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	05/08/2026

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

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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 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. Based on observation and interview, the facility failed to ensure expired and unlabeled food items were not in the kitchen.This deficient practice had the potential to cause foodborne illnesses for residents.Findings:During the initial kitchen tour observation of Freezer 1, on 5/6/2026 at 8:22 a.m., with the Dietary Services Supervisor (DSS), two opened frozen pizzas were observed in the freezer with expiration of 4/30/2026. The DSS stated the pizzas should have been discarded. The DSS stated the risk of having expired food items could result in residents falling ill if food was consumed. During an observation of the Walk-In Fridge 1, on 5/6/2026 at 8:28 a.m., a storage container of lettuce heads was observed with an expiration date of 4/25/2026 and an opened bag of sliced cheese had an expiration date of 5/4/2026. The DSS stated the risk of not discarding expired food could result in foodborne illnesses amongst residents.During an observation of Refrigerator 1, on 5/6/2026 at 8:36 a.m., two opened cartons of 2% reduced fat milk and a 32-ounce-bottle of coffee creamer was observed with no labels. The DSS stated the risk of not labeling food items could result in expired food.During an observation of the spices seasoning rack, on 5/6/2026 at 8:44 a.m., one 5-pound paprika seasoning bottle and one 5-pound garlic seasoning bottle were observed without a label. The DSS stated all opened food items should have a label with an open date and use by date. The DSS stated the risk of not labeling spices used for food could result in expired seasonings.During a review of the facility's policy and procedures (P&P), titled Food Storage, revised 5/1/2018, the P&P indicated to label and date all food items and food items will be stored, thawed, and prepared in accordance with good sanitary practice.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide dignity and respect for one of four sampled residents (Resident 67) when his indwelling urinary catheter (a flexible tube inserted into the bladder to continuously drain urine) collection bag was not covered with a privacy cover.This deficient practice resulted in Resident 67 feeling embarrassed that people could see his urine.Findings:During a review of Resident 67's admission Record, the admission record indicated Resident 67 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 67's diagnoses included retention of urine (inability to fully empty the bladder), unspecified urethral stricture (a narrowing of the urethra-the tube carrying urine out of the body), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 67's Minimum Data Set (MDS-a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 67 was able to understand and be understood by others. The MDS indicated Resident 67's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 67 was dependent (helper does all of the effort) on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear.During a review of Resident 67's History & Physical (H&P) dated 2/23/2026, the H&P indicated Resident 67 had the capacity to understand and make decisions.During a concurrent observation and interview on 5/5/2026 at 11:30 a.m. with Resident 67 in Resident 67's room, Resident 67's indwelling urinary catheter bag was not covered, which exposed the urine in the bag. Resident 67 stated he would feel embarrassed if people saw the bag of urine.During a concurrent observation and interview on 5/6/2026 at 10:19 a.m. with Certified Nursing Assistant (CNA 2) in Resident 67's room, Resident 67's indwelling urinary catheter bag was not covered. CNA 2 stated the bag should be covered for Resident 67's privacy.During a review of the Policy and Procedure (P&P) titled Privacy and Dignity revised May 01, 2018, the policy indicated residents are afforded a right to privacy and confidentiality.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and document informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for one of five residents (Resident 9) prior to administering treatment with psychoactive medications (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior.)This deficient practice violated Resident 9 and Resident 9's Responsible Party (RP)'s right to make an informed decision regarding the use of psychoactive medications. Findings:During a review of Resident 9's admission Record, the admission record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety disorder (persistent fear or worry that interferes with daily life), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission record indicated Resident 9's sister was Resident 9's responsible party and Resident 9's daughter was Resident 9's emergency contact.During a review of Resident 9's History and Physical (H&P) dated 1/6/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS-a resident assessment tool) dated 3/20/2026, the MDS indicated Resident 9's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 9 was dependent (helper does all for the effort) on staff for toileting, showering, and mobility.During a review of Resident 9's physician order, dated 1/6/2026, the physician order indicated to administer Escitalopram Oxalate (medication used for major depressive disorder) Oral Tablet 20 milligrams (mg, unit of measurement), 1.5 tablet by mouth daily.During a review of Resident 9's physician order, dated 3/10/2026 the physician order indicated to administer Seroquel (medication used for schizoaffective disorder) Oral Tablet 150 microgram (mcg, unit of measurement) give three 50 mcg tablets by mouth at bedtime.During a review of Resident 9's physician order, dated 3/19/2026, the physician