STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555441	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital of Gardena D/P Snf	1145 W. Redondo Beach 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 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 food items in walk-in refrigerator 1 were labeled and unexpired. Ensure the walk-in freezer 2 had an internal thermometer (used to check the refrigerator's inside temperature).Ensure the walk-in refrigerator 3 had an internal temperature that was within range (acceptable is 41 degrees F or lower) .This deficient practice had the potential to result in residents developing a foodborne illness (food poisoning). Findings:During a concurrent observation and interview, on 4/7/2026 at 8:48 a.m., with the Dietary Services Supervisor (DSS), an unopened cheese danish was observed unlabeled and undated, and a pack of opened hot dog buns had an expiration date of 4/4/2026 in the walk-in refrigerator 1. The DSS stated all food items should have been labeled and dated. The DSS stated all expired items should had been discarded. The DSS stated the risk of not discarding expired items and not labeling and dating food items could result in foodborne illnesses due to being possibly spoiled. During a concurrent observation and interview, on 4/7/2026 at 9:02a.m., with the DSS, there was no internal thermometer observed in walk in freezer 2 which contained a variety of meats such as chicken, fish and pork. The DSS stated the risk of not having an internal thermometer in a walk-in freezer could result in food defrosting leading to expired food.During a concurrent observation and interview, on 4/7/2026 at 9:06a.m., with the DSS, the walk in refrigerator 3 (which contained dairy products such as yogurt and milk) thermometer was observed/ read at 50 degrees Fahrenheit. The DSS stated the risk of not maintaining appropriate temperature for a refrigerator could result in expired food items.During a review of the facility's policy and procedures (P&P), titled Freshness Dating and Labeling, dated 6/2024, the P&P indicated Storage used for short-term holding of fresh, perishable and potentially hazardous food items at internal temperature of 41 degrees F or lower.During a review of the facility's policy and procedures (P&P), titled Food Purchasing and Handling, dated 6/2024, the P&P indicated Food which was prepared and not served shall be stored appropriately, clearly labeled and dated and there is a reliable thermometer in each refrigerator, freezer and in the storeroom.

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 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 ensure the Minimum Data Set ([MDS] - a resident assessment tool) was completed accurately for one of 17 sampled residents (Resident 22).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 22.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 respiratory failure (a serious condition that makes it difficult to breathe on your own) with placement of tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe), quadriplegia (loss of movement and/or sensation, to some degree, of the legs), and sepsis (a life threatening blood infection).During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22's cognitive (ability to think and reason) skills for daily decision making were severely impaired. The MDS indicated Resident 22 was dependent (resident does none of the effort to complete the activity) on staff for oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of the CMS MDS 3.0 NH Final Validation Report with an Assessment Reference Date ([ARD] - the specific date used as the endpoint of the observation period when assessing resident's condition) of 10/20/2025, the Report indicated Resident 22's information and the value that was submitted in the database did not match (7/14/2025) for Section A (Identification Information) A1010 (Race).During a concurrent interview and record review on 4/8/2026 at 2:02 p.m., with the Minimum Data Set Nurse (MDSN), Resident 22's MDS assessment dated [DATE] and 10/10/2025), were reviewed. The MDSN stated Resident 22's MDS, dated [DATE], were not completed accurately. The MDSN stated there should have been no check mark entered on Resident 22's MDS, Section A1010 (Race) A-White. Resident 22's race was Mexican, not White. The MDSN stated she completed the MDS assessment and failed to double-check whether the information was entered correctly. The MDSN stated it was important to complete the MDS assessment of residents accurately to formulate an acceptable plan of care based on the residents' demographic and comprehensive assessment.During a review of the facility's policy and procedure (P&P), titled, Minimum Data Sheet and Care Area Assessment, dated 1/2025, the P&P indicated the MDS assessment must accurately reflect the resident's status.