

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555848	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Providence Little Comp of Mary Subacute Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1322 West Sixth Street San Pedro, CA 90732	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dependent residents received timely and appropriate Activities of Daily Living (ADL-activities such as bathing, dressing and toileting a person performs daily) care for three of six sampled residents (Resident 42, Resident 51 and Resident 72). The facility failed to:1.Provide incontinent care to Resident 51 and Resident 72 in a timely manner and not leave the residents with soiled incontinence briefs (absorbent, disposable underwear with fastening tabs on both sides) for an extended time.2. Suction (a procedure that is done to help keep a resident ?s airway open and free of mucus) Resident 42 ?s mouth and right nostril who required suctioning to keep airway (the path that air and oxygen to get in and out of the body) clear from secretions (phlegm and saliva).These failures placed Resident 51 and Resident 72 at risk for discomfort, increased risk for skin breakdown, infection and had the potential to put Resident 42 at risk for shortness of breath and aspiration pneumonia (lung infection caused by breathing food, liquid, vomiting or saliva into the lungs).Findings:1. During an observation on 1/26/2026 at 3:34 p.m. and subsequent observation on 1/26/2026 at 3:52 p.m. in Resident 51's room, Resident 51 was lying in bed , grimaced and turned her back to the right side where a large amount of brown soft stool (feces- waste material produced during digestion and expelled from the body through the rectum and anus) was seen on resident's buttocks, brown stool and urine were present in the under pad (disposable or reusable highly absorbent sheet) and resident's gown. There was a strong smell of stool present in the room.During a concurrent observation and interview on 1/26/2026 at 4:22 p.m. with Certified Nursing Assistant (CNA)1, CNA1 entered Resident 51's room and stated there was a strong smell of stool present in the room. CNA1 stated the last time she had seen Resident 51 was around 1:00 p.m. and had not seen Resident 51 for the last three hours because her assignments are heavy.During a review of Resident 51's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder / urinary tract), traumatic brain injury (TBI-damage to the brain caused by an external force causing disruption of normal brain function), cervical neck fracture(broken bone in the neck), percutaneous endoscopic gastrostomy(PEG- feeding tube inserted directly into the stomach to provide a way to deliver nutrition, fluids and medications), and functional quadriplegia (complete inability to move due to extreme frailty or severe chronic disability).During a review of Resident 51's Minimum Data Set (MDS- a resident assessment tool) dated 1/12/2026, the MDS indicated the resident had moderately impaired cognitive skills (a person has noticeable ongoing trouble with thinking, memory and learning that goes beyond normal aging) and was dependent (the resident required full assistance from the staff to complete an activity)on staff with oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. The MDS indicated Resident 51 was always incontinent (having no or insufficient voluntary control over urination or defecation [movement of feces through the bowel and out the anus]) of urine and stool and at risk for developing pressure ulcer or injury (localized damage to the skin and/or underlying tissue usually over a bony prominence).During a review of Resident 51's Care Plan titled Altered Urinary Elimination/At risk for Skin Breakdown, dated 8/7/2024 and end date (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for pressure injury due to the acidic nature of stool and urine.2.During an observation on 1/26/2026 at 11:47 a.m. in Resident 42's room, Resident 42 was lying upright in bed receiving oxygen 28 % (percent- concentration of oxygen) through a T Bar (T shaped device attached directly to the tracheostomy tube [a small, curved plastic or metal tube inserted through a surgically created opening in the neck directly into the windpipe] to deliver humidified oxygen). Resident 42 was observed with clear secretions bubbling and dripping down on both sides of the mouth. Resident 42's right nostril was observed with thick greenish yellow mucus discharge.During a review of Resident 42's Face Sheet, the Face Sheet indicated Resident 42 was admitted on [DATE] to the facility with diagnoses including chronic respiratory failure(long term, progressive condition where the lungs become unable to supply enough oxygen or remove enough carbon dioxide from the body), tracheostomy status, anoxic encephalopathy(serious brain injury caused by a total lack of oxygen reaching the brain_, gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) dependent, and diabetes mellitus(DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42 was comatose (unconscious and unable to communicate often for a long period of time) and was dependent on staff with oral hygiene, toileting hygiene and bathing.During a review of Resident 42's Care Plan titled, Signs and symptoms of Listed Potential Problems will be Absent or Manageable, dated 12/1/2015 and end date of 4/9/2026, the Care Plan indicated Resident 42 had a tracheostomy tube due to chronic respiratory failure. The Care Plan interventions included providing oral care regularly, suctioning to reduce the risk of infection and monitoring for airway patency (clear, open and unobstructed passage for air to travel from the nose or mouth through the pharynx and into the lungs).During an interview on 1/28/2026 at 11:33 a.m. with LVN 3, LVN 3 stated all nursing staff could provide oral care to residents and performed twice a shift. LVN 3 stated residents are suctioned as needed and the frequency of suctioning depends on the amount of secretions. LVN 3 stated Resident 42 could aspirate his secretions, and his work of breathing can get worse if he is not suctioned in a timely manner.During an interview on 1/28/2025 at 4:43 p.m. with the Respiratory Therapist (RT)1, RT 1 stated Respiratory Therapist make rounds every 4 hours. RT 1 stated Resident 42 did not have a lot of secretions and saw Resident 42 on 1/26/2026 at 7:30 a.m. RT 1 stated licensed nurses could suction Resident 42 orally (via mouth) and nasally (via nose). RT 1 stated suctioning is provided to residents who are dependent on care to ensure their airway is clear. RT 1 stated not providing suctioning in a timely manner who had secretions in the mouth and nose can lead to aspiration pneumonia.During an interview on 1/29/2026 at 10:09 a.m. with the Director of Staff Development (DSD), the DSD stated CNAs and LVNs could change the residents if needed when the CNA is busy because they should work as a team. The DSD stated residents should not be left soiled with stool and urine for more than 5 minutes because it can cause skin injury to the residents. The DSD stated rounding should be performed by CNAs and licensed nurses every 2 hours and should check the residents physically especially the residents who had impaired cognition. The DSD stated Resident 42 should be suctioned and leaving him with secretions on the mouth and right nostril area was unacceptable because that is part of resident's hygiene.During a review of facility's policy and procedure (P&P) titled, Incontinent Resident, Care of, revised 12/2024, the P&P indicated the facility will ensure incontinent residents received appropriate care to prevent incontinence complications and is the responsibility of CNA to ensure care is provided. The P&P indicated incontinent residents should be checked periodically to ensure they are not left wet or soaked for prolonged periods.During a review of facility's P&P titled, Respiratory Care Services: Suctioning-Inline(Tracheal and Endotracheal Suctioning), Nasotracheal and or nasopharyngeal Suctioning, last revised 4/2022, the P&P indicated suctioning will be performed on residents who are unable to clear secretions by themselves and order is not needed to suction patients that are on aerosol therapy (medical treatment that delivers medication directly to the airways and lungs as a fine mist or aerosol) for tracheostomy management.