STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 1), did not develop pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence [any point of the body where the bone is immediately below the skin surface]) at the facility. The facility failed to:1). Implement its policy and procedure (P&P) titled, Pressure Ulcer Prevention which indicated, the facility should develop a care plan for residents at risk for pressure ulcers specific to the resident's risk factors (something that increases the chance of developing pressure ulcer).2). Provide care and services to promote the prevention of pressure ulcer development as indicated in its P&P titled, Pressure Ulcer Prevention. 3). Update Resident 1's care plan with additional interventions (actions), including turning and repositioning, offloading pressure, and address Resident 1's tendency to reposition himself back to his left side when Certified Nurse Assistant (CNA) 1 observed Resident 1 removed the pillows from under the right side of his back and throwing the pillow on the floor. 4). Check Resident 1's skin during Activities of Daily Living (ADL- like shower, bed bath) care and document any changes or findings on Resident 1's ADL Log. These failures resulted in Resident 1 acquiring: 1). Dark purple skin discoloration (a sign of various underlying conditions, including bruising or more serious health issues related to blood circulation) on the left heel on 9/5/2025 2). Dark purple skin discoloration on the first (1st) metatarsal head (bone on the 1st toe) of the right foot on 9/16/2025. 3). Deep tissue pressure injury (DTPI, a serious form of pressure injury) on the right lateral (side) foot and the 1st metatarsal head of the left foot on 9/19/2025. 4). Stage III (3) pressure ulcer (serious wounds characterized by full-thickness skin loss, exposing the underlying fatty tissue, and require immediate medical attention for proper treatment and healing) on the left trochanter (hip) on 9/20/2025.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included muscle weakness, affecting left non-dominant side (left side of the body), unspecified protein-calorie malnutrition (a condition that occurs when the body does not receive enough protein and calories to maintain proper health and functioning, leading to muscle loss, and dysphagia (difficulty swallowing [oral phase]). During a review of Resident 1's History and Physical (H&P) dated 7/2/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/4/2025, the MDS indicated Resident 1 had severe (intense) cognitive impairment (problems with the ability to think and reason). The MDS indicated Resident 1 had an impairment (the state of having a physical condition that limits function) on one side in both upper and lower extremities. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform ADLs such as eating. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff with mobility (the ability to move on bed) such as rolling left and right, changing positions from sitting to lying. The MDS indicated Resident 1 was unable to stand due to medical condition and safety concerns. The MDS indicated Resident 1 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident 1 had no wounds. During a review of Resident 1's Braden Scale (a standardized tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers, or bedsores) Evaluation, dated 6/28/2025, the evaluation indicated Resident 1 was at risk of developing pressure ulcers. During a review of Resident 1's care plan titled, Potential for pressure ulcer development, and/ or impaired skin integrity, dated, 6/30/2025, indicated the following interventions:a). Assess the resident's nutritional status, including weight, weight loss, and serum albumin levels (the amount of albumin protein present in the blood. Normal serum albumin level range 3.4 to 5.4 grams (gm- unit of measurement) per deciliter (g/dL). Abnormal levels can indicate various health issues, such as malnutrition [undernourished], or dehydration [a condition caused by the loss of too much fluid from the body]), if indicated.b). Assess the skin over bony prominences (sacrum [bone at the base of the spine], trochanters [bony prominence on the upper thigh bone], scapulae [bones at the shoulder blade], elbows, heels, inner and outer malleolus [bones on either side of the ankle], inner and outer knees, back of the head). These areas are at highest risk for breakdown resulting from tissue ischemia (restriction in blood supply) from compression (squeezed) against a hard surface.c). Encourage good nutrition and hydration (the process of replacing water in the body) to promote healthier skin.d). Keep skin clean and dry.e). Provide incontinence care promptly after resident's incontinent (uncontrolled urination and defecation) episode. During a review of Resident 1's Order Summary Report

