STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055072	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSECRANS CARE CENTER	1140 WEST ROSECRANS AVENUE , GARDENA, California, 90247

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F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an on-site visit for one Facility Reported incident and two complaints and to confirm compliance with federal requirements for Complaint 2630422. Facility reported incident Number: 2792381 Complaint Numbers: 2748495, 2794920 The department found the facility not in compliance with with 42 CFR, Part 483, federal requirements for Skilled Nursing Facilities and deficiencies were identified for Facility Reported incident 2792381 at F656 and Complaint 2748495 at F552. No deficiencies were issued for complaint 2794920 or Complaint 2630422.	F0000	Facility ID: 055072 Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence.. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907.	
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by:	F0552	How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; On March 5, 2026 the Treatment Nurse immediately notified the responsible party of the change in condition of the resident affected and documented this notification in the medical records. On March 5, 2026 the facility Social Services Department and Treatment Nurse interviewed residents' responsible party to address any concerns regarding the communication delay and Interdisciplinary Conference was scheduled for March 18, 2026. On March 5, 2026 the DON and Administrator issued a written warning and provided formal counseling to the treatment nurse for failing to document notifying the residents responsible party of the residents' change of condition. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The facility of Medical Records and DON conducted an audit of all residents who experienced a Change in Condition over the past 30 days and ensured that required notification to responsible parties were completed and properly documented. No other findings are noted. On March 6, 2026 and on March 20, 2026 the DON conducted a License Nurses in-service on the facility Change of Condition policy and procedure. The in-service focused on the critical requirement for timely notification of the responsible party and ensuring all communication is thoroughly documented.	3/5/26 3/5/26 3/5/26 3/20/26

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 reverse for further 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
R Bautista	Admin	3/26/26

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F0552 SS = D	Continued from page 1 Based on interview and record review, the facility failed to notify a residents' responsible party (RP) of a change in condition for one of three sampled residents (Resident 3). This deficient practice had the potential to violate Resident 3's RP's rights to be informed of changes to the plan of care. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on 8/2/2024 and readmitted on 2/24/2026. Resident 3's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), pressure ulcer of the sacral region (directly over tailbone), Stage Four (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 3's History and Physical (H&P) dated 1/14/2026, the H&P indicated Resident 3 was non-verbal and did not have the capacity to make medical decisions. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 3 had severe cognitive (ability to think and understand) impairment. The MDS indicated Resident 3 was dependent on staff for toileting, bathing and personal hygiene. During a concurrent interview and record review on 3/5/2026 at 10:39 a.m. with the Treatment Nurse (TXN), Resident 3's "Admission Skin Reassessment" dated 2/25/2026 was reviewed. The "Admission Skin Reassessment" indicated upon readmission to the facility from a General Acute Care Hospital (GACH), Resident 3 was observed to have a Stage Four pressure ulcer to her sacrum. TXN stated Resident 3's pressure ulcer was a Stage Two (partial-thickness loss of skin, presenting as a shallow open sore or wound) prior to transfer to the GACH. TXN stated progression of a wound from a Stage Two pressure ulcer to a Stage Four pressure ulcer would be considered a significant change. TXN stated she notified Resident 3's physician, nurse and certified nursing assistant, but was unable to notify Resident 3's responsible party. TXN stated she called Resident 3's responsible party once but was unable to speak with them or leave a voicemail. TXN	F0552	What measures will be put into place or what systemic changes will the facility make to ensure that deficient practice does not recur; On March 6, 2026 and on March 20, 2026, License Nurses received in-service and education on the facility Change of Condition policy and procedure, emphasizing the requirement to notify residents' responsible parties of any significant changes in a timely manner and the importance of documenting. The Medical Records will perform weekly audits of residents with a change of conditions to verify that the responsible party was notified and that such notification was documented. Findings will be reported to the DON and Administrator. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action is evaluated for its effectiveness. The POC is integrated into the quality assurance system; and The Medical Records will perform weekly audits of resident with a change of condition to verify that the responsible party was notified and that such notification was documented. These audits will continue weekly for four weeks, followed by monthly reviews for three consecutive months. Audit results will be reported to the facility QAPI Committee for further oversight and trend analysis. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency. All corrective actions will be monitored daily, weekly compliance audits will be conducted by the Medical Record for four weeks then monthly for three months thereafter that with findings reported to the committee members during the facility's QAPI meeting.	3/20/26

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F0552 SS = D	Continued from page 2 stated she should have made another attempt to update Resident 3's responsible party. TXN stated notifying residents and their responsible parties of significant changes in condition was important because they have a right to be informed of and participate in their plan of care. During an interview on 3/5/2026 at 2:30 p.m. with the Director of Nursing (DON), the DON stated licensed nurses were responsible for notifying the residents' responsible party when there was a significant change in condition. The DON stated notifying residents' responsible parties of significant changes in condition was important because it was their right to be informed of and included in any changes to the plan of care. During a review of the facility's policy and procedure (P&P) titled, "Change in a Resident's Condition or Status" dated February 2021, the P&P indicated, "Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status…"	F0552		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; On March 5, 2026 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) immediately reviewed and updated their care plan to ensure all behavior interventions are current. On March 5, 2026 the DON and Administrator counsel the charge nurse on the specific required documentation following an altercation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The facility of Medical Records and DON conducted an audit of care plans for residents with known behavioral episodes were documented, and any discrepancies found during this audit were corrected immediately. On March 6 and March 20, 2026, the Director of Nursing (DON) conducted in-service training for licensed nurses regarding behavioral de-escalation. The sessions specifically emphasized the requirement to document care plan interventions implemented when a resident exhibits behavioral symptoms.	3/5/26 3/5/26 3/20/26

