

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/07/2025
NAME OF PROVIDER OR SUPPLIER  Clear View Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE  15823 So. Western Ave. 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</b></p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Implement its undated Policy and Procedure (P&amp;P) titled, Reporting Suspected Crimes Under The Federal Elder Justice Act which indicated the reporting individual will notify local law enforcement immediately by phone and the Long Term care Ombudsman (an agency who investigates, reports on, and helps settle complaints against the facility) and licensing agency (California Department of Public Health) within 2 hours by fax when an incident involves abuse or serious bodily injury, after Resident 14 was alleged to have kicked Resident 56 in the stomach, approximately two weeks ago.</p> <p>This deficient practice had the potential to place Resident 56 at risk for further abuse.</p> <p>Findings:</p> <p>During a review of Resident 56's Admitting and Discharge Record (front page of the chart that contains a summary of basic information about the resident), the Admitting and Discharge Record indicated, Resident 56 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admitting and Discharge Record indicated, Resident 56's diagnoses included cerebral infarction (a brain injury caused by a lack of blood flow) and vascular dementia (a condition that affects memory, thinking, and behavior due to reduced blood flow to the brain).</p> <p>During a review of Resident 56's History and Physical (H&amp;P), dated 4/2/2024, the H&amp;P indicated, Resident 56 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 56's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/30/2024, the MDS indicated, Resident 56's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 56 required supervision (helper provides verbal cues) with eating and oral hygiene. Section C for cognitive skills and Section GG for ADLs.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 14's Admitting and Discharge Record (front page of the chart that contains a summary of basic information about the resident), the Admitting and Discharge Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admitting and Discharge Record indicated, Resident 14's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and anxiety disorder (a mental health condition that causes excessive fear and worry).</p> <p>During a review of Resident 14's History and Physical (H&amp;P), dated 11/10/2024, the H&amp;P indicated, Resident 14 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's MDS assessment, dated 11/6/2024, the MDS indicated, Resident 56's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 14 required supervision (helper provides verbal cues) with oral hygiene and toileting hygiene.</p> <p>During a medication pass observation on 2/6/2025 at 12:30 p.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 56 approached LVN 3 and reported he was kicked in the stomach by someone. LVN 3 stated he will talk to resident 56 later.</p> <p>During a review of facility fax cover sheet dated 2/7/2025 at 12:16 p.m. sent to CDPH, the cover sheet fax was regarding a Report of Suspected Dependent Adult/Elder Abuse (SOC 341). The SOC 341 indicated information of Resident 14's allegedly kicked Resident 56 in the stomach that occurred 2 weeks ago.</p> <p>During a review of Resident 56's Situation, Background, Assessment, Recommendation ([SBAR] - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/7/2025 at 7:23 a.m., the SBAR indicated, on 2/6/2025 at 5:00 p.m., Resident 56 stated another resident kicked him in the stomach 2 weeks ago.</p> <p>During an interview on 2/7/2025 at 1:49 p.m., with LVN 3, LVN 3 stated the allegation of Resident 14 that he was allegedly kicked in the stomach was reported to him on 2/6/2025 at around 12:30 p.m. during the medication pass observation. LVN 3 stated he did not report the allegation of physical abuse to his Director of Nursing (DON) and Administrator (ADM). LVN 3 stated he got sidetracked and was busy with other tasks and that was the reason why he did not report the allegation of physical abuse. LVN 3 stated he was a mandated reporter, and any allegation of abuse should be reported immediately or within 2 hours to the ADM, Ombudsman, and CDPH. LVN 3 stated it was the responsibility of the ADM being the abuse coordinator to notify the Ombudsman and CDPH. LVN 3 stated it was required by law to report in a timely manner any allegation of abuse to the Ombudsman and CDPH for the safety and well-being of residents. LVN 3 stated next time he would be better when it comes to reporting of abuse allegation.