STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555881	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clear View Sanitarium	15823 So. Western Ave. Gardena, CA 90247

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation were practiced in the kitchen when:1 dented can of pineapple chunks was mixed with regular non-dented cans in the dry storage area.6 cups of 8 ounces ([oz.] small unit of weight measurement) of thickened water and 1 cup of 8 oz of orange juice was on the tray with no use by date label.These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) for 70 out of 70 residents who received food from the kitchen. Findings:1. During an observation on 2/24/2026 at 9:24 a.m. in the kitchen's dry storage area, there was one dented can of pineapple chunks mixed with regular non-dented cans. During an interview on 2/26/2026 at 9:15 a.m. with the Dietary Service Supervisor (DSS), the DSS acknowledged there was one dented can of pineapple chunks mixed with regular non-dented cans found in the dry storage area on 2/24/2026. The DSS stated it was unacceptable to put a dented can on the same shelf with the regular non-dented cans. The DSS stated the dented cans should be placed in a designated area. The DSS stated the food inside the dented cans was no longer safe to consume. During a review of the facility's policy and procedure (P&P), titled Food Production and Storage, undated, the P&P indicated A separate defined storage area is provided for dented/rusted cans. 2. During an observation on 2/24/2026 at 9:27 a.m. in the kitchen, there were 6 cups of 8 oz of thickened water and 1 cup of 8 oz of orange juice with a sticker label on the tray indicating it was prepared on 2/23/2026 but there was no label of the use by date. During an interview on 2/26/2026 at 9:00 a.m., with the DSS, the DSS stated prepared food items in the kitchen should be labeled with the date it was prepared and the use by date. The DSS acknowledged there were 6 cups of 8 oz of thickened water and 1 cup of 8 oz of orange juice with no label of used by date identified in the kitchen on 2/24/2026. The DSS stated it was important to put the use by date so the dietary staff would know when the food items expired. During an interview on 2/26/2026 at 10:30 a.m. with the Director of Nursing (DON), the DON stated all food items should be labeled with received date and expiration date or use by date. The DON stated using food items past their use by date could cause abdominal discomfort and food poisoning to the residents. During a review of the facility's policy and procedure (P&P), titled Food Production and Storage, undated, the P&P indicated, All food left over are to be placed in appropriate containers which are covered and labeled. Labels should be attached to the container itself, rather than the lid, and must include the name of the item and the date prepared. The P&P did not disclose the need for and importance of putting a use by date label.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure written Notice of Proposed Transfer/Discharge contained the required content elements for one of three sampled residents (Resident 75).The deficient practice had the potential to compromise the resident's due process rights related to discharge.Findings:During a review of Resident 75's admission Record, the admission Record indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities) with psychotic disturbance, and chronic viral hepatitis C (a viral infection of the liver that leads to illness and can be spread by contact with the contaminated blood). During a review of Resident 75's History and Physical (H&P), dated 10/21/2025, the H&P indicated Resident 75 did not have the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 1/6/2026, the MDS indicated the resident was assessed to have moderate cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 75 required set-up or clean-up assistance from staff for activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, and dressing and was independent for positioning, transferring, and walking. During a concurrent interview and record review on 2/27/2026 at 9:30 a.m. with Registered Nurse (RN) 1, Resident 75's Notice of Proposed Transfer/Discharge form, dated 2/12/2026, was reviewed. RN 1 stated the Notice of Proposed Transfer/Discharge did not include the notification date, effective date, discharged location, date the notice was sent to the Long-Term Care Ombudsman, reason for the transfer/discharge, or the signature dates of the facility representative and resident/representative. RN 1 stated the notice should have been fully completed and dated prior to discharge. RN 1 stated she only signed the notice and did not ensure it was complete. RN 1 stated she did not know who was responsible for faxing the notice to the Ombudsman and believed the social worker completed the form. During an interview on 2/27/2026 at 10:00 a.m., with Social Service Assistant (SSA) 1, SSA 1 stated she was not responsible for completing the Notice of Proposed Transfer/Discharge and did not know who was responsible for faxing the notice to the Ombudsman. During a concurrent interview and record review on 2/27/2026 at 10:28 a.m. with RN 1, RN 1 presented an additional Notice of Proposed Transfer/Discharge