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to provide a safe and sanitary environment in the kitchen for all residents by failing to: a. Ensure cooking oil, powdered brown gravy, cream of wheat, pancake mix and corn starch had open dates. b. Ensure disposable food containers were stored in a sanitary manner. c. Ensure the utility carts in the clean area were free from crumbs, dried food particles and grime (dirt). d. Ensure open aluminum cans were not stored at the workstation. These failures had the potential to expose residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites) and put residents at risk for cross contamination (unintentional transfer of harmful bacteria from one object to another). Findings: During an observation on 1/26/2026 at 8:15 am in the kitchen, multiple open food items cooking oil, powdered brown gravy, cream of wheat, pancake mix and corn starch were observed without open dates. There was an observation of clean disposable food containers that were stored in a plastic bin with trash and food particles, and two food utility carts were observed to have dried food particles and dirt. There was also an observation of multiple open aluminum cans with dried food particles in a workstation. During a concurrent observation and interview on 1/26/2026 at 9:00 a.m. in the kitchen with the dietary aide 1(DA1). DA1 stated that the aluminum cans should not be stored at a workstation, and they should be in the trash. DA1 stated there is a risk for spreading germs and the open cans may attract cockroaches and ants. During an interview on 1/29/26 at 8:45 a.m. with the [NAME] (CK), the CK stated every time you open a food item you must put an open date on the package to ensure the food is fresh and not contaminated. The cook stated there is a possibility of having stomach issues if food is not fresh. During an interview on 1/29/2026 at 9:00 a.m. in the kitchen with DA 2, DA 2 stated disposable food containers are to be stored in clean well-organized manner and any utility carts that are in the clean area should be clean and well organized to prevent the risk of cross-contamination and food poisoning. During an interview on 1/29/2026 at 9:15 a.m. with the Dietary Supervisor (DS), the DS stated he was aware of the concerns that were found in the kitchen. The DS stated that any time food is opened it must have an open date to ensure the food is fresh. The DS stated that open aluminum cans should be in the trash not on the workstation because of the possibility of attracting flies and ants. The DS stated any utility cart in a clean area must be cleaned after each use to prevent cross-contamination and all disposable food storage containers must be stored in a sanitary manner to prevent food borne illness. During a review of the facility's policy and procedure (P&P) titled (Sanitation of Food Service Equipment and Facilities) dated 6/2024, the P&P indicated to prevent the spread of infection and food borne illness, standard procedures shall be followed to sanitize food service equipment and the facilities. The P&P indicated food service equipment and the facilities shall be cleaned and sanitized routinely and according to established procedures, work tables are cleaned before beginning work, between products or at least every 4 hours and at end of shift, work tables, counters and sinks are cleaned with solitaire soap, rinsed, sanitized and allowed to air dry. During a review of the facility's policy and procedure (P&P) titled Food Supplies and Storage dated 10/2025, the P&P indicated all food and non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P indicated to cover, label and date unused portions and open packages and after removing single -serve items such as disposable plates or containers from the original case or carton, they must be stored inverted on clean surfaces to prevent contamination. During a review of the facilities policy and procedure (P&P) Infection Prevention Program and Risk assessment dated 3/2025, the P&P indicated the purpose of the infection prevention program is to identify infections and mitigate the risks of disease transmission through the development and implementation of preventive measures. The P&P indicated Food Safety in nutritional Care services should have maintenance of a sanitary environment for food safety and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preparations, safe cooling of all potentially hazardous foods, appropriate hand hygiene, and safe discarding of potentially hazardous foods for pest or vector control.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the trash receptable was covered, not overflowing with trash and disposed of properly outside the kitchen. This failure had the potential to attract pest/rodents, pose health risk and cause infection control violations. Findings: During an observation on 1/26/26 at 9:12 am outside of the kitchen, there was trash stored in two trash cans that were not covered and one was overflowing with trash. During an interview on 1/29/26 at 9:15 am with the Dietary Supervisor (DS), the DS stated there were two trash cans that were not covered and one was overflowing with trash. The DS stated trash cans should not be overflowing with trash and that they should be covered to prevent the possibility of attracting pests like flies, ants and rodents. During an interview on 1/30/2026 at 7:26 am with the Director of Nurses (DON), the DON stated trash cans should not be overflowing with trash and need to be covered. The DON stated there could be issues with pest control when trash is not disposed of properly. During a review of the State Operations Manual (SOM-federal guidelines long term care) dated 11/28/17. The SOM indicated the facility must: -Dispose of garbage and refuse properly. Ensure waste is properly contained in dumpsters or compactors with lids or otherwise covered. -Ensure storage areas are maintained in a sanitary condition to prevent the harborage and feeding of pests. -Ensure garbage receptacles are covered when being removed from the kitchen area to the dumpster. During a review of the facilities policy and procedure (P&P) Infection Prevention Program and Risk assessment dated 3/2025. The P&P indicated the purpose of the infection prevention program is to identify infections and mitigate the risks of disease transmission through the development and implementation of preventive measures. The P&P indicated to have maintenance of a sanitary environment for food safety and safe discarding of potentially hazardous foods. The P&P indicated the storage and disposal of regulated and non-regulated waste is needed for pest or vector control.