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F0842 SS = D	Continued from page 3 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F0842	What measures will be put into place or what systemic changes will the facility make to ensure that deficient practice does not recur; The Medical Records Director (or designee) will conduct daily audits of the Electronic Medication Administration Record (EMAR) behavior monitoring. These audits will ensure that for every resident with a documented behavior, corresponding care plan interventions were implemented and charted. All findings will be reported directly to the Director of Nursing (DON) and Administrator for review. On March 6 and March 20, 2026, the Director of Nursing (DON) conducted in-service training for licensed nurses regarding behavioral de-escalation. The sessions specifically emphasized the requirement to document care plan interventions implemented when a resident exhibits behavioral symptoms. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action is evaluated for its effectiveness. The POC is integrated into the quality assurance system; and The Medical Records will perform weekly audits of behavioral monitoring and progress notes for four weeks, then monthly for the three months. The results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for further review and to determine if additional training or systemic adjustments are necessary. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency. All corrective actions will be monitored daily, weekly compliance audits will be conducted by the Medical Record for four weeks then monthly for three months there after that with all findings reported to the committee members during the facility's QAPI meetings.	3/20/26

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F0842 SS = D	Continued from page 4 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to document behavioral interventions as indicated on the care plan for one of two sampled residents (Resident 1) following an altercation with Resident 2. This failure had the potential to result in continued behavioral escalation and increased risk of physical harm to other residents. Findings: During a record review of Resident 1's "Admission Record" (Face sheet), the Admission Record indicated the facility admitted the resident on 12/10/2025 with diagnoses including anemia (low blood cells in body) and schizoaffective disorder (mental health disorder affecting how a person thinks and acts). During a record review of Resident 1's progress note dated 2/28/2026, the progress note indicated Resident 1 was transferred out for 5150 (a law code that allows a person in a mental health crisis to be taken to a hospital or mental health facility against their will) for danger to others. During a record review of Resident 2's "Admission Record," (Face sheet), the Admission Record indicated the facility admitted the resident on 2/14/2026 with diagnoses including chronic kidney disease (kidneys damaged and unable to filter blood) and hypertensive urgency (extremely high blood pressure). During an interview on 3/5/2026 at 11:01 with Registered Nurse (RN) 1, RN 1 stated the incident between Resident 1 and Resident 2 happened on 2/28/2026. RN 1 stated she was alerted when she heard Resident 1 screaming while walking down the hallway. RN 1 stated Resident 1 walked into Resident 2's room, when RN 1 arrived in Resident 2's room, Resident 2 was holding a foldable chair. RN 1 stated Resident 1 reported to her that Resident 2 had hit him on the head with the chair. During a concurrent interview and record review on	F0842		

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F0842 SS = D	Continued from page 5 3/5/2026 at 11:05 a.m. with Registered Nurse (RN) 1, Resident 1's care plan dated 2/28/2026 and progress notes dated 2/28/2026 were reviewed. The care plan indicated Resident 1 had an episode of increased aggression, was unable to be redirected, and was a danger to others. The care plan indicated intervention including for staff were to provide early redirection and de escalation techniques to reduce episodes of verbal aggression. During a review of Resident 1's progress notes, the progress notes indicated the incident between the residents happened at 11:20 a.m. and Resident 1 was picked up for transfer at 4:45 p.m. RN 1 stated progress notes for 2/28/2026 did not indicate early interventions, redirection, and/or de-escalation that were done during Resident 1's episodes of screaming while awaiting transfer. During a concurrent interview and record review on 3/5/26 at 11:48 a.m. with Assistant Director of Nursing (ADON), Resident 1's progress notes dated 2/28/26 were reviewed. The ADON stated Resident 1 was alert, oriented, and ambulatory (able to walk without assistance), and had episodes of screaming. The ADON stated on 2/28/2026, Resident 1 intermittently continued to yell while awaiting transfer to another facility. The ADON stated the progress notes dated 2/28/2026 did not indicate interventions, including non-pharmacological were documented. During an interview on 3/5/2026 at 2:00 p.m. with the Director of Nursing (DON), the DON stated care plans were initiated for Resident 1 and Resident 2 following the incident and the care plan interventions should have been documented if they were completed. The DON stated following care plan interventions was important to prevent further behavioral escalation and to keep residents and staff safe. During a review of the facility's policy and procedure (P&P) titled, "Behavioral Assessment, Intervention, and Monitoring, dated March 2019, the P&P indicated, "…If the resident is being treated for altered behavior or mood, the facility will seek and document any improvements or worsening in the individual's behavior, mood, and function…The facility will monitor progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported."	F0842		