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level 1 screening (a federally required preliminary screening for individuals seeking admission to a Medicaid-certified nursing facility) was conducted and resubmitted for one of two sampled residents (Resident 5), who had diagnoses of mental illness (abnormal behavior or disturbing feelings, thoughts, or actions that interfere with every day functioning) and was receiving psychotropic medications (any drug that affects brain activities associated with mental process and behavior).This deficient practice had the potential to result in Resident 5 not appropriately evaluated and not provided the necessary specialized services for mental illness.Findings:During a review of Resident 5's untitled document (front page of the chart that contains a summary of basic information about the resident), the document indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), respiratory failure (a serious condition that makes it difficult to breathe on your own), and placement of tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe).During a review of Resident 5's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/4/2026, the MDS indicated, Resident 10 was independent (decisions consistent and reasonable) with cognitive (ability to think and reason) skills in daily decision making. The MDS indicated, Resident 5 had the ability to make self-understood and understand others. The MDS indicated, Resident 5 required dependent assistance (resident does none of the effort to complete the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of Resident 5's Order Summary Report (a document containing active orders), dated 4/1/2026, the Order Summary Report indicated, on 3/15/2026, the physician placed a telephone order for Resident 5 to start on Klonopin (a drug used to treat anxiety disorder (a mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life) 1 milligram ([mg] - metric unit of measurement, used for medication dosage and/or amount) via gastrostomy tube ([GT] - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every 12 hours as needed for anxiety. The Order Summary Report indicated, the physician placed a telephone order on 3/19/2026 for Resident 5 to start on Zoloft (a drug used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) daily (9 a.m.) via GT for depression.During a concurrent interview and record review on 4/8/2026 with the Case Manager (CM), Resident 5's PASARR Level 1 screening completed by another facility, on 5/5/2025, was reviewed. The CM stated the PASARR Level 1 screening indicated, Resident 5 had no serious mental illness diagnoses and was not on prescribed psychotropic medications. The CM stated the PASARR Level 1 screening also indicated, Resident 5's case was closed, and a PASARR level II mental health evaluation was not required. The CM stated the facility should have completed and resubmitted a new PASARR Level 1 screening under Resident Review because Resident 5 had a mental illness diagnoses of bipolar disorder, anxiety disorder, and depression and Resident 5 was prescribed with Klonopin and Zoloft. The CM stated by not resubmitting PASARR Level 1 screening, Resident 5's mental health treatment might have been neglected by the facility. The CM stated it was important to resubmit PASARR Level 1 screening immediately in order to provide mental health care and services to residents with mental illness.During a review of PASRR reference manual, dated 2/2023, the PASRR reference manual indicated, an additional requirement has been added for Nursing Facilities (NF) to promptly notify the state mental health and/or intellectual or developmental disability authority, as applicable, if there is a significant change in the physical or mental condition of an individual who is mentally ill or has an (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intellectual or developmental disability. This would warrant a re-evaluation to determine if a NF is still the most appropriate setting and/or if the individual could benefit from specialized services for his/her mental illness or intellectual disability.During a review of the facility's policy and procedure (P&P), titled Minimum Data Sheet and Care Area Assessment, dated 1/2025, the P&P indicated, The MDS Nurse will coordinate assessments with the preadmission screening and resident review program under Medicaid.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the low air loss mattresses (special mattress for skin management) settings for one of eight sampled residents (Resident 7), were correct basing on the resident's weight.This deficient practice resulted in inaccurate settings and placed the resident at risk for further skin breakdown.Findings:During a review of Resident 7's untitled document (front page of the chart that contains a summary of basic information about the resident), the document indicated Resident 7 was admitted to the facility on [DATE]. Resident 7's diagnoses included acute respiratory failure (a sudden, life-threatening emergency where the lungs cannot get enough oxygen into the blood or fail to remove carbon dioxide), hypoxia (low levels of oxygen in your blood) and hypercapnia (a medical condition where there is too much carbon dioxide in your blood).During a review of Resident 7's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/31/2025, the MDS indicated Resident 7's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 7 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an observation, on 4/8/2026 at 1:19 p.m., Resident 7 was observed lying in bed on a low air loss mattress with weight settings at [PHONE NUMBER] pounds ([lb], a fundamental unit of weight and mass).During a record review, on 4/8/2026 at 3:00p.m., of Resident 7's weight, Resident 7's weight indicated Resident 7 weighed 151 lbs.During a concurrent observation and interview, on 4/9/2026 at 10:02 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 observed Resident 7's low air loss mattress settings and stated Resident 7's low air loss mattress settings were set to [PHONE NUMBER] lbs. LVN 4 stated Resident 7's low air loss mattress settings were incorrect as Resident 7 only weighed 151 lbs. LVN 4 stated the risk of inaccurate low air loss mattress settings could result in further skin breakdown.During a review of the low air loss mattress set up instructions, titled Airnest Orange, dated 2020, the set up instructions indicated to Using the soft/firm keys, set the patient comfort pressure settings by selecting the number corresponding closest to the patient's weight.