order indicated to administer Duloxetine HCL (medication used for major depressive disorder) Oral Capsule Delayed Release Sprinkle 30 mg give three capsules by mouth dailyDuring a review of Resident 9's physician order, dated 3/20/2026, the physician order indicated to administer Buspirone HCL (medication used to treat anxiety disorder) Oral Tablet 7.5 mg by mouth twice daily.During a review of Resident 9's Medical Administration Record (MAR) dated 5/1/2026 - 5/31/2026, the MAR indicated Buspirone HCL, Duloxetine HCL, Escitalopram Oxalate, and Seroquel were administered as ordered from 5/1/2026 through 5/7/2026.During a concurrent interview and record review on 5/7/2026 at 3:45 p.m. with the Director of Nursing (DON), Resident 9's Psychotherapeutic Drug Informed Consents for duloxetine HCL 90 mg, escitalopram oxalate 20 mg, and Quetiapine (brand name for Seroquel) 100 mg, dated 1/6/2026, were reviewed. The Informed Consents indicated there were no signatures from the Prescriber (physician), Resident 9 or Resident 9's RP. The DON stated there were no signatures on the consents because Resident 9 did not have the capacity to make decisions and Resident 9's family refused to be involved in decision-making. The DON stated the facility should have had an IDT (Inter Disciplinary Team) meeting regarding consent before the medications were administered.During a review of the facility's Policy and Procedure (P&P) titled Informed Consent revised 1/6/2026, the P&P indicated the Attending Physician/LHP (Licensed Healthcare Practitioner) will obtain an informed consent from the resident or authorized representative before administration of a therapy requiring informed consent. The use of an informed consent will be done for but not limited to psychotherapeutic drugs.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an interdisciplinary team ([IDT] team members from different disciplines who come together to discuss resident care) meeting was conducted after a Significant Change in Status Assessment ([SCSA]) - a comprehensive assessment that must be completed when the IDT has determined that a resident meets the significant change guidelines for either improvement or decline) for one of one sampled resident (Resident 10).This deficient practice violated Resident 10's and his representative's rights to be fully informed and had the potential to result in a delay of care and services.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness (a loss of strength throughout most of the body, causing fatigue, and difficulty performing daily tasks).During a review of Resident 10's Census Report, the Census Report indicated Resident 10 was discharged to General Acute Care Hospital (GACH) on 11/15/2025 under medical hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) and readmitted to the facility on [DATE] under Medicare skilled nursing care (daily nursing or rehabilitation services that can only be safely and effectively performed by, or under the supervision of, professional medical personnel).During a review of Resident 10's History and Physical (H&P), dated 11/23/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions.During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 10's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor, cues and supervision required). The MDS indicated Resident 10 was dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a concurrent interview and record review on 5/6/2026 at 11:34 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 10's IDT Care Conference Notes, were reviewed. MDSN 1 stated Resident 10 was discontinued from hospice service on 11/15/2025 (the day he was sent to General Acute Care Hospital [GACH]) and readmitted to the facility on [DATE] under skilled care services (daily nursing or rehabilitation services that can only be safely and effectively performed by, or under the supervision of, professional medical personnel) for rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) to improve his physical function. MDSN 1 stated there was no IDT care conference meeting with Resident 10's and his representative after a SCSA from hospice care to skilled care on 11/20/2025. MDSN 1 stated an IDT care conference meeting should be conducted every 3 months, as needed, and if there was a significant change in the resident's status. MDSN 1 stated Resident 10 had a change in care, treatment, and interventions that would warrant an IDT care conference meeting. MDSN 1 stated it was important to conduct an IDT care conference meeting with Resident 10 and his representative so they would know Resident 10's change of plan of care.During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 10/24/2022 the P&P indicated, The resident has a right to be informed, in advance, of changes to the plan of care. The P&P also indicated the facility will invite the resident, if capable, and their family to care plan meetings.Cross Reference: F637

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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 interview and record review, the facility failed to accommodate the needs and preferences of one out of three sampled residents (Resident 22) by failing to honor and carry out a physician-ordered therapeutic Out-on-Pass.This deficient practice resulted in Resident 22 not being able to go out on pass when preferred. Findings:During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including acute bronchiolitis (lung infection when the lungs get swollen and filled with mucus), dysphagia (difficulty swallowing), Type II diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypothyroidism (a condition where the thyroid gland does not make enough hormones, causing the body to slow down).During a review of Resident 22's History and Physical (H&P) dated 2/12/2026, the H&P indicated Resident 22 had the capacity to understand and make