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of 20 sampled residents (Resident 105) was provided with an adaptive call light (specialized device for patients with limited mobility) upon admission. This failure put Resident 105's at risk for falls, delay of care, and emotional neglect. Findings: During a concurrent observation and interview on 1/26/26 at 2:14 pm at Resident 105's bedside, Resident 105 was able to mouthed the words that he did not have a call light and could not move his body. During a review of Resident 105's admission Record (Face sheet), dated 1/28/26, the admission record indicated Resident 105 was admitted on [DATE]. Resident 105's diagnosis included hemorrhagic stroke (bleeding in the brain), quadriplegic (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), respiratory failure (lung disease) and GERD (indigestion). During a review of Resident 105's Physical Therapy (PT) Initial Evaluation, dated 1/26/26, the PT evaluation indicated Resident 105 was unable to mobilize his neck, bilateral upper extremities (both arms) and bilateral lower extremities (both legs) so a trial of sip and puff call light (breath operated call light) was recommended. During an interview on 1/26/26 at 2:18 pm with Resident 105's family member (FM1), FM1 stated Resident 105 was admitted on [DATE] and has not had a call light to call staff for assistance. During a concurrent observation and interview on 1/26/26 at 2:28 pm at Resident 105's bedside with the Social Worker1 (SW1), SW1 stated Resident 105 did not have a call light that was accessible and he should have had one upon admission. SW1 stated that Resident 105 was at risk of his needs not being met because he didn't have an accessible call light. During an interview on 1/28/26 at 3:54 pm with Nursing Manager 1 (NM 1), NM 1 stated all residents upon admission should have a call light that is accessible, so they can communicate their needs to the staff. During an interview on 1/30/26 at 12:12 pm with the Director of Nursing (DON), the DON stated all residents upon admission should have a call light. The DON stated he was made aware that Resident 105 did not have a call light that was appropriate for Resident 105's medical condition. The DON stated there was a potential for Resident 105's needs not to be met when not having the proper call light. During a review of the facility's policy & procedure (P&P) Call light Responsibilities (undated), the P&P indicated the purpose was to ensure the safety of all residents and timely response to call lights. The P&P indicated it is the responsibility of the Licensed Nurse/Certified Nurse Assistant (CNA), when admitting the resident, to explain the use of the call light, the emergency light in the bathroom, and the intercom at the nurse station.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 10) had a Level 2 Preadmission Screening and Resident Review (PASARR-a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) assessment done when diagnosed with a mental illness prior to admission. This failure had the potential to result in Resident 10 not receiving the necessary services and appropriate psychiatric level of treatment and evaluation in the facility. Findings: During a review of Resident 10's Face Sheet, the Face Sheet indicated Resident 10 was re-admitted to the facility on [DATE]. Resident 10 had diagnoses including cerebral palsy (the most common motor disability in childhood, affecting movement, balance, and posture), intellectual disability (a neurodevelopmental condition characterized by significant limitations in both intellectual functioning (such as learning, reasoning, and problem-solving) and adaptive behavior (practical, social, and everyday life skills), pneumonia (a common lung infection that causes the tiny air sacs in one or both lungs to become inflamed and fill with fluid or pus) and chronic respiratory failure (a long term condition where the lungs cannot properly oxygenate blood or remove carbon dioxide). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 11/5/2025, the MDS indicated Resident 1 rarely had the ability to make self-understood and to understand others. The MDS indicated Resident 10 was severely impaired (refers to a significant, long-term (12 plus months) physical or mental limitation that severely restricts an individual's ability to perform basic work activities or age-appropriate daily functions) regarding task of daily life. The MDS indicated Resident 10 was dependent (a person or a thing that relies on another for support, existence, or determination) on nursing staff for eating, oral hygiene, toileting, and showering. The MDS indicated Resident 10 was dependent on nursing staff with dressing, putting on and taking off footwear, personal hygiene and rolling from left to right. During a review of Resident 10's Notice of PASARR Level 1 Screening Results, dated 11/4/2025, the Notice of PASARR Level 1 Screening Results indicated Resident 10 was positive for intellectual disability, developmental disability (a group of diverse, lifelong conditions caused by impairments in physical, learning, language, or behavior), or related conditions. The Notice of PASARR Level 1 Screening Results indicated Resident 10 required a PASARR Level 2 Mental Health Evaluation Referral for intellectual disability, developmental disability, or related conditions. During an interview on 1/30/2026 at 9:12 a.m. with Registered Nurse (5), RN 5 stated she reviewed Resident 10's diagnoses, medication and mental status for appropriate admission to the facility. RNS 5 stated if a resident has a diagnosis of any mental illness, or psychiatric issues these residents would need a Level 2 PASARR evaluation. RN 5 stated Resident 10 needed a Level 2 PASARR Mental Health Evaluation. RN 5 stated Resident 10 needed a level 2 evaluation referral to address and to receive appropriate care and services. RN 5 stated Resident 10's Notice of PASARR Level 1 Screening Results were not reviewed accurately. During a concurrent interview and record review on 1/30/2026 at 12:08 p.m. with the Director of Nursing (DON), Resident 10's Notice of PASARR Level 1 Screening Results, dated 11/4/2025, was reviewed. The Notice of PASARR Level 1 Screening Results indicated a Level 2 Mental health Evaluation Referral for intellectual disability, developmental disability, or related conditions was needed. The DON stated this was missing. The DON stated the negative outcome of not receiving an evaluation referral resulted in Resident 10 not receiving the appropriate level of care. During a review of the Facility's Policy and Procedure (P&P), titled South Division Care Management Standard Work, revised date 9/2024, the P&P indicated the Person completing the screening must submit in the system as soon as possible. Level 1 Screening, the results of this screening will be known immediately after submission. During a review of the P&P, titled California Standard admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities, dated 8/2023, the P&P indicated, It is the intent of the Legislature that persons with (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developmental disabilities shall have rights including, but not limited to, the following a right to treatment and habilitation services and supports in the least restrictive environment. The P&P indicated Treatment and habilitation services, and support should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. The P&P indicated such services shall protect the personal liberty of the individual and shall provide with the least restrictive conditions necessary to achieve the purpose of the treatment, services, or supports.		