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 the normal saline ([NS] - sterile solution of sodium chloride) intravenous (IV - into or connected to vein), 500 cubic centimeter ([cc] metric unit of volume) solutions, used to keep-vein-open (a continuous, very slow-rate IV infusions to prevent blood clots, drug precipitates, or obstructions from forming within an IV catheter), were not used longer than 24 hours, for two of two sampled residents (Residents 3 and 37) as indicated in its policy and procedure (P&P) titled, IV Therapy Administration.This deficient practice had the potential to placed Resident Residents 3 and 37 at risk for infection and IV therapy complications.Findings:A. During a review of Resident 3's untitled document (front page of the chart that contains a summary of basic information about the resident), the document indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own) with placement of tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe), gastrostomy tube placement (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain).During a review of Resident 3's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/23/2026, the MDS indicated, Resident 3's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never and rarely made decisions). The MDS indicated, Resident 3 required dependent assistance (resident does none of the effort to complete the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a concurrent observation and interview on 4/7/2026 at 10:44 a.m., with Registered Nurse 1 (RN 1), in Resident 3's room, Resident 3 had an IV midline (a long, flexible tube inserted into a large vein in the upper arm, with the tip resting just below the armpit, used in patients needing prolonged medication, fluid replacement, or IV therapy without requiring central venous access) on right upper arm. RN 1 stated Resident 3 had an IV fluid (fluids (F) given directly into the blood stream) of NS, 500 cc dated 4/5/2026 at 6 p.m. RN 1 stated the IVF of NS is used to keep vein open and can be used for 4 days or until it is consumed.B. During a review of Resident 37's untitled document (front page of the chart that contains a summary of basic information about the resident), the document indicated, Resident 37 was admitted to the facility on [DATE]. Resident 3's diagnoses included respiratory failure with placement of tracheostomy, GT placement, and osteomyelitis (inflammation of bone or bone marrow, usually due to infection).During a review of Resident 37's MDS, dated [DATE], the MDS indicated, Resident 37's cognitive skills for daily decision making were moderately impaired (decisions poor, cues and supervision required). The MDS indicated, Resident 37 required dependent assistance (resident does none of the effort to complete the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a concurrent observation and interview on 4/7/2026 at 10:48 a.m., with Registered Nurse 1 (RN 1), in Resident 37's room, Resident 37 had an IV midline on right upper arm. RN 1 stated Resident 37 had an IVF of NS 500 cc dated 4/3/2026 at 6 a.m. RN 1 stated the IVF of NS is used to keep vein open and can be used for 4 days or until it is consumed.During an interview on 4/8/2026 at 1:25 p.m., with the NM, the NM stated it was a standard of practice to use the IVF solution to keep vein open for 24 hours for the safety of the residents.During an interview on 4/8/2026 at 1:33 p.m., with the Director of Nursing (DON), the DON stated IVF should hang no longer than 24 hours because bacteria might grow in the IVF solution that would put residents at risk for infection.During a review of the facility's policy and procedure (P&P), titled IV Therapy Administration, dated 4/2026, the P&P indicated, Standardized the frequency of IV tubing set changes and ensure safe administration of IV fluids and medications. The P&P indicated small bags of IV solutions (250 cc or 500cc) should be used for keep-open IV's so that they do not hang longer than 24 hours.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 9) was free of unnecessary psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) by failing to monitor resident's behavior and implement non-pharmacological interventions (intervention that does not primarily use medicine) prior to initiation of psychotropic medication.This failure had the potential to place Resident 9 at risk for avoidable harm from unwanted adverse effects (a harmful and undesired effect resulting from a medication) related to psychotropic medication use.Findings:During a review of Resident 9's untitled document (front page of the chart that contains a summary of basic information about the resident), the document indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own) with placement of tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and gastrostomy tube placement (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).During a review of Resident 9's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/25/2026 the MDS indicated, Resident 9's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never and rarely made decisions). The MDS indicated, Resident 9 required dependent assistance (resident does none of the effort to complete the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated, Resident 9 had no potential indicators of psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality) such as hallucinations (perceptual experiences in the absences of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated, Resident 9 had no physical behavioral symptoms directed toward others such as hitting, kicking, and pushing.During a review of Resident 9's Order Summary Report (a document containing active orders), dated 4/1/2026, the Order Summary Report indicated, the physician placed a telephone order on 10/16/2025 for Resident 9 to start on Olanzapine (a psychotropic medication, used to treat certain mental/mood disorder) 5 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) daily (9 a.m.) via GT for mood disorder.During a concurrent interview and record review, on 4/9/2026 at 1:56 p.m., with the Nurse Manager (NM), Resident 9's Progress Notes from 10/9/2025 to 10/15/2025, were reviewed. The NM stated Resident 9 is on olanzapine for mood disorder manifested by agitation. The NM stated Resident 9's behavior manifestation of agitation was vague (unclear) and not specific. The NM stated there was no documentation by nursing staff to justify putting Resident 9 on psychotropic medication. The NM stated there was no behavior monitoring of Resident 9's agitation and the facility did not attempt less restrictive measures such as providing a sitter and redirection of behavior prior to utilization of psychotropic medication. The NM stated it was important to monitor and document resident's behavior for 72 hours to have concrete evidence supporting the use of psychotropic medication. The NM stated lack of adequate monitoring of behavior manifestation of psychotropic medications would be considered as an unnecessary medication.During a review of the facility's policy and procedure (P&P), titled Psychoactive Medication, dated 4/2026, the P&P indicated, When psychoactive medications are ordered, the assessment process will be utilized to assure alternative behavioral management programs have been attempted prior to the use of psychoactive medications. The P&P also indicated anti-psychotic medications will not be initiated for residents who have not used them previously unless the clinical record documents the medication is necessary to treat a specific condition and when psychoactive medications are initiated on the unit, the resident's medical record will contain completed assessments and documented interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 remove Resident 25's one vial of expired Lispro (type of fast acting insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication]) insulin from medication cart 5.This deficient practice placed Resident 25 at increase risk to receive expired insulin that could be ineffective in treating the resident's high blood sugar levels.Findings:During a review of Resident 25's untitled document (front page of the chart that contains a summary of basic information about the resident) the document indicated, Resident 25 was admitted to the facility on [DATE]. Resident 25's diagnoses included Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), respiratory failure (a serious condition that makes it difficult to breathe on your own), and end stage renal disease ([ESRD] - irreversible kidney failure).During a review of Resident 25's Minimum Data Set ([MDS] - a resident assessment tool), dated [DATE], the MDS indicated, Resident 25's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never and rarely made decisions). The MDS indicated, Resident 25 required dependent assistance (resident does none of the effort to complete the activity) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of Resident 25'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 25 to start on Lispro insulin, to inject subcutaneously ([SQ] - beneath or under the layer of the skin) every 6 hours per sliding scale (increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal): if blood sugar 150-200 = 2 units, 201-250= 4 units, 251-300= 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400, to give 12 units and call the Medical Doctor (MD).During a concurrent observation and interview on [DATE] at 10:18 a.m., with Licensed Vocational Nurse 3 (LVN 3) in medication cart 5, one vial of expired Lispro insulin for Resident 25 was found. LVN 3 stated Resident 25's Lispro insulin was dispensed by the pharmacy on [DATE] and was opened on [DATE]. LVN 3 stated the pharmacy placed a label of beyond use date of [DATE] on Resident 25's Lispro insulin. LVN 3 stated expired medication should not be placed in the medication cart and should be discarded in the medication waste container. LVN 3 stated giving expired insulin medication would be ineffective in treating Resident 25's high blood sugar. LVN 3 stated he will re-order Resident 25's Lispro insulin to the pharmacy immediately.During an interview on [DATE] at 12:15 p.m., with the Director of Nursing (DON), the DON stated the validity of opened insulin is 30 days. The DON stated it will not make any difference for giving expired insulin medication to residents in 2 days.During a review of the manufacturer's product labeling of Lispro insulin, indicated opened Lispro insulin vials must be discarded after 28 days, even if insulin remains. Store opened vials at room temperature and keep away from direct heat/light.During a review of the facility's policy and procedure (P&P), titled Multiple Dose Medication Containers, dated 4/2026, the P&P indicated, All insulin or injectable multiple dose vials will have a 28-day expiration after initial entry. The P&P also indicated these vials dispensed by the pharmacy department will have a label stated expiration.