for Resident 75, dated 2/12/2026, which was reviewed. The new notice that was presented included the discharged location, the discharge date , and reflected an electronic signature by RN 1 on 2/12/2026, the notice did not include the date the notice was sent to the Long-Term Care Ombudsman, reason for the transfer/discharge, or the signature of the resident/representative. RN 1 stated the form was automatically generated from the facility's electronic software system. During an interview on 2/27/2026 at 11:45 a.m. with the Director of Nursing (DON), the DON acknowledged the Notice of Proposed Transfer/Discharge for Resident 75 was incomplete. The DON stated the notice should have been fully completed prior to providing it to the resident and prior to sending it to the Long-Term Care Ombudsman. The DON stated staff discharging the resident were responsible for ensuring the notice was complete. The DON stated that once the notice was completed and electronically signed, it was automatically sent to the Ombudsman through the facility's electronic system. During a review of the policy and procedure (P&P) titled, Transfer/Discharge Policy, undated, the P&P failed to identify the federally required content elements of the written Notice of Proposed Transfer/Discharge and did not include procedures requiring notification to the Long-Term Care Ombudsman at time of a proposed transfer or discharge.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the quarterly (every 3 months) Minimum Data Set Assessment ([MDS] - a resident assessment tool) for one of one sampled resident (Resident 4) was completed within the required timeframe.This deficient practice had the potential to result in a billing error and inaccurate data on Resident 4's care needs.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own), diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN] - high blood pressure). During a review of Resident 4's History and Physical (H&P), dated 7/19/2024, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set Assessment ([MDS] - a resident assessment tool), dated 7/18/2025, the MDS indicated Resident 4's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor, cues and supervision required). The MDS indicated Resident 4 required supervision (helper provides verbal cues as resident completes activity) from staff with upper and lower body dressing and personal hygiene. During a review of the Center of Medicare and Medicaid (CMS) MDS 3.0 NH Final Validation Report, the CMS MDS 3.0 NH Final Validation Report, with an Assessment Reference Date ([ARD] - the specific date used as the endpoint of the observation period when assessing resident's condition) of 7/18/2025, indicated Resident 4's MDS assessment was completed late. The CMS MDS 3.0 NH Final Validation Report indicated a comprehensive or quarterly assessment is due every quarter unless the resident is no longer in the facility. During a concurrent interview and record review on 2/25/2026 at 10:36 a.m., with the Minimum Data Set Nurse (MDSN), Resident 4's MDS assessment, dated 4/16/2025 and 7/18/2025, were reviewed. The MDSN stated Resident 4's quarterly MDS assessment, dated 7/18/2025, was completed for more than 92 days. The MDSN stated MDS quarterly assessment should be completed less than or within 92 days. The MDSN stated the facility did not follow the timeframe for MDS completion as indicated in the Reference Assessment Instrument ([RAI] - a guide that helps nursing home staff use to assess residents and develop care plans). The MDSN stated late completion of MDS assessment would result in facility billing errors and would affect the care provided to the residents. During an interview on 2/25/2026 at 11:37 a.m., with the Director of Nursing (DON), the DON stated late completion of MDS assessment would result in late payment and inaccurate data of resident's condition. During a review of the facility's policy and procedure (P&P), titled Record Assessment Instrument/Record Content, undated, the P&P indicated, Schedule for completion for quarterly assessment should be no less than every 90 days.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for one of 18 sampled residents (Resident 3) by failing to ensure Resident 3's use of antibiotic (a drug used to treat infections) was encoded in the recent MDS assessment.This deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Resident 3.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's History and Physical (H&P), dated 10/29/2025, the H&P indicated, Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's MDS assessment, dated 2/24/2026, the MDS assessment indicated Resident 3's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated Resident 3 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 3's Physician's Order, dated 2/15/2026, the Physician's Order indicated Resident 3 was prescribed Macrobid (an antibiotic drug) 100 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth twice (9:00 a.m. and 9:00 p.m.) for 5 days for treatment of urinary tract infection ([UTI] - an infection in the bladder/urinary tract).During a review of Resident 3's medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 2/16/2026 to 2/20/2026, the MAR indicated, Resident 3 was given Macrobid 100 mg by mouth