneumonia (an infection/inflammation in the lungs), urinary tract infection ([UTI] - an infection in the bladder/urinary tract), and bacteremia (presence of bacteria in your blood).During a review of Resident 39's History and Physical (H&P), dated 3/5/2026, the H&P indicated, Resident 39 had the capacity to understand and make decisions.During a review of Resident 39's Order Summary Report (a document containing active orders), dated 3/10/2026, the Order Summary Report indicated, the physician placed a telephone order on 3/5/2026 for Resident 39 to start on Unasyn (medication to treat infection) 3 grams (([gm] - unit of measurement, used for medication dosage and/or amount) intravenously (into the vein) three times a day (9:00 a.m., 1:00 p.m., and 5:00 p.m.) for UTI for 10 days.During a concurrent observation and interview on 3/10/2026 at 10:21 a.m., with the Infection Preventionist Nurse ([IPN] - a healthcare professional who works to prevent spread of infections in the healthcare setting) in Resident 39's room, Resident 39 had a PICC line on right upper arm. The IPN stated EBP is practiced on residents that have a medical device like a PICC line. The IPN stated Resident 39 was not placed on EBP since he was admitted to the facility on [DATE]. The IPN stated there should be a personal protective equipment ([PPE] - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) supplies outside the room of Resident 39 such as gown, gloves for staff to use to provide care to Resident 39. The IPN stated it was an oversight on her part by not putting Resident 39 on EBP. The IPN stated it is important to place Resident 39 on EBP to prevent the spread of infection to residents and staff.During an interview on 3/12/2026 at 12:09 p.m., with the Director of Nursing (DON), the DON stated residents with medical devices such as central line, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and foley catheter (a thin, flexible tube inserted into the bladder to drain urine) should be placed on EBP immediately to prevent cross contamination and spread of infection.During a review of the facility's policy and procedure (P&P), titled Enhanced Barrier Precautions, revised 1/2025, the P&P indicated, EBP are indicated for residents with indwelling medical device that include central lines.During a review of the facility's P&P, titled Infection and Prevention Control, revised 1/2026, the P&P indicated, The facility staff ensure EBP are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing.