

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Las Flores Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 ensure resident call lights were placed within reach, for three of four sampled residents (Residents 1, 2 and 3). This failure resulted in the residents being unable to reach the call lights and had the potential that residents could not call nurses for help when immediate assistance is needed. This failure had the potential to negatively impact the residents' psychosocial well-being and delay in providing the needed care and services. Findings: a). During a concurrent observation and interview on 7/24/2026 at 9:45 a.m., in Resident 1's room, Resident 1's touch call light (a unit to press when resident need nurse's help) was observed on the floor, on the right side of the bed. Resident 1 was unable to reach the call light and was unable to communicate when asked about it. Licensed Vocational Nurse (LVN) 1 entered the room and observed the call light on the floor. LVN 1 stated that the call light should be within Resident 1's reach so nurses can respond promptly to Resident 1's needs. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis affecting one side of the body) following cerebral infarction (stroke) affecting the right non-dominant side, muscle weakness (reduction in the strength of muscles) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical examination (H&P) dated 12/24/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/15/2026, the MDS indicated Resident 1 had cognitive impairment. The MDS indicated Resident 1 was dependent assistance on staff with Activities of Daily Living (ADLs) such as dressing, toilet use, shower/bathing, transfer and mobility. During a review of Residents 1's care plan titled, ADL self-care performance deficit related to confusion, generalized muscle weakness, dated 4/16/2025, the intervention indicated to encourage the residents to use bells to call for assistance. b). During a concurrent observation and interview on 7/24/2026 at 9:55 a.m., with LVN 1 in Resident 2's room, Resident 2's call light was observed on the left side of her arm, underneath a pillow. When Resident 2 was asked for the call light, she was unable to reach it. Resident 2 stated, My left arm is paralyzed (incapable of movement). Resident 2 stated that she call the nurse when she needs pain medication. Resident 2 stated that the call light should be placed on her right side, on top of her bedside table, so she can easily reach it. LVN 1 placed the call light on top of Resident 2's bedside table and stated that the call light should be placed on Resident 2's functional side. LVN 1 stated that call lights must be kept close to the residents so that they can contact the nurses in case of an emergency. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses included contracture of the left elbow (elbow stiff, limiting its range of motion and affecting daily activities). Epilepsy (Epilepsy is a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures), and dementia. During a review of Resident 2's H&P dated 6/8/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Residents 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition. The MDS indicated Resident 2 was dependent on staff with ADLs such as dressing, toilet use, shower/bathing, transfer and mobility. During a review of Residents 2's care plan titled, ADL self-care performance deficit related to generalized muscle weakness, dated 4/16/2025, the intervention indicated to encourage the resident to use bell to call for assistance. c) During a concurrent observation and interview on 7/24/2026 at 10:05 a.m., with Certified Nurse Assistant (CNA 1), in Resident 3's room, Resident 3's call light was observed out of reach and was hanging behind the bed. When Resident 3 was asked about the call light, she pointed toward the wall and was unable to reach it (call light). Resident 3 stated, She needs the call light to call for the nurses. I need assistance from the nurses to change my brief. CNA 1 stated that call lights must be kept close to residents. CNA 1 stated that if Resident 3 needs help, nurses could not attend to the resident's needs promptly. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included metabolic encephalopathy (is a reversible brain dysfunction caused by an underlying metabolic disturbance), epilepsy and muscle weakness. During a review of Resident 3's H&P dated 3/22/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions but is capable to make decisions for activities of daily living. During a review of Residents 3's MDS dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment. The MDS indicated Resident 3 was dependent assistance on staff with ADLs such as dressing, toilet use, shower/bathing, transfer and mobility. During a review of Residents 3's care plan titled, Resident has a functional abilities deficit, dated 9/22/2023, the intervention indicated keep call system within reach and answer promptly. During an interview on 7/24/2026 at 2:00 p.m. with the Director of Nursing (DON), the DON stated that call lights must be placed close to the residents and within reach. The DON explained that if a resident has weakness in one extremity, the call light should be positioned on the unaffected side. In an emergency, residents must be able to reach the call light to request assistance. The DON emphasized that all nurses are responsible for checking the placement of call lights. During a review of facility's policy and procedures (P&P) titled, Call System, dated 10/24/2022, the P&P indicated the call system should be accessible to a resident lying on the bed, in toileting and bathing facilities. Call cords will be placed within the resident's reach in the resident's room.		