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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 develop and implement an individualized and person-centered care plan for two of six residents (Resident 8 and Resident 15) by failing to:a. Develop a new care plan when Resident 8 rash reoccurred.b. Implement the care plan for monitoring Resident 15's inappropriate sexual behavior and providing a psychiatric (relating to mental illness and its treatment) consult to assess Resident 15's behavior. These failures had the potential to put Resident 8 and Resident 15 at risk not to receive the necessary care and services to meet their needs which could compromise Resident 8 and Resident 15 physical and psychosocial well-being. Findings: a. During a review of Resident 8's Face Sheet (front page of the chart that contains a summary of basic information about the resident) dated 1/28/2026. The Face Sheet indicated that Resident 8 was admitted on [DATE] to the facility. During a review of Resident 8's History and Physical (H&P), dated 4/14/25, the H&P indicated Resident 8 was in a persistent vegetative state. The H&P indicated Resident 8 had the diagnosis including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), chronic respiratory failure (lung disease), ventilator dependent (machine that moves air in and out of the lungs) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool) dated 9/12/2025. The MDS indicated Resident 8 was cognitively impaired. The MDS indicated Resident 8 was totally dependent (staff member does all the work) with activities of daily living (ADLs such as toileting, dressing and personal hygiene). During a review of Resident 8's Order Summary Report dated 1/19/2026. The order summary report indicated Resident 8 was prescribed, vitamin A & D (topical ointment) apply to left and right upper arm, left and right upper leg, left and right groin (lower stomach meets the inner thigh) areas BID start date 1/19/2026 end date 1/26/2026. During a concurrent interview and record review on 1/27/2026 with RN 4, Resident 8's weekly wound assessment dated [DATE] and vitamin A&D order dated 1/19/2026 was reviewed. RN 4 stated Resident 8's rash resolved to left lateral back, left upper back, left lateral leg, left upper quadrant, right lateral back and right medial leg on 12/23/25 and that on 1/18/2026 Resident 8's rashes came back to left and right upper arm left, left and right groin areas. RN 4 stated she should have started a new care plan when the rashes started on 1/18/2026. RN 4 stated a care plan is a guideline on how the staff are going to take care of the residents, if there is no care plan there is no goal there is a risk of residents not being healed because staff won't know the plan of care. During an interview on 1/30/26 at 7:50 a.m. with the Director of Nursing (DON). The DON stated the moment the rashes come back the care plan should have been started, that is where we reflect the treatment and the plan to care for the residents. The care plan is the general rule to guide the staff when providing care to the residents. During a review of facility's policy and procedure(P&P) titled, Comprehensive Care Plan, dated 1/2026, the P&P indicated the facility will provide care and services that will attain and maintain (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's highest practical, physical, mental, and psychosocial well-being. The P&P indicated the facility will implement appropriate treatment to assist in attaining or maintaining quality of life and according to residents' goals and preferences. b. During a review of Resident 15's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE] to the facility. Resident 15's diagnosis included Pneumonia (PNA-an infection/inflammation in the lungs), muscular dystrophy (group of diseases that muscles weaker and tighter over time making harder to move), chronic respiratory failure (long-term condition where the body cannot maintain healthy levels of oxygen and carbon dioxide on its own) requiring use of nocturnal mechanical ventilation (use of breathing machine at night) through a tracheostomy(procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck). During a review of Resident 15's Minimum Data Set, dated [DATE], the MDS indicated Resident 15 had an intact cognition (thought process) and used a manual or electric wheelchair as a mobility device (any device or equipment that helps a person with limited mobility, injuries or limited strength to move around more easily, safely and independently). The MDS indicated Resident 15 required partial/moderate assistance (helper or caregiver provides less than half the effort to complete the activity with bathing, upper body dressing (ability to dress and undress above the waist) and toileting hygiene. During a review of Resident 15's Care Plan titled, Identify Related Risk Factors and Signs and Symptoms, dated 9/25/2025 and end date of 4/8/2026, the Care Plan indicated the patient was verbally inappropriate towards staffs, calling staff names and making sexual remarks. The Care Plan indicated Resident 15 asked female staff to clean his private area despite the resident was able to do it. The Care Plan interventions included monitoring Resident 15's behavior every shift and providing psychiatric consult as needed. During a concurrent interview and record review on 1/28/2026 at 3:46 p.m. with the Social Worker (SW)1, Resident 15's Progress Notes of Social Worker dated 9/18/2025 and 10/23/2025 were reviewed. SW 1 stated Resident 15 showed inappropriate sexual behavior towards female Certified Nursing Assistants (CNAs) especially young women. SW 1 stated Resident 15 was assigned male CNAs because he wanted female CNAs to touch him on his private area. SW 1 stated the Resident 15 could clean his private area by himself but asked female CNAs to do it. SW 1 stated he was not aware if the physician was notified about his inappropriate sexual behavior towards female CNAs. SW 1 stated no psychiatric consult was provided to address the behavior. During an interview on 1/28/2026 at 10:25 a.m. with Nurse Manager (NM) 1, NM 1 stated Resident 15's inappropriate sexual behavior towards the female CNAs started on 5/1/2025. NM 1 stated three female CNAs had come to him and were concerned of Resident 15's inappropriate sexual behavior. NM 1 stated Resident 15 liked young female CNAs and disliked old CNAs. NM 1 