</p> <p>During an interview on 2/7/2025 at 2:32 p.m., with the DON, the DON stated ADM 2 completed and faxed the SOC 341 and reported the allegation of physical abuse between Resident 56 and Resident 14 to the Ombudsman and CDPH on 2/7/2025 (one day later). The DON stated she was aware of the allegation of physical abuse between Resident 56 and Resident 14 on 2/6/2025 but did not report to the CDPH and Ombudsman. The DON stated it was important to report allegation of abuse to the CDPH within 2 hours after knowledge of the incident so there would be no delay in their investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/7/2025 at 3:33 p.m., with ADM 2, the facility's undated P&amp;P titled, Reporting Suspected Crimes Under The Federal Elder Justice Act was reviewed. ADM 2 stated the P&amp;P indicated, The reporting individual will notify local law enforcement immediately by phone and the Long-Term Care Ombudsman, law enforcement and licensing agency within 2 hours by fax when an incident involves abuse or serious bodily injury. ADM 2 stated this was the facility's policy when it comes to abuse reporting. ADM 2 stated the DON reported to him today (2/7/2025) between 8:30 a.m. to 9:00 a.m. regarding Resident 56's allegation he was kicked in the stomach by Resident 14. ADM 2 acknowledged he completed the SOC 341 and faxed to the Ombudsman and CDPH on 2/7/2025 at around 12:00 p.m. ADM 2 stated the allegation of abuse should have been reported to the Ombudsman and CDPH on 2/6/2025. ADM 2 stated it was important to report any allegation of abuse within 2 hours to the CDPH so they could intervene and prevent the recurrence of abuse. ADM 2 stated the facility was cited in the past for late reporting of allegation of abuse.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</b></p> <p>Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) was completed accurately for one of 19 sampled residents (Resident 23) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Resident 23's Lasix (a diuretic drug that helps reduce the amount of excess fluid in the body by increasing the amount of urine produced) medication was coded as diuretic and reflected in the MDS assessment under Section N (N0415) High-Risk Drug Classes) Medications.</li> </ol> <p>This deficient practice resulted in incorrect data transmitted to Center for Medicare and Medicaid Services (CMS) related to facility's inappropriate MDS care screening and assessment tool practices.</p> <p>Findings:</p> <p>During a review of Resident 23's Admitting and Discharge Record (front page of the chart that contains a summary of basic information about the resident), the Admitting and Discharge Record indicated, Resident 23 was admitted to the facility on [DATE]. The Admitting and Discharge Record indicated, Resident 23's diagnoses included hypertension ([HTN] - high blood pressure) and chronic kidney disease (a long-term condition that occurs when the kidneys are damaged and can't filter blood properly).</p> <p>During a review of Resident 23's History and Physical (H&amp;P), dated 11/29/2024, the H&amp;P indicated, Resident 23 did not have the capacity to understand and make decision.</p> <p>During a review of Resident 23's MDS assessment, dated 11/11/2024, the MDS indicated, Resident 23's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 23 required moderate assistance (helper does less than effort) from staff with oral hygiene, upper body dressing, and personal hygiene.</p> <p>During a review of Resident 23's Physician Orders, dated 7/1/2024, the Physician Orders, indicated, Resident 23's physician prescribed Lasix 20 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth daily at 9 a.m. for HTN.</p> <p>During a concurrent interview and record review on 2/5/2025 at 9:19 a.m., with the Minimum Data Set Nurse (MDSN), Resident 23's MDS assessment, dated 11/11/2024, was reviewed. The MDSN stated the MDS assessment was completed inaccurately. The MDSN stated there was a wrong entry and omission on the MDS section N0415. The MDSN stated Resident 23 was taking Lasix which was considered as a diuretic medication and was not checked on Resident 23's MDS assessment under section N0415. The MDSN stated MDS assessment serve as a tool to recognize residents problem and reflects facility's plan of care. The MDSN stated inaccuracy of assessment in the MDS could affect the plan of care of the resident, the data sent to CMS, and facility's quality measures (a tool that quantifies how well a facility provides healthcare).</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/5/2025 at 10:02 a.m., with the Director of Nursing (DON), the DON stated accuracy of assessment in the MDS was important because the plan of care of resident was based on the need of the resident.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P), titled Record Assessment Instrument/Record Content, the P&amp;P indicated, Healthcare professionals completing portions of the MDS are to certify the accuracy of the section they have completed.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47923</p> <p>Based on interview and record review the facility failed to develop a person-centered care plan for two of 19 sampled residents (Resident 23 and Resident 85) by failing to:</p> <ol style="list-style-type: none"> <li>1. Develop a comprehensive care plan addressing Resident 23's use of diuretic (drug that helps reduce the amount of excess fluid in the body by increasing the amount of urine produced) medication.</li> <li>2. Develop a comprehensive care plan addressing Resident 85's diagnosis of Post Traumatic Stress Disorder ([PTSD] - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).</li> </ol> <p>This deficient practice had the potential to result in a lack of meeting necessary care and addressing medical needs for Resident 23 and Resident 85.