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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 a comprehensive, person-centered care plan for one of four sampled residents' (Resident 4) refusal of nicotine patch (transdermal patches that deliver a steady dose of nicotine through the skin to help reduce cravings and withdrawal symptoms such as restlessness, low mood, irritability, and poor concentration). This deficient practice resulted in no further interventions provided and had the potential to delay the resident's goal to quit smoking. Findings: 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 diagnoses included anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome) insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep) and major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems). During a review of Resident 4's History and Physical examination (H&P) dated 10/20/2025, the H&P indicated Resident 4 had the capacity to understand and make medical decisions. During a review of Residents 4's Minimum Data Set (MDS - a resident assessment tool) dated 5/22/2026, the MDS indicated Resident 4 had intact cognition. Resident 4 required supervision or touching assistance with staff on Activities of Daily Living (ADLs) such as dressing, toilet use, transfer and mobility. Resident 4 was independent of toileting hygiene, shower/ bathing self. During a review of Resident 4's Physicians Orders dated 7/1/2025, the physician's orders indicated an order of Nicotine Transdermal Patch 24 hours 21 milligrams (mg), one time a day for smoking cessation for 1 week and removed per schedule. During a review of Resident 4's Physicians Orders dated 7/10/2025, the physician's orders indicated Nicotine Transdermal Patch 24 hours 14 mg, transdermal (on the skin) one time a day for smoking cessation for 1 week and removed per schedule. During a review of Resident 4's Medications Administration Record (MAR) for the month of 7/2026, the MAR indicated Resident 4 refused the Nicotine transdermal patch on the following dates: 1). Nicotine transdermal patch 21mg, on 7/3/2026, 7/4/2026, 7/5/2026, 7/7/2026 and 7/8/2026. 2). Nicotine transdermal patch 14 mg, on 7/10/2026, 7/11/2026 and 7/12/2026. During a review of Resident 3's Care Plan, there was no care plan created for Resident 3's refusal of nicotine transdermal patches. During a concurrent interview and record review on 7/24/2026 at 1:17 p.m., with Licensed Vocational Nurse (LVN) 2, the MAR for 7/2026 was reviewed. LVN 2 stated that, based on the MAR, Resident 4 refused the 21 mg nicotine patches for the entire week and refused the 14 mg patches for three days. LVN 2 stated that when residents refuse medications for consecutive days, it is the nurse's responsibility to inform the physician and create a care plan addressing the refusal. LVN 2 explained that developing a care plan for refusal was important to identify interventions and ensure proper care was provided to Resident 4. During an interview on 7/24/2026 at 2:00 p.m. with the Director of Nursing (DON), the DON stated that when residents continue to refuse medications, nurses must notify the physician. The DON stated that nurses must create a care plan addressing the refusal. The DON explained that addressing the refusal of the nicotine patches was important because the facility needs to determine the reason why Resident 4 refused the medications. During a review of the facility's policy and procedures (P&P) titled, Care Planning, dated 10/24/2022, the P&P indicated the care plan should describe the services to be furnished to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being and any services that would be required but were not provided due to the resident's exercise of rights, which included the right to refuse treatment.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 sampled residents (Resident 4), received the nicotine transdermal patch (which delivers nicotine through the skin to help reduce smoking cravings) as ordered and notify the physician when the resident refused the medications. These failures placed the resident at risk for withdrawal symptoms such as restlessness, low mood, irritability, and poor concentration, which can affect the Resident 4's ability to maintain their highest practicable physical, mental and psychosocial well-being. Findings: 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 anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome) insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep) and major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems). During a review of Resident 4's History and Physical (H&P) dated 10/20/2025, the H&P indicated Resident 4 had the capacity to understand and make medical decisions. During a review of Residents 4's Minimum Data Set (MDS - a resident assessment tool) dated 5/22/2026, the MDS indicated Resident 4 had intact cognition. The MDS indicated Resident 4 required supervision or touching assistance on staff with Activities of Daily Living (ADLs) such as dressing, toilet use, transfer and mobility. Resident 4 was independent of toileting hygiene, shower/ bathing self. During a review of Resident 4's Physicians Orders dated 7/1/2025, the physician's orders indicated an order for Nicotine Transdermal Patch 24 hours 21 milligrams (mg), one time a day for smoking cessation for 1 week and remove per schedule. During a review of Resident 4's Physicians Orders dated 7/10/2025, the physician's orders indicated an order for Nicotine Transdermal Patch 24 hours 14 mg, one time a day for smoking cessation, for 1 week and remove per schedule. During a review of Resident 4's Physician Orders dated 7/24/2026 the physician's orders indicated Resident 4 had an order for Nicotine Transdermal Patch 24 hours 7 mg apply transdermal one time a day for smoking cessation for 1 week and removed per schedule. During a review of Resident 4's Medications Administration Record (MAR) for the month of 7/2026, the MAR indicated Resident 4 refused Nicotine transdermal patch on the following:a). Nicotine transdermal patch 21mg on 7/3/2026, 7/4/2026, 7/5/2026, 7/7/2026, 7/8/2026.b). Nicotine transdermal patch 14 mg on 7/10/2026, 7/11/2026, 7/12/2026. During an interview on 7/24/2026 at 10:20 a.m., with Resident 4 in Resident 4's room, Resident 4 stated, The doctor told me he would give me nicotine patches to help me quit smoking. I am craving cigarettes; I need the patches. Resident 4 reported receiving only Nicotine patch 7 mg since 7/14/2026 and stated, I have never received the 21 mg or 14 mg patches. Resident 4 stated I do not recall refusing the medications. During a concurrent interview and record review on 7/24/2026 at 2:00 p.m., with the Director of Nursing (DON), Residents 4's progress notes were reviewed. The DON stated Residents 4's progress notes did not indicate the nurses had informed the physician regarding the nicotine patches that were not given to Resident 4. The DON stated it was important to determine the reason why Resident 4 refused the medication. When Resident 4 continued to refuse the medication (Nicotine patch), the nurses should have notified the physician so that alternative medicine can be considered or the medication regimen can be restarted. During a concurrent observation and interview on 7/24/2026 at 3:00 p.m. with Licensed Vocational Nurse (LVN) 2, medication cart station 2 was checked. Resident 4's Nicotine patch 21 mg (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	box had 14 patches. LVN 2 stated that the 21 mg Nicotine patch box was full. LVN 2 stated I do not know why the Nicotine 21 mg box are still full. LVN 2 stated that if medications were no longer in use, they should be discarded. During a review of facility's policy and procedures (P&P) titled Medication Administration dated 5/1/2018, the P&P indicated if resident repeatedly refuse a medication, the Licensed Nurse should contact the physician to discuss alternatives measures for medications administration. During a review of facility's P&P titled, Refusal of treatment, dated 5/1/2023, the P&P indicated when resident refuse a treatment, the charge nurse or Director of Nursing interviews the resident to determine why the resident refused the treatment. The charge nurse or DON will document information relating to the refusal in residents' medical records, including the date and time the Attending Physician was notified and his or her response.		