stated the facility had to take immediate action because of sexual harassment and immediately pulled all three CNAs from taking care of Resident 15. NM 1 stated Resident 15 was now assigned to male CNAs, but sometimes female CNAs were assigned due to inadequate number of male CNAs. During a concurrent interview and record review on 1/29/2026 at 12:06 p.m. with NM1, Resident 15 Plan of Care Note dated 5/1/2025, Progress Notes, Plan of Care Notes and Care Plan titled Identify Related Risk Factors and Signs and Symptoms were reviewed. NM 1 stated the facility documented the inappropriate sexual behavior of Resident on 9/23/2025. NM 1 stated interventions of the Care (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan included monitoring of Resident 15's behavior every shift. NM 1 stated there was no documentation addressing specific inappropriate sexual behavior that was monitored by the staff. NM 1 stated the facility should have placed monitoring of specific behavior addressing the inappropriate sexual behavior of Resident 15. NM 1 stated there was no documentation the physician was notified about Resident 15's inappropriate sexual behavior towards female CNA's for a psychiatric consult was ordered by a physician to address Resident 15's behavior. NM 1 stated the importance of care plan is to individualize the care of a resident and interventions like monitoring of inappropriate sexual behavior should be monitored according to Resident 15's Care Plan. NM 1 stated other residents had the potential to be at risk for abuse or mental distress if Care Plan was not followed. During a review of facility's policy and procedure(P&P) titled, Comprehensive Care Plan, dated 1/2026, the P&P indicated the facility will provide care and services that will attain and maintain resident's highest practical, physical, mental, and psychosocial well-being. The P&P indicated the facility will implement appropriate treatment to assist in attaining or maintaining quality of life and according to residents' goals and preferences.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 20 sampled residents (Resident 8) was seen by a Dermatologist (doctor who specializes in skin disorders) for an unresolved whole-body rash that started on 7/18/2025. This failure caused Resident 8 to suffer with discomfort and itching and had the potential for infection, sleep disruption and emotional distress. Findings: During an observation on 1/26/26 at 2:04 p.m. at Resident 8's bedside, Resident 8 had scattered rashes with red patches all over his body. During a review of Resident 8's admission Record (Face sheet), dated 1/28/26, the admission record indicated Resident 8 was admitted on [DATE]. Resident 8 had diagnosis including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), chronic respiratory failure (lung disease), ventilator dependent (machine that moves air in and out of the lungs), gastrostomy tube ([GT] a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/12/2025. The MDS indicated Resident 8 was cognitively impaired. The MDS also indicated Resident 8 was totally dependent (staff members do all the work) with activities of daily living (ADLs such as toileting, dressing and personal hygiene). During a review of Resident 8's order summary reports dated 7/2025-1/2026. The order summary report indicated Resident 8 was prescribed: 1. Diphenhydramine (medication used for itching) 2% topical (on the skin) cream three times a day (tid) as needed (PRN) for itching to apply to the upper chest, shoulder and neck for a skin rash, starting 6/28/2025 -7/12/2025. 2. Triamcinolone (medication used to treat inflammatory conditions) 0.1% topical ointment once a day for rashes on the abdomen (stomach) starting 7/25/25-8/22/2025. 3. Triamcinolone 0.1% topical ointment once a day for a rash on the back, arm, starting 9/01/2025- 9/22/2025. 4. Clotrimazole- betamethasone (anti-fungal medication) 0.5% cream apply topically for rashes to the left posterior arm, left flank, left side of abdomen and right anterior (front) arm two times a day (BID) starting 9/28/2025-10/19/2025. 5. Hydrocortisone (medication used for itching) 1% ointment apply to left upper arm rash four times a day (QID) starting 10/29/2025-11/18/2025. 6. Fluocinonide (steroid) 0.5% cream apply topically BID to left upper back, right upper back, left upper arm and right upper arm rashes, starting 11/18/2025-2/2/2025. 7. triamcinolone 0.1% topical ointment BID for rashes on the left lateral back, left quadrant, left lateral leg, right medial leg and the right lateral back start date 12/07/25 end date 12/21/25. 8. Vitamin A&D ointment (skin moisturizer) apply topically to left and right upper arm left and right upper leg, left and right groin (lower stomach meets the inner thigh) areas BID starting 1/19/2026 -1/26/2026. 9. Diphenhydramine (medication used for itching) 25 milligrams (mg-unit of measure) via g-tube every six hours as needed for itching starting 1/18/2026 and treatment is ongoing. During a review of Resident 8's Interdisciplinary team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) care conference dated 8/22/2025, the IDT care conference indicated, the family was concerned about rashes spreading all over the left side of Resident 8's body. During a review of Resident 8's IDT care conference dated 9/26/2025, the IDT care conference indicated Resident 8 had rashes that started on 8/12/2025 to the left abdomen, left lateral flank (side of body between the rib and the hip) and left upper arm. During a review of Resident 8's IDT care conference dated 10/25/2025, the IDT care conference indicated Resident 8 had rashes on the left upper arm, left abdomen and left lateral flank. During a review of Resident 8's consultation to case management dated 11/16/2025, the consultation to case management indicated to: Obtain an authorization for a dermatology (specializing in diagnosing and treating skin conditions) consult for dry skin and scattered skin rashes to the entire body. During a review of Resident 8's IDT care conference dated (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/11/2025, the IDT care conference indicated Resident 8 still had rashes and there was minimal response to the previously ordered hydrocortisone cream and a dermatology referral was pending. During a review of Resident 8's IDT care conference dated 1/16/2026, the IDT care conference indicated Resident 