decisions.During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool) dated 2/22/2026, the MDS indicated Resident 22's cognition (ability to think and process) was intact. The MDS indicated Resident 22 required supervision for mobility and transfers. The MDS indicated Resident 22 utilized a walker and did not have the ability to walk at least ten feet in a room, corridor or similar space.During a concurrent interview and record review on 5/6/2026 at 1:04 p.m. with the Social Services Assistant (SSA), Resident 22's physician order, dated 4/16/2026, was reviewed. The physician order indicated Resident 22 may go out on pass with family. The SSA stated Resident 22 filed a grievance on 4/20/2026 requesting to go out on weekends, however, Resident 22's only family member lived out of state in Arizona. The SSA stated the grievance, documented by the Social Services Director (SSD), indicated the physician agreed to change the order to require someone to go with Resident 22 due to Resident 22's history of multiple falls with fractures. The SSA stated as of 5/6/2026, the physician order had not been changed since 4/20/2026. During a concurrent interview and record review on 5/6/2026 at 3:43 p.m. with Licensed Vocational Nurse (LVN) 5 and LVN 6, LVN 5 stated the physician's out-on-pass order for Resident 22 indicated Resident 22 may go out on pass with a family member. LVN 5 stated if family member was not available, a staff member could escort the resident, or Social Services (SS) or Administration could coordinate Resident 22's request to go out-on-pass. LVN 6 stated Resident 22 could not go out on pass if a family member was not available and there was nothing that could be done for the Resident.During a concurrent interview and record review on 5/7/2026 at 9:35 a.m. with Registered Nurse (RN) 1, RN 1 stated the SSA informed her of Resident 22's grievance on 5/6/2026 at approximately 4:15 p.m. RN 1 stated the SSA asked her to contact the physician to change the out-on-pass order from go-out-on pass with family to go-out-on pass with an escort. RN 1 stated the SSD did not inform her on 4/20/2026 to call the physician to clarify the out-on-pass order.During a concurrent interview and record review on 5/7/2026 at 1:46 p.m. with the Administrator (ADM), the ADM stated she was familiar with Resident 22's grievance dated 4/20/2026. The ADM reviewed the physician's order for Resident 22 written on 5/6/2026 indicated the resident may go out on pass with family. The ADM stated the nurse was responsible for contacting the physician to request an order change. The ADM stated they did not know why the order was not changed on 4/20/2026 and stated the licensed nurse or designee was responsible for updating the order. The ADM stated if a physician's order was not updated timely, residents may experience dissatisfaction with care, and services and accommodations may be delayed which can affect residents' quality of life and care.During a record review of the facility's policy and procedure (P&P), titled Out on Pass, dated 5/1/2023, the P&P indicated, if the resident's use of the out on pass order conflicted with the resident's plan of care or jeopardizes the resident's safety, facility staff would notify the attending physician of the need to review the resident's status prior to permitting the resident to leave the facility on a pass.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a federally mandated resident assessment tool) for Significant Change in Status Assessment ([SCSA]) - is a comprehensive assessment that must be completed when the Interdisciplinary Team ([IDT] - team members from different disciplines who come together to discuss resident care) has determined that a resident meets the significant change guidelines for either improvement or decline) was completed for one of one sampled resident (Resident 10).This deficient practice had the potential to result in inaccurate care and services for Resident 10 due to inappropriate MDS care screening and assessment tool practices.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness (a loss of strength throughout most of the body, causing fatigue, and difficulty performing daily tasks).During a review of Resident 10's Census Report, the Census Report indicated, Resident 10 was discharged to General Acute Care Hospital (GACH) on 11/15/2025 under medical hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) and readmitted to the facility on [DATE] under Medicare skilled nursing care (daily nursing or rehabilitation services that can only be safely and effectively performed by, or under the supervision of, professional medical personnel).During a review of Resident 10's History and Physical (H&P), dated 11/23/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions.During a concurrent interview and record review on 5/6/2026 at 11:23 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 10's MDS assessment, dated 11/25/2025, was reviewed. MDSN 1 stated Resident 10's MDS completed on 11/25/2025 was for 5-day scheduled assessment for Medicare Part A Stay (Initial Medicare assessment). MDSN 1 stated the facility did not complete a MDS SCSA for Resident 10. MDSN 1 stated there should be a MDS SCSA because Resident 10 had a change of payor from Medical hospice to Medicare and a significant change in resident's status. MDSN 1 stated Resident 10 was discontinued from hospice service on 11/15/2025. MDSN 1 stated MDS SCSA should be completed within 5 to 7 days after Resident 10 was readmitted to the facility. MDSN 1 stated failure to complete an MDS SCSA would lead to inaccurate care plan of resident.During a review of Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated 10/2025, page 46, indicated an SCSA was required to be performed when a resident receiving hospice services and decided to discontinue those services (known as revoking of hospice care).