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 23's Admitting and Discharge Record (front page of the chart that contains a summary of basic information about the resident), the Admitting and Discharge Record indicated, Resident 23 was admitted to the facility on [DATE]. The Admitting and Discharge Record indicated, Resident 23's diagnoses included hypertension ([HTN] - high blood pressure) and chronic kidney disease (a long-term condition that occurs when the kidneys are damaged and can't filter blood properly).</li> </ol> <p>During a review of Resident 23's History and Physical (H&amp;P), dated 11/29/2024, the H&amp;P indicated, Resident 23 did not have the capacity to understand and make decision.</p> <p>During a review of Resident 23's MDS assessment, dated 11/11/2024, the MDS indicated, Resident 23's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 23 required moderate assistance (helper does less than effort) from staff with oral hygiene, upper body dressing, and personal hygiene.</p> <p>During a review of Resident 23's Physician Orders, dated 7/1/2024, the Physician Orders, indicated, Resident 23's physician prescribed Lasix 20 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth daily at 9 a.m. for HTN.</p> <p>During a concurrent interview and record review on 2/5/2025 at 9:45 a.m., with the Minimum Data Set Nurse (MDSN), Resident 23's electronic clinical records were reviewed. The MDSN stated when the problem was identified then the facility staff needs to develop a care plan. The MDSN stated there was no care plan addressing Resident 23's use of diuretic medication. The MDSN stated Resident 23 was taking Lasix which was considered as a diuretic medication. The MDSN stated by not developing a care plan for Resident 23's diuretic medication, the facility staff would not be able to monitor its side-effects (an effect of a drug beyond its desired effect) and provide interventions to care for resident. The MDSN stated it was important to develop an individualized focused care plan so the facility could safely care the needs of the residents.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of Resident 85's Admitting and Discharge Record (front page of the chart that contains a summary of basic information about the resident), the Admitting and Discharge Record indicated, Resident 85 was admitted to the facility on [DATE]. The Admitting and Discharge Record indicated, Resident 85's diagnoses included PTSD, hypertension ([HTN] - high blood pressure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 85's MDS assessment, dated 12/10/2024, the MDS indicated, Resident 85's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 85 required supervision (helper provides verbal cues) from staff with oral hygiene, lower body dressing, and personal hygiene. The MDS indicated, Resident 85's had a diagnosis of PTSD.</p> <p>During a concurrent interview and record review on 2/5/2025 at 1:48 p.m., with the Social Service Designee (SSD), Resident 85's electronic clinical records were reviewed. The SSD stated there was no care plan addressing Resident 85's PTSD and no interventions to alleviate his trauma. The SSD stated it was important to develop a care plan for resident's continuity of care.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P), titled Resident's Care Plan Long and Short Term. the P&amp;P indicated, Problems which are triggered from the MDS and will proceed to care planning.</p> <p>During a review of the facility's undated P&amp;P, titled Record Assessment Instrument/Record Content, indicated care plans shall be updated when necessary and as the resident's condition or need change.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</b></p> <p>Based on observation, interview and record review, the facility failed to:</p> <p>1. Ensure one of one sampled resident (Resident 85) with Post Traumatic Stress Disorder ([PTSD] - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) received Trauma Informed Care ([TIC] - an intervention and approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health).</p> <p>This deficient practice had the potential for the staff's inability to identify possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past traumatic experience) for Resident 85.</p> <p>Findings:</p> <p>During a review of Resident 85's Admitting and Discharge Record (front page of the chart that contains a summary of basic information about the resident), the Admitting and Discharge Record indicated, Resident 85 was admitted to the facility on [DATE]. The Admitting and Discharge Record indicated, Resident 85's diagnoses included PTSD, hypertension ([HTN] - high blood pressure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 85's MDS assessment, dated 12/10/2024, the MDS indicated, Resident 85's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 85 required supervision (helper provides verbal cues) from staff with oral hygiene, lower body dressing, and personal hygiene.</p> <p>During a review of Resident 85's Physician Orders, dated 6/7/2024, the Physician Orders indicated, may have psychological evaluation and follow-up.</p> <p>During a review of Resident 85's Trauma Informed Care Note, dated 6/10/2024, the Trauma Informed Care Note indicated, Resident 85 served in a war or served in non-combat job that exposed to war-related casualties.