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to ensure a contingency plan (a pre-defined set of actions to be taken if an original plan fails or an unexpected event occurs) for staffing was developed and included in the Facility Assessment (a process for evaluating a facility's resident population and identifying the resources needed to provide care and services).This deficient practice had the potential for the facility to ineffectively respond during unexpected circumstances and negatively impact resident care.Findings:During a concurrent interview and record review on 4/8/2026 at 4:34 p.m., with the Director of Nursing (DON), the Facility Assessment, dated 2/2026, was reviewed. The DON stated the Facility Assessment should be revised when there are changes in the general staffing plan, a new leadership or in the operation of the facility and was responsible in updating the Facility Assessment. The DON stated the Facility Assessment contains the operation of what the facility staff do on a day to day, but not on an emergency. The DON stated the revised Facility Assessment did not indicate the contingency plan on staffing during emergency. The DON stated it was important to include the staffing plan during emergency in the Facility Assessment to safeguard the health and safety of the residents. During a review of the facility's policy and procedure (P&P) titled, Scope of Care, dated 2/2026, the P&P did not mention the contingency plan during emergency in the Facility Assessment. During a review of Centers for Medicare and Medicaid Services (CMS), reference QSO-24-13-NH, dated 6/18/2024, titled Revised Guidance for Long-Term Care Facility Assessment Requirements, indicated the new requirements specify that the facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations including nights and weekends and emergencies. The QSO-24-13-NH also indicated the facility must used this facility assessment to inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555441	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital of Gardena D/P Snf	1145 W. Redondo Beach 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 and interview, the facility failed to:Ensure the Certified Nurse Assistant 1 (CNA 1) had a disposable gown on when performing direct- resident care to Resident 64, as indicated in its policy and procedures (P&P), titled Enhanced Barrier Precautions (EBP- infection control steps used in nursing homes to prevent the spread of germ-resistant bacteria) for Subacute Unit, which indicated to don (put on) gown and gloves prior to high contact care activity (hands-on tasks performed by healthcare staff involving direct contact with residents and/or immediate environment, often resulting in the transfer of multidrug-resistant organisms (MDROs) to staff clothing and hands). This deficient practice had the potential to result in cross contamination (process by which bacteria or other microorganisms are unintentionally transferred from one object or person to another, with harmful effect) of organisms from residents to staff or staff to residents.Findings: During a review of Resident 64's untitled document (front page of the chart that contains a summary of basic information about the resident), the document indicated Resident 64 was admitted to the facility on [DATE]. Resident 64's diagnoses included acute respiratory failure (a sudden, life-threatening emergency where the lungs cannot get enough oxygen into the blood or fail to remove carbon dioxide), hypoxia (low levels of oxygen in your blood) and hypercapnia (a medical condition where there is too much carbon dioxide in your blood). During a review of Resident 64's Minimum Data Set (MDS- a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 64's cognitive (thinking) skills were severely impaired. The MDS indicated Resident 64 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation, on 4/7/2026 at 10:23 a.m., CNA 1 was observed rendering care to Resident 64 who had a tracheostomy (a surgical opening in the neck for an airway) connected to a cool aerosol (a medical treatment that delivers a mist of water particles [sterile water or saline] and a fixed concentration of oxygen to a patient's airway), without a disposable gown (a personal protective equipment designed to cover the body or clothing to protect against dirt or other outside contaminants). During an interview, on 4/7/2026 at 10:26 a.m., with CNA 1, CNA 1 stated he was not wearing a gown while changing Resident 64's diaper, linen and padding, and was providing oral care which included swabbing of Resident 64's tongue and brushing the resident's teeth. CNA 1 stated he should have worn a disposable gown while providing resident care to protect himself and other residents, in case of splash of body fluids. During an interview, on 4/9/2026 at 3:25 p.m., with the Infection Preventionist Nurse 2 (IPN 2), IPN 2 stated when providing patient care to residents, staff were required to wear full Personal Protective Equipment ([PPE] protective clothing, garments or equipment designed to protect the wearer or the resident from infections) to prevent any infections from spreading and to protect staff and residents. IPN 2 stated CNA must wear PPE when brushing a resident's teeth, changing residents, and when providing care due to the risk of cross contamination of organisms from residents to staff or staff to residents. During a review of the facility's policy and procedures (P&P), titled Enhanced Barrier Precautions for Subacute Unit, dated 4/2026, the P&P indicated to don gown and gloves prior to high contact care activity.