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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 interview and record review, the facility failed to ensure one of three sampled residents (Resident 52) had care plans (a personalized document outlining a resident's health needs, goals, and specific interventions) for diagnosis Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication.)This deficient practice had the potential to result in delayed care and services for Resident 52.Findings:During a review of Resident 52's admission Record, the admission record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses that included DM, anemia (a condition where the body does not have enough healthy red blood cells), and anxiety disorder (persistent fear or worry that interferes with daily life.)During a review of Resident 52's Minimum Data Set (MDS-a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 52 would sometimes be able to understand and be understood by others. The MDS indicated Resident 52's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 52 required partial assistance (helper does less than half the effort) for eating and mobility.During a review of Resident 52's History and Physical (H&P) dated 4/19/2025, the H&P indicated Resident 52 did not have the capacity to understand and make decisions.During a review of Resident 52's physician order, dated 4/30/2026, indicated to administer Humalog (fast-acting insulin that is absorbed quickly and starts working within fifteen minutes of administration) Injection Solution 100 UNIT/ML (Insulin Lispro [generic brand of Humalog]) as per sliding scale (progressive increase in the insulin dose based on pre-defined blood sugar ranges.)During a concurrent interview and record review on 5/8/2026 at 10:38 a.m. with Registered Nurse (RN) 1, Resident 52's Care Plan was reviewed. There were no care plans for DM or insulin use. RN 1 stated there should be a care plan for DM and for insulin so the staff would know what interventions and care to give Resident 52. RN 1 stated Resident 52's sugar could be too low or high, or he could go into a diabetic coma (a life-threatening emergency causing unconsciousness in people with diabetes).During a review of the facility's Policy and Procedure (P&P) titled Care Planning revised 10/24/2022, the P&P indicated a comprehensive care-plan would be developed for each resident based on their individual assessed needs to meet a resident's medical, nursing, mental and psychosocial needs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen was administered as ordered for one out of one sampled resident (Resident 62).This deficient practice had the potential to lead to oxygen toxicity.Findings:During a review of Resident 62's admission record, the admission record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a sudden, life-threatening syndrome where the respiratory system fails to properly oxygenate the blood or remove carbon dioxide), sepsis (a life-threatening blood infection), pneumonia (an infection/inflammation in the lungs) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 62 history and physical (H&P), dated 4/20/2026, the H&P indicated Resident 62 had the capacity to understand and make medical decisions.During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 4/25/2026, the MDS indicated Resident 62's cognitive (thinking) skills were intact. The MDS indicated Resident 62 required substantial assistance (helper does more than half the effort) from staff members with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 62's physician orders, dated 4/17/2026, the physician orders indicated to administer continuous oxygen at 2 liters (a unit of measurement) per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen)During an observation on 5/5/2026 at 3:11 p.m., Resident 62 was observed receiving oxygen at 4 liters per minute via nasal cannula.During a concurrent observation and interview on 5/7/2026 at 8:19 a.m., with Registered Nurse 1 (RN 1) in Resident 62's room, Resident 62's oxygen concentrator was set to 4 liters per minute. RN 1 stated Resident 62 had a physician order for oxygen to be administered. RN 1 stated the physician's order indicated to administer continuous oxygen at 2 liters per minute via nasal cannula. RN 1 stated Resident 62 was receiving 4 liters per minute instead of 2 liters per minute as ordered. RN 1 stated Resident 62 should have been receiving 2 liters per minute. RN 1 stated the risk of administering a higher dosage of oxygen than ordered could result in altered carbon dioxide levels and oxygen toxicity.During a review of the facility's policy and procedures (P&P), titled Oxygen Administration, revised 5/1/2018, the P&P indicated a physician's order was required to initiate oxygen therapy, except in an emergency situation, and the order shall include the oxygen flow rate.