8 still had a rash, there was minimal response to the previously used hydrocortisone cream, dermatology referral pending. During a review of Resident 8's medical doctor (MD) progress dated 1/19/2026, the progress note indicated Resident 8 still had a rash and there was minimal response to the previously used hydrocortisone cream. During a review of Resident 8's case manager progress note dated 1/23/2026, the progress note indicated Resident 8 did not need an authorization and will call hospital staffing and look for possible dermatologic provider. During a telephone interview on 1/26/26 at 2:08 p.m. with FM2, FM2 stated Resident 8 had a rash all over his body for over six months. FM 2 stated the facility just kept putting cream on the rashes. FM 2 stated they wanted Resident 8 to be seen by a Dermatologist. During a concurrent observation and interview on 1/27/26 at 11:15 a.m. with Treatment Nurse (TXN) 1, Resident 8's skin treatments were observed. TXN 1 stated Resident 8 has had these rashes for months all over his body. TXN 1 stated many different steroid creams have been used on Resident 8 rashes, but they come back. TXN 1 stated Resident 8 is waiting to be seen by a Dermatologist. TXN 1 stated Resident 8 was neglected and should have been seen by a dermatologist sooner. During a concurrent interview and record review on 1/27/2026 at 3:21 p.m. with Registered Nurse (RN) 4, Resident 8's progress note was reviewed. RN 4 stated Resident 8 had a rash all over his body since 7/25/2025 and that the rash comes and goes. RN 4 stated we have been waiting for authorization from Resident 8's insurance company to see a Dermatologist. RN 4 stated Resident 8 was not comfortable and that she (RN 4) should have escalated the dermatology consultation. RN 4 stated there was a delay in care for Resident 8. During an interview on 1/28/2026 at 11:49 a.m. with the Case Manager (CM). The CM stated Resident 8 does not need an authorization to see a Dermatologist. The CM stated after she talked to RN 4 on 1/26/26 that is when CM started looking for a Dermatologist for Resident 8. The CM stated regardless of Resident 8's insurance, he needed to be seen by a dermatologist. The CM stated Resident 8 was a human being and should not have to suffer. During an interview on 1/30/26 at 7:50 a.m. with the Director of Nurses (DON), the DON stated he was aware of what was going on with Resident 8's Dermatologist consultation. The DON stated there was a gap in the system and that the Dermatologist consult should have been escalated. The DON stated the rashes on Resident 8 would continue to spread if the cause was not found. The DON stated if it were his family member, he would be worried. During a review of the facilities Case Management job description dated 1/2026, the case management job description indicated, Case Management process facilitates communication and care coordination. The goals of Case Management include the achievement of optimal health, access to services, advocacy, appropriate utilization of resources and collaboration with post-acute care providers to ensure patient's needs are met in the community. The Care Manager utilizes the following processes to meet the patient's individual healthcare needs: assessment, planning/intervention, implementation, care coordination, monitoring, evaluation of the plan of care and communication. During a review of the facility's Policy and Procedure (P&P), titled Abuse prevention dated 5/2025, the P&P indicated neglect was failure to exercise that degree of care that a reasonable person would exercise including but not limited to failure to assist in personal hygiene or provision of food, clothing or shelter; failure to provide medical care; failure to protect from health and safety hazards. During a review of the facility's Policy and Procedure (P&P), titled Residents Rights dated 1/2025, the P&P indicated all residents have rights guaranteed to them under Federal and State law. The P&P indicated resident rights shall include but are not limited to choosing a physician and treatment and participating in decisions and care planning activities.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 15) with behavioral problems was adequately monitored and received the necessary care and services by failing to: Monitor Resident 15's inappropriate sexual behavior towards female and implement plan of care. Provide psychiatric (relating to mental illness and its treatment) care to evaluate and assess Resident 15's inappropriate sexual behavior. This failure placed Resident 15 at risk with a delay in psychosocial (having to do with the mental, emotional, and spiritual aspects of a person's life) needs/care which had the potential for worsening behavior that could pose a danger to other residents. Findings: During a review of Resident 15's Face Sheet (front page of the chart that contains a summary of basic information about the resident) the Face Sheet indicated the resident was admitted on [DATE] to the facility. Resident 15 had diagnoses including Pneumonia (PNA-an infection/inflammation in the lungs) muscular dystrophy (group of diseases that muscles weaker and tighter over time making harder to move) and chronic respiratory failure (long-term condition where the body cannot maintain healthy levels of oxygen and carbon dioxide on its own) requiring use of nocturnal mechanical ventilation (use of breathing machine at night) through tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck). During a review of Resident 15's Minimum Data Set (MDS- resident assessment tool) dated 12/30/2025, the MDS indicated Resident 15 had an intact cognition (thought process) and used a manual or electric wheelchair as a mobility device (any device or equipment that helps a person with limited mobility, injuries or limited strength to move around more easily, safely and independently). The MDS indicated Resident 15 required partial/moderate assistance (helper or caregiver provides less than half the effort to complete the activity with bathing, upper body dressing (ability to dress and undress above the waist) and toileting hygiene. During a review of Resident 15's Care Plan titled, Identify Related Risk Factors and Signs and Symptoms, with start date of 9/25/2025 and end date of 4/8/2026, the Care Plan indicated Resident 15 was verbally inappropriate towards staffs, calling staff names and making sexual