STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Gardena Post Acute	16530 S Broadway Street Gardena, CA 90248

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 During an interview and record review the facility failed to ensure one of 12 sampled resident (Resident 25) advance directive (a legal document that specifies what actions should be taken for your health if you are no longer able to make decisions for yourself) had a signature of a witness when it was signed by Resident 25. This failure had the potential to cause conflict with the residents' wishes regarding health care in the event residents became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions that would not be identified and/or carried out by the facility staff. Findings: During a review of Resident 25's Admission Record. the Admission Record indicated, Resident 25 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic kidney disease (a condition where the kidneys are damaged and cannot filter the blood properly), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control). During a review of Resident 25's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/2/2024, the MDS indicated Resident 25 had the ability to make self understood and the ability to express ideas and wants. The MDS indicated Resident 25 had the ability to understand others. The MDS indicated Resident 25 needed partial to moderate assistance with eating. The MDS indicated Resident 25 was dependent on nursing staff for oral hygiene, toileting, showering, bathing, dressing, putting on and taking off shoes, personal hygiene, repositioning and transferring. The MDS indicated Resident 25 had an advance directive available and reviewed. During a review of Resident 25's History and Physical (H&P), dated 8/11/2024, the H&P indicated Resident 25 had the capacity to understand and make medical decisions. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's Care Plan, dated 8/21/2024, the Care Plan indicated Resident 25 had an advance directive done on 2/5/2023. The Care Plan indicated to review Resident 25's advance directive/ Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) with resident, family, and IDT (Interdisciplinary Team-a group of professionals from different healthcare disciplines who work together to coordinate and deliver personalized care to patients) at least quarterly to ensure they are current and provide education as needed. During a review of Resident 25's 10/02/24 POLST dated 7/22/2024, the POLST indicated Resident 25 had an advance directive dated 2/5/2023 available and reviewed. During a concurrent interview and record review on 10/2/2024 at 3:41 p.m., with Social Services Director (SSD), reviewed Resident 25's advance directive. The advance directive indicated on 2/5/2023 there was no signature for a witness. The advance directive indicated it was not valid without two signatures for a witness. The SSD stated an advance directive was when the Resident assigns somebody to make medical decisions when they lose the mental capacity. The SSD stated the Resident must have the mental capacity to initiate an advance directive. The SSD stated the advance directive needs to have at least one witness or it was not valid, and we cannot honor the residents' wishes. During a review of Resident 25's Progress Notes by the SSD, dated 10/3/2024 at 9:27 a.m., the Progress Notes indicated, a call was placed to Resident 25's Power of Attorney (a legal authorization for a designated person to make decisions about another person's property, finances, or medical care) to inform them that the advance directive that was done on 2/5/2023 was not complete and needs to be notarized and had to have at least one witness. During an interview on 10/03/2024 at 1:39 p.m., with the Director of Nursing (DON) the DON stated if an advance directive was not valid the residents' health care decision may not be honored. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, revised 12/2016, the P&P indicated Advance directives will be respected in accordance with state law and facility policy.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview and record review, the facility failed to ensure two of three sampled residents (Resident 4 and 19) was provided their activities of choice (preference). This failure had the potential for Resident 4 and 19 to have no mental and emotional interaction that could negatively impact their quality of life. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cardiomyopathy (diseases of the heart muscle, where the walls of the heart chambers have become stretched, thickened, or stiff), depression (a common mental health condition that causes a persistent feeling of sadness and changes in how you think, sleep, eat and act), and atrial fibrillation (an irregular or abnormal heart beat and often very rapid heart rhythm). During a review of Resident 4's Minimum Data Set ([MDS] MDS - a federally mandated resident assessment tool) dated 9/13/2024, the MDS indicated Resident 4 had severe cognitive (ability to learn, understand, and make decisions) impairment and requires assistance for all activities of daily living. During a review of Resident 4's care plan titled Resident 4 likes to do independent activities such as watching television, listening to music, going outside for fresh air when weather