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent one of six sampled residents (Resident 1) from having unplanned severe (greater than 5 percent weight loss in one month) weight loss by failing to:Implement Resident 1's Care Plan titled, Has Potential for Nutrition Problems which indicated to monitor and document Resident 1's meal percentage consumed for each meal. Implement Resident 1's Care Plan titled, Malnourished as evidenced by Nutritional Screening Tool Score of 02, which indicated to offer supplement to Resident 1 if his intake was below 50 percent. Follow the Registered Dietician's (RD) recommendations on 7/14/2025 and 9/3/2025 to provide large-portion meals to Resident 1. 4. Conduct an interdisciplinary Team ([IDT] group of healthcare professionals working together to plan the care needed for each resident) meeting to address Resident 1's unplanned severe weight loss on 9/1/2025 and make recommendations or Care Plan to prevent further weight loss. These failures resulted in Resident 1 having severe weight loss of 12.6 pounds (lbs.) from 8/4/2025 to 9/1/2025 (within 28 days) and 15 pounds from 9/15/2025 to 9/23/2025 (within 8 days). Resident 1 was transferred to the General Acute Care Hospital (GACH) and underwent a Percutaneous Endoscopic Gastrostomy (PEG) tube placement (a feeding tube that is inserted directly into the stomach for administering nutrition, fluids for residents who have difficulty swallowing or cannot get enough nutrition by mouth). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included hemiplegia(total paralysis of the arm, leg and trunk on the same side of the body) and hemiparesis (weakness on one side of the body affecting the arm and/or face) following cerebral infarction (loss of blood flow to a part of the brain) affecting the left non-dominant side, unspecified protein-calorie malnutrition (serious condition from not getting enough protein and calories, causing poor growth, weight loss, weakened immunity and organ dysfunction), and dysphagia (difficulty swallowing). During a review of Resident 1's Nutritional Evaluation dated 6/30/2025, the Evaluation indicated Resident 1 had a score of 0-7 points (reference range 12-14 points, normal nutritional status, 8-11 points at risk of malnutrition, 0-7 points malnourished).During a review of Resident 1's Care Plan titled, Has potential for Nutrition Problems dated 6/30/2025, the Care Plan interventions indicated for RD to evaluate and make diet change recommendations as needed (PRN). The Care Plan interventions indicated the facility would monitor and record the Resident's intake on each meal. During a review of Resident 1's Care Plan titled, Malnourished as evidenced by Nutritional Screening Tool score of 02 dated 6/30/2025, the Care Plan indicated Resident 1 was at risk for increased susceptibility to infections, muscle wasting/weakness, chronic diseases, impaired wound healing, cognitive impairment, dehydration, constipation, weight loss, low Body Mass Index ([BMI - a calculation that uses a person's weight and height to estimate whether someone is at a healthy weight]). The Care Plan goal indicated Resident 1 would receive adequate nutrition and avoid weight loss as much as possible. The Care Plan Interventions included to record meal percentage for every meal and offer supplement to Resident 1 if intake was below 50%.During a review of Resident 1's History and Physical (H&P) dated 7/2/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/4/2025, the MDS indicated Resident 1 had severe cognitive impairment (problems with the ability to think and reason). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as eating and was dependent (helper does all of the effort) for bed mobility (the ability to move) such as rolling left and right, changing positions from sitting to lying.During a review of Resident 1's Nutritional assessment dated [DATE], the Nutritional Assessment indicated Resident 1 was visually assessed as underweight with low albumin (blood test used to check general health and nutrition) level of 3.3 grams per deciliter ([g/dl] unit of measurement, therapeutic range of 3.5-5.7 g/dl). The Nutritional Assessment indicated Resident 1 was 146 lbs., with an ideal body weight (IBW) of 178 lbs. (32 lbs. under IBW) and BMI of 19.9. The Nutritional Assessment indicated Resident 1 was at risk for weight loss, due to low BMI. The Nutritional Assessment indicated the RD's Nutritional interventions and recommendations included to provide a mechanical (mech) soft diet with large portions to Resident 1. During a review of Resident 1's Physician's Orders dated 7/2025 -8/2025, the Orders did not indicate Resident 1 had Physician's orders for large portions during meals. During a review of Resident 1's Weight Summary dated 8/4/2025, the Summary