remarks. The Care Plan Indicated Resident 15 asked female staff to clean his private area despite the resident was able to do it. The Care Plan interventions included monitoring Resident 15's behavior every shift and providing psychiatric consult as needed. During an interview on 1/28/2026 at 8:02 a.m. with Resident 15, Resident 15 stated Certified Nursing Assistant (CNA) 3 came to the room (unknown date) around 2:00 am or 3:00 a.m. and saw him with a penile erection (caused by sexual stimulation) then reported him to the Nurse Supervisor. During a telephone interview on 1/28/2026 at 9:29 a.m. with CNA3, CNA 3 stated she entered Resident 15's room around early morning to check his roommate, Resident 15 called and told her to look at him. CAN 3 stated Resident 15 had exposed himself, was holding his penis and this incident was reported to the Nurse Manager (NM) 1. CNA 3 stated this incident happened before but did not report the incident to the supervisor. During a concurrent interview and record review on 1/28/2026 at 3:46 p.m. with the Social Worker (SW)1, Resident 15's Progress Notes of Social Worker dated 9/18/2025 and 10/23/2025 were reviewed. SW 1 stated Resident 15 showed inappropriate sexual behavior towards female certified nursing assistants (CNAs) especially young women. SW 1 stated Resident 15 was assigned male CNAs because he wanted female CNAs to touch him on his private area. SW 1 stated the resident can clean his private area by himself but asked female CNAs to do it. SW 1 stated he was not aware if the physician was notified about his inappropriate sexual behavior towards female CNAs. SW 1 stated no psychiatric consult was provided to address the behavior. During an interview on 1/28/2026 at 10:25 a.m. with the Nurse Manager (NM) 1, NM 1 stated Resident 15's inappropriate sexual behavior towards the female CNAs started on 5/1/2025. NM1 stated three female CNAs had come to him and were concerned of Resident 15's inappropriate sexual behavior. NM1 stated Resident 15 liked young female (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNAs and disliked old CNAs. NM 1 stated the facility had to take immediate action because of sexual harassment and immediately pulled all three CNAs from taking care of Resident 15. NM 1 stated Resident 15 was now assigned to male CNAs, but sometimes female CNAs were assigned due to inadequate number of male CNAs. During a concurrent interview and record review on 1/29/2026 at 12:06 p.m. with the NM1, Resident 15 Plan of Care Note dated 5/1/2025, Progress Notes, Plan of Care Notes and Care Plan titled Identify Related Risk Factors and Signs and Symptoms were reviewed. NM 1 stated the facility documented the inappropriate sexual behavior of Resident on 9/23/2025. NM 1 stated interventions of the Care Plan included monitoring of Resident 15's behavior every shift. NM 1 stated there was no documentation addressing specific inappropriate sexual behavior that was monitored by the staff. NM 1 stated the facility should have placed monitoring of specific behavior addressing the inappropriate sexual behavior of Resident 15. NM1 stated there was no documentation the physician was notified about resident's inappropriate sexual behavior towards female CNA's or psychiatric consult was ordered by a physician to address Resident 15's behavior. NM1 stated the importance of care plan is to individualize the care of a resident and interventions like monitoring of inappropriate sexual behavior should be monitored according to Resident 15's Care Plan. NM 1 stated other residents had the potential to be at risk for abuse or mental distress if Care plan was not followed. During an interview on 1/30/2026 at 11:20 a.m. with the Director of Nursing (DON), the DON stated Resident 15 is mobile (able to move or be moved easily) but he used his electric wheelchair to move around the facility and can get into other residents' rooms. The DON stated there are no specific behavioral monitoring addressing Resident 15's inappropriate sexual behavior and the physician was not notified about resident 15's display of inappropriate sexual behavior towards female CNAs on several occasions. The DON stated there were gaps in the care because Resident 15 was not assessed or evaluated by a mental health provider to address his behavior. The DON stated there was no documentation in the Nursing Notes about Resident 15's inappropriate sexual behavior and they failed to notify the physician about resident's behavioral problem. The DON stated other residents could be at risk for Resident 15's display of inappropriate sexual behavior if not addressed. During a review of facility's policy and procedure (P&P) titled, SACC Psychosocial Assessment, revised 12/2024, the P&P indicated each resident will be reassessed as indicated or upon significant change in status such as change in psychosocial/emotional behavior patterns and all assessment documentation will be entered in resident medical record. During a review of facility's P&P titled, SACC Psychiatric Consultation and Evaluation, revised 12/2024, the P&P indicated the facility will identify and address each resident with psychiatric problem and provide care as needed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555848	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Providence Little Comp of Mary Subacute Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1322 West Sixth Street San Pedro, CA 90732	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review, the facility failed to observe infection control practices for one of six sampled residents (Resident 34) by failing to:1. Ensure the linen hamper lid was closed and not overflowing with dirty gowns in Resident 34's bathroom.This failure had the potential to cause cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spread of infection among the residents, staff and visitors in the facility.Findings:During an observation on 1/26/2026 at 9:31 a.m. in Resident 34's bathroom, a linen hamper had an open lid filled with soiled non-disposable isolation gowns that were hanging outside the hamper. There was an observation of signage for Enhanced Barrier Precaution (EBP-infection control intervention designed to reduce transmission of multi drug resistant organism [MDRO, superbug bacteria or germs that have changed to resist many common antibiotics]) in nursing homes which involved gown and glove use