is nice and doing some group activities like playing dominos sometimes and socializing with residents dated 05/21/2024, the care plan interventions including activities will continue to encourage resident to participate in activities of choice, will remind resident of activities of choice, will do one on one activities as needed. During an observation on 9/30/2024 at 8:41 a.m., and 11:02 a.m., observed Resident 4 in bed sleeping. During an observation on 10/1/2024 at 10:35 a.m., and 2:03 p.m., observed Resident 4 in bed sleeping. During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing), major depressive disorder (a serious mood disorder that can cause a range of symptoms that affect a person's daily life), and chronic kidney disease ([CKD] a condition where the kidneys are damaged and cannot filter blood properly). During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 had moderate cognitive impairment and requires assistance for all activities of daily living. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's care plan titled Resident 19 prefers independent activities and Resident 19 likes listening to the television in the lobby with other residents from time to time dated 10/02/2024, the care plan interventions including aid with daily care to meet accommodation request and needs and incorporate preferences to daily care and schedule of resident while in the facility. During an observation on 9/30/2024 at 11:14 a.m., and 2:57 p.m., observed Resident 19 in bed sleeping. During an observation on 10/1/2024 at 9:03 a.m., and 11:31 a.m., observed Resident 19 in bed sleeping. During an interview on 10/1/2024 at 2:52 p.m., Resident 19 stated that he would like to go to the activity room and socialize with other residents and was not offered to the resident in the last couple of days. During a concurrent interview and record review on 10/2/2024 at 3:15 p.m., the licensed vocational nurse (LVN 2) stated that if the activity documentation was empty, it means that activity was not provided. Reviewed Resident 19 activity documentation for 9/25/2024 through 9/30/2024 indicated no documentation of activities were rendered and was not signed. During a concurrent interview and record review on 10/2/2024 at 4:07 p.m., with the Activity Director (AD), reviewed activity documentation for Resident 4 and 19. The activity documentation for 9/25/2024 through 9/30/2024 indicated no documentation of activities were rendered and was not signed. The AD stated that those dates mentioned above are had no documentation activities were given. The AD stated if a resident (in general) was not getting the activities according to plan it affects the resident psychosocial wellbeing including their mental health. During the review of facility's policy and procedure (P&P) titled Activity Programs revised 6/2018, indicated: Activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well being of each resident. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. All activities are documented in the resident's medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on observation, interview, and record review, the facility failed to provide appropriate safety precautions to residents at risk for fall and seizures (involuntary muscle movement) for two of three sampled residents (Resident 246, 4). Facility failed to ensure: a. Resident 246, who was on fall risk precaution with one floor mat placed on the left corner of the bed had no foot metal bedside table on top of the floor mat. b. Resident 4, who was placed on fall precautions and seizure precaution with a floor mat by the left corner of the bed had no big sized wheelchair placed on top of the floor mat. This deficient practice had the potential for injury when Residents 246 and 4 would fall out of bed and hit their head on the metal equipment placed on top of the floor mat. Findings: During a review of Resident 246's Admission Record, the Admission Record indicated Resident 246 was admitted to the facility on [DATE], with diagnosed including muscle weakness, lack of coordination (impairment in movement), fracture (broken bone) of other part of pelvis (hip bones). During a review of Resident 246's Minimum Data Set (MDS, ([MDS] a federally mandated resident assessment tool) dated 9/23/24, indicated Resident 246 had severe cognitive (ability to think and memorize) impairment. During a review of Resident 246's care plan titled Resident at high risk for falls and injuries related to advancing age, cognitive impairment, visual impairment, communication impairment, limitation of mobility, . dated 9/17/24, indicated interventions including, resident may have floor mat on left side of bed. Educate the resident/family/caregivers about safety reminders, causative risks/factors and what to do if a fall occurs. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cardiomyopathy (diseases of the heart muscle, where the walls of the heart chambers have become stretched, thickened, or stiff), depression (a common mental health condition that causes a persistent feeling of sadness and changes in how you think, sleep, eat and act),atrial fibrillation (an irregular or abnormal heart beat and often very rapid heart rhythm) and epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures [involuntary muscle movements]). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had severe cognitive (ability to learn, understand, and make decisions) impairment and requires assistance for all activities of daily living. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/30/2024 at 12:32 p.m., with Licensed Vocational Nurse (LVN) 1 in Resident 246's room, observed Resident 246 lying in a low bed with two grab bars up on both side, floor mat (a cushioning pad designed to help prevent injuries from falls by absorbing the force of impact) by the left side of the bed with an iron bedside table placed on top of the floor mat LVN 1, stated the bedside table was not supposed to be placed on the floor mat as the floor mat was used for safety precaution because resident was a fall risk. LVN 1 stated if Resident 246 fall out of bed, Resident 246 could hit her head on the heavy iron bedside table that was placed on top of the floor mat. LVN 1 stated it was better to move bedside table away from the floor mat when not in use. b. During a concurrent observation and interview on 10/01/24 at 1:30 p.m., observed Resident 4 bed side rails was padded, and floor mat, with a wheelchair placed on top of the floor mat. LVN 1 stated the wheelchair should not be placed on top of the floor mat because Resident 4 was a fall risk and on seizure precaution. LVN 1 stated if Resident 4 falls out of bed he could hit his head on the big sized wheelchair placed on top of the floor mat. LVN 1 stated the wheelchair should be removed on top of the floor mat when not in use. During an interview on 10/02/24 at 10:53 a.m., with LVN 1, LVN 1 stated the floor mat was for fall risk precaution. LVN 1 stated the floor mat can prevent injury in case resident falls from the bed. LVN 1 stated having a side table on top of the floor mat can cause injury to the resident when resident falls out of bed. During an interview on 10/02/24 at 11:15 a.m., with Certified Nursing Assistant (CNA) 1 stated floor mat keeps the resident safe in the vent resident falls out of bed. CNA 1 stated the floor mat serves a cushion to prevent injury. CNA 1 stated there should not be anything placed on top of the floor mat because resident (in general) can hit their head from the bedside table and wheelchair when they fall out of bed. During a review of facility's policy and procedure (P&P) titled Falls -clinical protocol dated 3/2018, the P&P indicated The staff and practitioner will review each resident's factors for falling and document in the medical record. a. Examples of risk factors for falling include lightheadedness, dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, hypotension, cognitive impairment, weakness, environmental hazards, confusion, visual impairment. Fall risk factors include environmental factors that contribute to the risk of falls include obstacle in the foot path.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on observation, interview and record review, the facility failed to assess for pain before wound care treatment on one of three sampled residents (Resident 246) who had a skin tear on right upper knee. This failure had the potential for Resident 246 to experience unrelieved pain during wound care treatment. Findings: During a review of Resident 246's Admission Record, the Admission Record indicated Resident 246 was admitted to the facility on [DATE], with diagnoses including muscle weakness, lack of coordination (impairment in movement), fracture (broken bone) of other part of pelvis (hip bones). During a review of Resident 246's Minimum Data Set (MDS, ([MDS] a federally mandated resident assessment tool) dated 9/23/24, indicated Resident 246 had severe cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 246's Physician Order dated 9/16/24, the Physician Order indicated to clean the wound with normal saline (NS-cleaning solution for the wound), pat dry, apply Xeroform (type of dressing), wrap with kerlix (type of dressing) daily for self-inflicted skin tear on right knee. Monitor right knee skin tear for signs and symptoms of infection, pain, or any other complications. During a review of Resident 246 Physician Order dated 10/2/24, the Physician Order indicated to monitor for pain during, before, and after treatment of right upper knee skin tear every shift. During a concurrent observation and interview on 10/2/24 at 10:27 a.m., with Licensed Vocational Nurse (LVN) 3, observed Resident 246 complained of pain during wound care treatment. LVN 3 stated Resident 246 had no physician order for pain medication to be given prior to wound care treatment. During an interview on 10/2/24 at 11: 43 a.m., with LVN 3 stated prior to starting wound care treatment she should have assess Resident 246 pain level. LVN 3 stated she was not aware that Resident 246 did not have an order for pain medication. LVN 3 stated she should assess Resident 246 pain prior to wound treatment and during wound treatment. LVN 3 stated Resident 246 does not have an order for pain medication and had to call the physician to get a physician order. Review of facility policy and procedure (P&P) titled Treatment Nurse Competency dated 11/15/23, indicated Pain assessed/ observed before, during, and after treatment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Clarify physician order for Combivent (generic name - ipratropium bromide and albuterol sulfate Inhalation Aerosol [a medication in form of inhalation spray to treat chronic obstructive pulmonary disease {COPD} - a chronic lung disease causing difficulty in breathing) in accordance with manufacturer's specifications for one of ten sampled residents (Resident 14) during medication administration. 