STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555880	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clear View Convalescent Center	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)
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 a comprehensive person-centered care plan for one of one sampled residents (Resident 37) after Resident 37 developed two stage 2 pressure ulcers/injuries (partial-thickness loss of skin, presenting as a shallow open sore or wound).This deficient practice has the potential to result in Resident 37 experiencing worsening skin breakdown, infection and delayed healing.FindingsDuring a review of Resident 37's Admitting and Discharge record, the Admitting and Discharge record indicated Resident 37 was admitted to the facility on [DATE]. Resident 37's diagnoses included dementia, severe without behavioral disturbances (a progressive state of decline in mental abilities), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood) and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 37's History and Physical (H&P) dated 12/16/2025, the H&P indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool) dated 12/17/2025, the MDS indicated Resident 37's cognition (process of thinking) was significantly impaired for memory and thinking and required cueing and supervision in daily tasks. Resident 37 required moderate assistance from one staff member for activities of daily living (bathing, toileting and eating). Resident 37 walked using a walker with set up and supervision assistance from one staff member. During a review of the Weekly Skin Evaluation note dated 3/11/2026 at 8:40 a.m., the note indicated the presence of a right buttock stage 2 pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) measuring 5 x 1.6 x 0.1 centimeters (cm-a unit of measurement) and a left buttock stage 2 pressure ulcer measuring 6 x 1.3 x 0.1 cm. During a concurrent interview and record review on 3/26/2026 at 12:27 p.m. with the Director of Nursing (DON), Resident 37's care plans were reviewed. The DON confirmed care plans were not developed or implemented for Resident 37's two stage 2 pressure ulcers. The DON stated care plan interventions were not created for the management of Resident 37's two stage 2 pressure ulcers. The DON stated not having a care plan for stage 2 pressure ulcers put Resident 37 at risk for worsening pressure ulcers and the wounds could get worse. During a review of the facility's policy and procedure (P&P) titled, Pressure Sore and Wound Management, undated, the P&P indicated if pressure areas were present, documentation of findings would be entered in nursing progress notes, care plan and weekly skin assessment. During a review of the facility's P&P titled, Resident's Care Plan Long & Short Term, undated, the P&P indicated a skin break was an example of a short-term problem that required a short-term care plan.

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