twice a day for 5 days.During a concurrent interview and record review on 2/27/2026 at 10:39 a.m., with the Minimum Data Set Nurse (MDSN), Resident 3's MDS assessment, dated 2/24/2026, was reviewed. The MDSN stated MDS Section N0415 - Medications (High-Risk Drug Classes: Use and Indication) look back period (the specific time frame within which certain resident conditions and events are assessed) was 7 days before the completion date. The MDSN stated Resident 3's MDS assessment was completed inaccurately. The MDSN stated there should be a checked mark on MDS Section N0415 (F) Antibiotic since Resident 3 received the antibiotic on 2/18/2026, 2/19/2026, and 2/20/2026 which covered the 7 days look back assessment period. The MDSN stated it was an oversight on her part by not encoding the antibiotic in the MDS assessment. The MDSN stated inaccuracy of MDS assessment would affect facility's quality measures (standardized, data-driven metrics derived from CMS-mandated resident assessments to monitor care quality in nursing homes).During a review of the facility's policy and procedure (P&P), titled Record Assessment Instrument/Record Content, undated, the P&P indicated, HealthCare professionals completing portions of the MDS are to certify the accuracy of the section they have completed. The P&P indicated the accuracy of the transcription of the data and computer data entry are important and special attention must be given to correct these errors.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review ([PASARR] - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level 1 screening (a mandatory preliminary screening required for all individuals seeking admission to a Medicaid-certified nursing facility) was completed and re-submitted for one of four sampled residents (Resident 3).This failure had the potential for Resident 3 not being appropriately identified for further evaluation of serious mental illness leading to resident not receiving necessary specialized services, treatment planning interventions, or appropriate placement.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's History and Physical (H&P), dated 10/29/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set Assessment ([MDS] - a resident assessment tool), dated 2/24/2026, the MDS indicated Resident 3's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 3 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 3's Physician's Order, dated 12/23/2025, the Physician's Order indicated Resident 3 was prescribed Seroquel (anti-psychotic drug used for treatment of psychosis) 75 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth daily at 9:00 a.m. and Seroquel 50mg by mouth at bedtime at 9:00 p.m. for psychosis manifested by aggressive behavior as evidenced by pushing and swinging her hands to staff during care administration.During a concurrent interview and record review on 2/25/2026 at 11:14 a.m., with the Director of Nursing (DON), Resident 3's PASARR Level 1 screening, completed by another facility on 8/14/2023, was reviewed. The DON stated the PASARR Level 1 screening indicated Resident 3 had no serious mental illness diagnoses and was not receiving psychotropic medications The DON stated the PASARR Level 1 screening indicated Resident 3's case was closed, and a PASARR level II (an in-depth, person-centered assessment triggered by a positive Level 1 screen to confirm serious mental illness or intellectual disability) mental health evaluation was not required. The DON stated the facility should have completed and resubmitted a new PASARR Level I screening based on Resident 3's diagnoses of psychosis and depression which were mental illnesses, and Resident 3 was currently taking psychotropic medications. The DON stated a positive PASARR Level 1 screening would trigger a Level II mental health evaluation. The DON stated it was important to complete the PASARR screening accurately to provide specialized treatment and care for residents with mental illness diagnoses, create a treatment plan suited to control resident's behavior, and make sure the resident was appropriately placed at the nursing facility.During a review of the facility's policy and procedure (P&P), titled Preadmission Screening and Resident Review (PASARR), undated, the P&P indicated, The facility participates in the Preadmission Screening and Resident Review screening process (Level 1) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorders (SMI/SMD), intellectual disability (ID) related condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plan interventions were implemented to ensure a dialysis (a treatment to cleanse the blood of wastes and extra fluid artificially through a machine when the kidney(s) have failed) emergency kit (E-KIT - supplies to help meet the needs of a dialysis resident in the event of an emergency) was always available at bedside for one of one sampled resident (Resident 8).This deficient practice has the potential to result in staff's inability to manage and control the bleeding from Resident 8's dialysis access site in the event of an emergency.Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 8's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 8's History and Physical (H&P), dated 12/22/2025, the H&P indicated Resident 8 did not have the capacity to understand and make decisions.During a review of Resident 8's Minimum Data Set Assessment ([MDS] - a resident assessment tool), dated 1/9/2026, the MDS indicated Resident 8 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 8 was independent (Resident completes the activity with no assistance from a helper) with oral hygiene, toileting hygiene, and upper and lower body dressing.During a review of Resident 8's Physician's Order, dated 11/3/2022, the Physician's Order indicated Resident 8 was on dialysis treatment 3x/week every Monday, Wednesday, and Friday. The Physician's Order indicated to observe Resident 8's dialysis access site on left forearm for drainage and bleeding.During a concurrent observation and interview on 2/24/2026 at 1:38 p.m. with Registered Nurse 1 (RN 1) in Resident 8's room, RN 1 stated Resident 8's dialysis E-KIT was not available at bedside. RN 1 stated Resident 8's dialysis E-KIT was kept at one of the drawers at the nurse station.During a concurrent interview and record review on 2/24/2026 at 3:29 p.m. with RN 1, Resident 8's care plan, titled ESRD/Dependence on Renal Dialysis, dated 10/14/2025, was reviewed. RN 1 stated the care plan intervention included to make sure the dialysis kit was always available at bedside. RN 1 stated the facility did not follow and implement Resident 8's care plan intervention to keep dialysis E-KIT at bedside. RN 1 stated the dialysis E-KIT should be kept at bedside for the facility staff to easily access in case of an emergency and if the resident has an episode of bleeding when removing the dressing. RN 1 stated it was important to follow and implement care plan interventions to provide proper care and for resident's safety.During an interview on 2/26/2026 at 10:18 a.m., with the Director of Nursing (DON), the DON stated it was very important to follow care plan interventions because the care plan is a set of standardized care the facility staff provides to the residents.During a review of the facility's policy and procedure (P&P), titled Assessments and Care Plan, undated, the P&P did not disclose the importance of implementing care plan interventions.During a review of the facility's P&P titled, Record Assessment Instrument/Record Content, undated, the P&P indicated, Care plans shall be updated when necessary and as the resident's condition or needs change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review, update, and revise the care plan to address the use of bolster pads (a soft barrier along the edges of the bed, reducing the risk of rolling out of bed) for one of one sampled resident (Resident 1). This deficient practice has the potential to affect the delivery of necessary care, treatment, and services for Resident 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 1's History and Physical (H&P), dated 12/30/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 1/2/2026, the MDS indicated the resident was assessed to have severe cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs) such as oral hygiene, toileting, showering, dressing and positioning. During a concurrent interview and record review on 2/26/2026 at 2:46 p.m. with Registered Nurse (RN) 1, Resident 1's Fall Care Plans were reviewed. The fall care plan was not revised to show interventions regarding use of bolster pads. RN 1 stated that Resident 1's care plans did not include one for the use of bolster pads. RN 1 stated the care plan should have been revised to reflect the use of bolster pads when the intervention was implemented. During an interview on 2/27/2026 at 11:55 a.m., with the Director of Nursing (DON), the DON stated care plans are revised quarterly and with any change of condition or new physician orders. The DON acknowledged the resident's care plan should have been revised to reflect the use of a bolster pad. During a review of the policy and procedure (P&P) titled, Record Assessment Instrument/Record Content, undated, the P&P indicated, Care plans shall be updated when necessary and as the resident's condition or needs change.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure one of the trash dumpsters was closed and not overfilled.This deficient practice has the potential for harboring and feeding of pests.Findings:During an observation on 2/24/2026 at 9:30 a.m. outside of the facility, one of the trash dumpsters lids was observed filled with thrash and the lid was opened.During an interview on 2/26/2026 at 9:25 a.m. with the Dietary Service Supervisor (DSS), the DSS stated the lid of the trash dumpsters should be closed all the time and should not be overfilled. The DSS acknowledged that one of the trash dumpsters was opened and overfilled on 2/24/2026. The DSS stated the risk of having an opened trash dumpsters are that they can attract rodents and insects and provide a place for them to harbor.During an interview on 2/26/2026 at 10:23 a.m. with the Director of Nursing (DON), the DON stated the facility had deficiency five years ago for an opened trash dumpster. The DON stated trash bins that are open attract unwanted pests to the facility.During a review of the 2022 U.S. Food and Drug Administration Food Code, code number 5-501.116 Cleaning Receptacles indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.