during high-contact resident care activities) posted on the wall before the entrance of the room.During a subsequent observation on 1/26/2026 at 2:02 p.m. in Resident 34's bathroom, there was a linen hamper open and some of the soiled yellow non-disposable gowns were not completely inside the hamper.During a review of Resident 34's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 34 was admitted on [DATE] to the facility. Resident 34's diagnosis included chronic respiratory failure (long-term condition where the body cannot maintain healthy levels of oxygen and carbon dioxide on its own), anemia (a condition where the body does not have enough healthy red blood cells), atrial fibrillation(irregular heartbeat) and deep vein thrombosis of right leg(DVT- blood clot forms in a vein located deep inside the body).During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool) dated 11/3/2025, the MDS indicated Resident 34 had an intact cognition (thought process) and was dependent on staff with toileting hygiene, bathing, and dressing.During an interview on 1/28/2026 at 7:49 a.m. with the Housekeeping (HSK) 1, HSK 1 stated all staff in the facility are responsible in ensuring linen hampers are closed after using to prevent cross contamination and spread of infection. HSK 1 stated it is not sanitary if the hamper is open and overflowing with dirty linens and isolation gowns inside the bathroom of a resident. HSK 1 stated if the hamper is overflowing with soiled linens and isolation gowns, the hamper should be emptied and lid should be closed.During concurrent observation and interview on 1/29/2026 with the Certified Nursing Assistant (CNA) 5, CNA 5 stated the linen hamper in Resident 34's bathroom had an open lid, full and non-disposable isolation gowns were not completely inside the hamper. CNA 5 stated the hamper should be checked if the lid was closed and the hamper should have been emptied because it was almost full. CNA 5 stated residents can be at risk of infection if dirty linens, non-disposable yellow gowns were not disposed in the hamper properly by ensuring the lid is closed and all soiled linens and gowns are completely inside the hamper.During an interview on 1/29/2026 at 10:26 a.m. with the Director of Staff Development (DSD), the DSD stated linen hamper's lid should be closed and no dirty linens or soiled isolation gowns should be tucked inside and nothing is hanging. The DSD stated if the hamper bag should be emptied if the bag is full or three quarters (3/4) full. The DSD stated open lid and soiled linens and gowns not disposed completely inside the hamper bag could transmit infection to the caregivers, the environment and visitors using Resident 34's bathroom.During a review of facility's policy and procedure(P&P) titled, Linen and Laundry Policy, dated 9/2024, the P&P indicated soiled linen shall be handled by observing universal precautions, be placed in an impervious blue plastic liner and handled with minimal agitation and covered hampers for soiled linen should be used in all areas.		

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NAME OF PROVIDER OR SUPPLIER Providence Little Comp of Mary Subacute Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1322 West Sixth Street San Pedro, CA 90732	
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review the facility failed to ensure one of two residents (Resident 22) and resident representatives were provided education regarding the risks and benefits of refusing influenza (flu - a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs) vaccination. This failure had the potential to result in the resident or resident representative making uninformed decisions regarding refusal of influenza vaccine, increasing the risk for vaccine-preventable illness, complications, hospitalization, and transmission of infection within the facility. Findings: During a review of Resident 22's Face Sheet (admission Record), the Face Sheet indicated the facility re-admitted Resident 22 on 1/7/2026 with diagnoses including chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately transfer oxygen into the blood, resulting in low blood oxygen levels). During a review of Resident 22's history and physical (H&P) dated 11/21/2025, the H&P indicated Resident 22 was nonverbal and was unable to give any information. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool) dated 11/21/2025, the MDS indicated Resident 22 was comatose (in a state of deep unconsciousness for a long period or could not be woken up) and was unable to think or make decisions. The MDS indicated Resident 22 did not receive influenza vaccination for the 2025-2026 flu season. During a review of Resident 22's Care Plan titled Absence of Infection Signs and Symptoms dated 11/21/2025, the Care Plan indicated family refused flu vaccine to be administered to patient for 2025-2026 flu season. The care plan did not indicate Resident 22's family were educated regarding declination of the flu vaccine. During a concurrent interview and record review on 1/27/2026 at 3:06 p.m. with the Infection Preventionist (IP), Resident 22's immunization screening was reviewed. The IP stated Resident 22's family declined flu vaccine on 11/22/2025 and 12/22/2025 but was not given the Vaccine Information Statement (VIS - paper hand out). The IP stated resident or family education regarding declination of vaccines should be documented on the care plan. The IP stated the importance of providing education and the VIS to resident was to explain the risks of not receiving the vaccine and benefits of receiving the vaccine. The IP stated if the resident or family was not educated regarding the flu vaccine and the resident or family declined the vaccine, there would be an increased risk of exposure to the flu virus and development of other flu virus related complications. During a review of the facility's policy and procedure (P&P) titled SACC: Guidelines for Pneumococcal, Influenza and COVID-19 Vaccination of Adult Residents in Subacute & Long-Term Care revised 7/2025, indicated .Before offering immunization, the resident or their legal representative will be given the appropriate Vaccine Information Statement (VIS) for education regarding benefits and potential side effects of the immunization(s). This education and the edition date of the VIS given will be documented on the medication administration record (MAR).		