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services (services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health) such as an outside referral for anger management support group therapy (a structured, supportive environment where people learn to recognize triggers and develop healthy coping skills to manage anger, rather than suppressing it) for one of one sampled resident (Resident 12).This deficient practice placed Resident 12 at risk for increased anxiety and ineffective coping ability that would diminish his quality of life.Findings:During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing).During a review of Resident 12's Psychiatric Follow-up Note, dated 10/23/2025, the Psychiatric Follow-up Note indicated Resident 12 continued to experience physical symptoms of anxiety, including muscle tension, restlessness, and occasional shortness of breath, which impacted daily functioning. The Psychiatric Follow-up Note indicated a supportive therapy will continue.During a review of Resident 12's History and Physical (H&P), dated 3/13/2026, the H&P indicated Resident 12 had the capacity to understand and make decisions.During a review of Resident 12's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 12 was able to understand and be understood by others. The MDS indicated Resident 12's cognition (ability to think and process) was intact. The MDS indicated Resident 12 was independent (Resident completes the activity with no assistance from the helper) from staff with Activities of Daily Living ([ADLs] - routine tasks/activities) such as oral hygiene, toileting hygiene, and upper body dressing.During an interview on 5/5/2026 at 10:54 a.m. with Resident 12, Resident 12 stated he verbalized to facility staff that he wanted to attend an anger management support group therapy to release his anxiety. Resident 12 stated facility staff told him the facility did not offer services for anger management support group therapy. Resident 12 stated he was seen by a psychiatrist only once and he wanted to have more treatments to address his anger and anxiety.During an interview on 5/6/2026 at 11:00 a.m. with Social Service Assistant 1 (SSA 1), SSA 1 stated Resident 12 was pleasant and anxious. SSA 1 stated the facility's psychiatrist does not provide group therapy, but facility could have referred Resident 12 to outside resources for anger management support group therapy. SSA 1stated Resident 12 was seen by a psychiatrist on 10/23/2025 and there were no further follow-up treatments. SSA 1 stated it was important for Resident 12 to participate in an anger management support group therapy so they could help him manage his anger and relieve his anxiety. SSA 1 stated Resident 12 would benefit from anger management support group therapy so he could express his emotions and show coping skills that would improve his quality of life and psychosocial well-being.During an interview on 5/8/2026 at 8:37 a.m. with Resident 12, Resident 12 stated SSA 1 visited him 2 days ago and did not offer outside resources for anger management support group therapy.During an interview on 5/8/2026 at 9:23 a.m. with Resident 12, as witnessed by SSA 1, Resident 12 verbalized that he was interested in attending anger management support group therapy.During a review of the facility's policy and procedure (P&P) titled Social Service Program, dated 5/19/2025, the P&P indicated Medically related social services are provided to residents in order to maintain and improve resident's wellbeing. The P&P indicated one of the responsibilities of the Social Services Department was to identify individual and social needs of the resident and to research external support groups, as necessary.