</p> <p>During an interview on 2/4/2025 at 9:28 a.m., with Resident 85, Resident 85 stated he was in the United States [NAME] Corps and served during the Vietnam war. Resident 85 stated they were in patrol and ambushed the enemy which are young Vietnamese female soldiers. Resident 85 was very emotional narrating his Vietnam war experience. Resident 85 stated until now he was still thinking the experienced, he had during the Vietnam war. Resident 85 stated that was the worst experience and traumatic event in his life. Resident 85 stated there were certain things that could trigger his war trauma experience. Resident 85 stated when the phone rang, he thinks it was a fierce battle like the sound of a bullet. Resident 85 stated he exercise to cope up with that trauma experience. Resident 85 stated he would like to attend group therapy so he could share his thoughts and experience. Resident 85 stated he attended psychological counselling (a therapy that helps people address emotional and mental health challenges) at the Veterans Affairs (VA) and would like to continue the treatment but was not offered by the facility staff.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/5/2025 at 1:48 p.m., with the Social Service Designee (SSD), Resident 85's electronic clinical records were reviewed. The SSD stated Resident 85 was never referred to the psychologist (a mental health professional who studies and treats the human mind, emotions, and behavior) since he was admitted to the facility. The SSD stated she could not validate if the facility staff had interventions to alleviate his trauma and address Resident 85's PTSD. The SSD stated there was no documentation that Trauma Informed Care was provided to Resident 85. The SSD stated it was important to provide Trauma Informed Care to residents in order to identify the risk involved and to prevent re-traumatization.</p> <p>During an interview on 2/6/2025 at 11:53 a.m., with the Director of Nursing (DON), the DON stated the facility did not provide individual counselling and group therapy to Resident 85. The DON stated it was essential to provide Trauma Informed Care to residents in order to assess, monitor, and address residents past traumatic experience. The DON stated the risk of not providing Trauma Informed Care had the possibility that resident would diminish his psychosocial functioning that would affect his activities of daily living.</p> <p>During a review of the document titled Facility Assessment, dated 1/23/2025, under Part 2: Services and Care We Offer Based on our Resident's Needs, the Facility Assessment Indicated, Residents with mental health and behavior to identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairments, care of individuals with depression, trauma/PTSD, schizophrenia, bipolar disorder and other psychiatric diagnoses.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>47923</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure a competency assessment skill (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual need to perform work roles or occupational functions successfully) checks performed annually for one out of five randomly selected staff.</li> </ol> <p>This deficient practice had the potential for the facility not be able to assess the skills necessary to provide nursing services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident will not be performed within the acceptable standards of practice.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 2/6/2025 at 8:02 a.m., with the Director of Staff Development (DSD), five random employees file were checked. The DSD stated Minimum Data Set Nurse (MDSN) did not have an annual competency assessment skills check on file. The DSD stated MDSN last competency skills check was 12/6/2023. The DSD stated competency assessment skills check must be done upon hire and annually. The DSD stated the Director of Nursing (DON) was responsible in completing the annual competency assessment skills check for licensed nursing staff.</p> <p>The DSD stated licensed nursing staff cannot work on the floor without completing and passed a competency assessment skills. The DSD stated the importance of completing the competency assessment skills was to validate the staff capability of performing their job. The DSD stated without an annual and updated competency assessment skills checklist of licensed nursing staff, there was a possibility that residents health and safety would be jeopardized.</p> <p>During an interview on 2/6/2025 at 8:38 a.m., with the DON, the DON stated it was important to conduct an annual competency assessment checklist to review the skills of the licensed nursing staff for them to perform their daily tasks and to validate their skills to provide standard of care. The DON stated it was an oversight on her part by not completing MDSN annual competency assessment skills checklist.</p> <p>During an interview on 2/6/2025 at 3:52 p.m., with the DON, the DON stated the facility has no policy and procedure (P&amp;P) on staff competency check.</p> <p>During a review of the document titled Facility Assessment, dated 1/23/2025, the Facility Assessment indicated, Competency skills evaluation and skill set are checked on hire and annually thereafter.</p>