2. Ensure availability of Combivent as ordered by the prescriber for one of ten residents (Resident 14). These failures had the potential to cause duplication of therapy and/or result in worsening of COPD symptoms such as difficulty breathing, and hospitalization . Findings: During a review of Resident 14's Admission Record, dated [DATE], the Admission Record indicated, Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including COPD and sleep apnea (a sleep disorder that causes people to repeatedly stop breathing or breathe shallowly while they sleep). During a review of Resident 14's History and Physical (H&P), dated [DATE], the document indicated Resident 14 had the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated the Resident 14 had intact cognition (ability to think, understand, learn, and remember). The MDS indicated the resident required partial/moderate assistance to maximal assistance from facility staff for activities of daily living (tasks of everyday life that include personal hygiene, dressing, getting in and out of bed or chair, bathing, and toileting.) During a review of Resident 14's Physician Order Summary Report, dated [DATE], the Physician Order Summary Report indicated the following orders: Combivent Aerosol ,d+[DATE] microgram (mcg - a unit of measurement) / actuation (act - spray of dose) (ipratropium-albuterol) 2 puffs inhale orally as needed for shortness of breath (SOB), order date [DATE], start date [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ipratropium-Albuterol Inhalation Solution (the inhalation solution administered via jet nebulizer [small machine that turns liquid medicine into a mist that can be inhaled to treat respiratory illnesses] connected to an air compressor with an adequate air flow, equipped with a mouthpiece or suitable face mask) 0XXX, d+[DATE].5 (3) milligram (mg - a unit of measurement for mass) / 3 milliliter (mL - a unit of measurement for volume) 3 mg/ml inhale orally every 4 hours as needed for shortness of breath or wheezing (high-pitched, whistling sound that can occur during breathing when the airways in the lungs become narrowed or blocked) , order date [DATE], start date [DATE]. During an observation on [DATE] at 12:35 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 prepared one medication including Humalog (medication to treat DM) 100 units (a unit of measurement for insulin)/mL insulin 6 units to be administered subcutaneously as directed per sliding scale. During a review of Resident 14's active orders as part of medication reconciliation method on [DATE] at 9:53 a.m., the following order was identified with instructions not in accordance with manufacturer specifications: Combivent Aerosol ,d+[DATE] mcg/act 2 puffs inhale orally as needed for shortness of breath (SOB), order date [DATE], start date [DATE]. According to manufacturer's package instructions, the instructions for Combivent Inhalation Aerosol are two inhalations four times a day. May take additional inhalations as required; however, the total number of inhalations should not exceed 12 in 24 hours. Safety and efficacy of additional doses of Combivent Inhalation Aerosol beyond 12 puffs/24 hours have not been studied . According to manufacturer's package instructions, the instructions for Combivent Respimat (generic name - ipratropium bromide and albuterol inhalation spray) are one inhalation four times a day, not to exceed six inhalations in 24 hours. During a concurrent interview and record review on [DATE] at 12:03 p.m. with LVN 4, the physician order summary document for Combivent Aerosol ,d+[DATE] mcg/act, dated [DATE] was reviewed. The physician order summary indicated Combivent Aerosol ,d+[DATE] mcg/act (ipratropium-albuterol) with instructions as two (2) puffs inhale orally as needed for SOB. LVN 4 stated, the frequency for Combivent was not indicated on the order. LVN 4 stated there would be a risk for medication to be overdosed or underdosed because the instructions did not indicate how many times could the medication be used and/or what would be the maximum dosage. LVN 4 stated she should have checked on Resident 14's Combivent's appropriate dosing frequency and if the facility had the medication in stock for Resident 14. LVN 4 stated there would be a high risk of side effects such as shortness of breath if Combivent was underdosed because it would not be effective and may lead to hospitalization . LVN 4 stated if Combivent was overdosed, there would be a risk for chest pain, dry throat, and upper respiratory infections. LVN 4 stated that Combivent was prescribed as needed and Resident 14 had not requested the medication. LVN 4 stated she could not confirm or remember if she had Combivent Inhalation Aerosol in stock in the medication cart because it was as needed. LVN 4 stated Combivent was not administered at all although there was an active physician order since [DATE]. LVN 4 stated Resident 14 was also on ipratropium-albuterol inhalation solution for shortness of breath and wheezing. LVN 4 stated the resident was receiving continuous positive airway pressure (CPAP - a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) for sleep apnea but did not know if it helped with COPD and did not want to say something that she was not sure about. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:09 p.m., with the Director of Nurses (DON), the DON stated, Combivent usually prescribed four times a day, not to exceed six times a day for shortness of breath and could be an as needed order. The DON stated Resident 14's physician order for Combivent was missing dose frequency. The DON stated the licensed nurse failed to clarify the medication order with the physician. The DON stated, the resident was usually vocal and will ask for medication, but she has not requested the Combivent to be given. The DON stated it was the nurses' responsibility to clarify the Combivent order and ensure that it was available. The DON stated failure to clarify the order with Resident 14's physician could have resulted in administering more than the manufacturer recommended dose and/or less than the manufacturer recommended dose. The DON stated, Resident 14 was not treated pharmacologically (a term used to describe treatment with a medication) for COPD. The DON stated Resident 14 could have experienced adverse effects such as shortness of breath, tachycardia (a faster heart rate than normal), and hospitalization . During an interview on [DATE] at 1:17 p.m., with Resident 14, Resident 14 stated she did not remember receiving Combivent Inhalation Aerosol treatment. Resident 14 stated she only used the CPAP machine and would tell the nurse when she needed the breathing treatment. During a review of Resident 14's Medication Administration Record (MAR) for [DATE] ([DATE] to [DATE]) and [DATE] ([DATE] to [DATE]), the MAR indicated there were no doses of Combivent documented as administered. During a review of Resident 14's MAR for [DATE] ([DATE] to [DATE]), [DATE] ([DATE] to [DATE]) and [DATE] ([DATE] to [DATE]), the MAR indicated there were no doses of ipratropium-albuterol inhalation solution 0XXX,d+[DATE].5 (3) mg / 3 mL documented as administered. During a review of Resident 14's pharmacy deliveries for [DATE], dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] there was no delivery receipt for Combivent Inhalation Aerosol. During a review of the facility's policy and procedure (P&P) titled, Medication Orders, dated ,d+[DATE], the P&P indicated, When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration. During a review of the facility's P&P titled, Administering Medications, dated ,d+[DATE], the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Gardena Post Acute	16530 S Broadway Street Gardena, CA 90248

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview and record review, the facility failed to ensure 21 of 25 residents rooms met of 80 square feet ([sq. ft] a unit of area measurement) per residents in multi-bed resident rooms. Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 15, 16, 17, 18, 20, 21, 22, 23, 25, and 26 were occupied with two residents and room [ROOM NUMBER] was occupied with three residents per room, and room [ROOM NUMBER] was occupied with four residents per room. This deficient practice had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents. Findings: On 10/01/24 at 1:57 p.m., during the initial tour of the facility, residents' rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 18, 17, 18, 19, 20, 21, 22, 23, 25, and 26, did not meet the requirement of 80 sq. ft per resident. A review of Client Accommodations Analysis form, provided by the facility Maintenance Supervisor (MS) rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,12 ,14,15, 16, 17, 18, 19,20,21,22,23, 25, and 26 were occupied by two residents each and total square feet measurement ranged between 139.43 square feet to 148.19 square feet. During an interview on 10/01/24 at 2:23 p.m., with the Director of Nursing (DON), the DON stated all the residents' rooms were small and the facility submits room waiver every recertification survey yearly. During a review of Room Waiver letter, dated 9/16/2024, provided by the ADM, the Room Waiver letter indicated, that rooms had enough space to provide for each resident's care, dignity, and privacy. The letter indicated the lack of space on the new building code has no adverse effect in the resident's health and safety or in maintaining the wellbeing of the residents. The following rooms were included in the Room Waiver request: Rooms 1, 2, 3, 4, 5, 6, 7. 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 29, 21, 22, 23, 25, 26. During a review of Room Waiver letter, dated 9/16/2024, provided by the ADM, the Room Waiver letter indicated, Any concerns regarding room space expressed by any of the resident will be discussed during the Interdisciplinary Team ([IDT a group of professionals that plan, coordinate and deliver personalized health care) meeting for proper Intervention. During an observations, from 9/30/24 through 10/3/24, the residents residing in these rooms had enough space to move freely inside the rooms. Each resident in the above rooms had beds and side tables with drawers. There was adequate room for the operation and use of wheelchairs, walkers, or canes. Resident room size did not affect the nursing care or privacy provided to the residents.