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	05/08/2026

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 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 interview and record review, the facility failed to ensure:A Narcotic Key Controlled Release Form (a log signed by licensed nurses during shift change endorsing over responsibility for the controlled substances in the cart) was completed accurately.The Controlled Drug (medications that the use and possession of are controlled by the federal government) Record (a log containing the date, time, quantity, and nurse's signature each time a dose is administered) was completed accurately for one of five sampled residents (Resident 113).These deficient practices increased the risk of loss or diversion of controlled medications.Findings:1. During a concurrent interview and record review on 5/6/2026 at 7:27 a.m. with Licensed Vocational Nurse 1 (LVN 1), medication cart 1 Narcotic Key Controlled Release Form, dated April 2026, was reviewed. LVN 1 stated the Narcotic Key Controlled Release Form for April 2026 was not completed accurately. LVN 1 stated there were missing licensed nurses' signatures of licensed nurses on shift changes on 4/1/2026, 4/16/2026, and 4/27/2026. LVN 1 stated Narcotic Key Controlled Release Form should be signed by an incoming and outgoing licensed nurse completely to validate the amount of controlled drugs remaining. LVN 1 stated there would be a risk for theft and drug diversion if the Narcotic Key Controlled Release Form was not completed accurately.2. During a review of Resident 113's admission Record, the admission Record indicated Resident 113 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 113's diagnoses included epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), and sepsis (a life-threatening blood infection).During a review of Resident 113's History and Physical (H&P), dated 2/24/2026, the H&P indicated Resident 113 did not have the capacity to understand and make decisions.During a review of Resident 113's physician's order, dated 2/25/2026, the physician's order indicated Resident 113 was prescribed phenobarbital (controlled medication used to treat seizure disorder) 32.4 milligrams (mg, a unit of measurement) twice a day (9:00 a.m. and 5:00 p.m.)During a review of Resident 113's Minimum Data Set ([MDS]- a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 113's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 113 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, upper and lower body dressing, and mobility.During a concurrent interview and record review on 5/6/2026 at 7:52 a.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 113's Controlled Drug Record was reviewed. LVN 2 stated there were 23 tablets remaining of phenobarbital 32.4 mg in the bubble pack (a secure, organized method of packaging pills in individual, sealed plastic bubbles, mounted on a card). LVN 2 stated the amount of phenobarbital 32.4 mg remaining in the Controlled Drug Record was 24 tablets. LVN 2 stated Resident 113's phenobarbital medication was not properly accounted for. LVN 2 stated she administered Resident 113's phenobarbital 32.4 mg at 7:20 a.m. and she did not sign the Controlled Drug Record form. LVN 2 stated it is a standard of practice to sign the Controlled Drug Record form after the drug was given or administered for resident's safety.During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 5/1/2018, the P&P indicated the licensed nurse would chart the drug, time administered and initial his/her name with each medication administration.During a review of the facility's P&P titled, Receiving Controlled Substances, dated 1/2018, the P&P indicated medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt, and recordkeeping requirements by the facility. The P&P indicated controlled substance inventory sheets are completed and filed appropriately.

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	555057	A. Building B. Wing	05/08/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the removal of one of one sampled resident's (Resident 10) indwelling foley catheter (a hollow tube inserted into the bladder to drain or collect urine) was documented in the resident's progress notes. This deficient practice had the potential for miscommunication, not receiving continuity of care and the potential to not receive the appropriate care and services Resident 10 needs.Findings:During a review of Resident 10's admission Record, the admission Record indicated, Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness (a loss of strength throughout most of the body, causing fatigue, and difficulty performing daily tasks).During a review of Resident 10's History and Physical (H&P), dated 11/23/2025, the H&P indicated, Resident 10 did not have the capacity to understand and make decisions.During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/25/2026, the MDS indicated, Resident 10's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor, cues and supervision required). The MDS indicated, Resident 10 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated, Resident 10 had an indwelling catheter.During a review of Resident 10's physician's order, dated 4/23/2026, the physician's order indicated Resident 10's foley catheter was discontinued.During a concurrent interview and record review on 5/6/2026 at 2:40 p.m., with Treatment Nurse 1 (TN 1), Resident 10's Progress Notes, from 4/15/2026 to 4/30/2026, was reviewed. The TN 1 stated there was no documentation in the Progress Notes by nursing staff indicating Resident 10's foley catheter was discontinued. Resident 10's foley catheter was discontinued and removed on 4/23/2026 because his pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) have been resolved. It was important for the facility to document Resident 10's foley catheter removal in the progress notes so the licensed nursing staff could monitor the resident for urinary retention (a condition in which you are unable to empty all the urine from your bladder). Accurate and complete documentation is very important for the resident's plan of care. During an interview on 5/6/2026 at 4:09 p.m., with the Director of Nursing (DON), the DON stated complete documentation is important for the collaboration of resident's care among facility staff.During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter, dated 2/24/2026, the P&P indicated to document the date and time in the resident's medical records the removal of indwelling catheter, its quantity and color of urine, and pertinent observations including resident response and tolerance of procedure.During a review of the facility's P&P titled, Nursing Documentation, dated 5/1/2018, the P&P indicated, the facility must provide documentation of resident status and care given by nursing staff.