STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055052	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	3615 E. Imperial Hiwy Lynwood, CA 90262

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR, a preliminary assessment completed for all individuals prior to admission to a Medicaid-certified Nursing Facility) was accurate for one of four sampled residents (Resident 3). This deficient practice placed Resident 3 at risk of not receiving the required care and services needed for his diagnosed mental illnesses, including a Level II PASRR screening (a comprehensive, person-centered evaluation to confirm the suspected Level I PASRR condition and determine the most appropriate placement and services). Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted on [DATE]. Resident 3's admitting diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and anxiety disorder (a condition characterized by excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life). During a review of Resident 3's Nursing Admission Assessment, dated 4/7/25, the assessment indicated Resident 3 was disoriented, could sometimes understand others, and was sometimes understood by others. The assessment indicated Resident 3 could ambulate without any problems with a device. During a review of Resident 3's active physician orders, dated 4/7/2025, the orders indicated Resident 3 was receiving: Ativan (lorazepam, a medication that acts on the brain and nerves to produce a calming effect that relieves symptoms of anxiety), one (1) milligram (mg, a unit of dose measurement) every six (6) hours as needed for anxiety Ativan (lorazepam) two (2) mg every six (6) hours as needed for excessive anxiety Chlordiazepoxide HCl (a sedative and hypnotic medication used to treat anxiety) 25 mg every 12 hours for anxiety (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Level I PASRR, dated 4/8/2025, the Level I PASRR did not indicate Resident 3's diagnoses of serious mental illness, such as schizophrenia, anxiety disorder, and psychosis. The Level I PASRR did not indicated Resident 3 had prescriptions for psychotropic medications (any drug that affects brain activities associated with mental processes and behavior). During a review of Resident 3's record titled Notice of PASRR Level I Screening Results, dated 4/8/2025, the record indicated a Level II Mental Health Evaluation was not required because the Level I PASRR screening indicated Resident 3 did not have diagnoses of serious mental illness. During a concurrent interview and record review, on 4/16/2025 at 12:26 p.m., with the Director of Nursing (DON), Resident 3's Admission Record, physician orders dated 4/7/2025, and Level I PASRR screening, dated 4/8/25, were reviewed. The DON stated the Admission Record, and physician orders dated 4/7/25, indicated Resident 3 had diagnoses of serious mental illness and was receiving psychotropic medications. The DON stated the Level I PASRR did not indicate Resident 3's diagnoses of serious mental illness, or his orders for psychotropic medications. The DON stated an inaccurate Level I PASRR screening placed Resident 3 at risk of being placed in a facility that could not meet his behavioral health needs, and could prevent him from receiving the mental health services he required. During a review of the facility policy and procedure (P&P) titled Psychoactive Medication Management, dated 7/2017, the P&P indicated residents were to have an individualized care was to be developed for residents with behavioral and psychotropic medications. The P&P indicate the care plan was to include the mood or behavior problem and its manifestations, and non-drug interventions. The P&P indicated residents were to be monitored for behaviors every shift. During a review of the facility P&P titled Behavioral Health Services, dated 1/2023, the P&P indicated it was the facility's policy to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The P&P indicated these behavioral health services included a PASRR screening, ongoing monitoring of mood and behavior, and development and implementation of a care plan. Cross-reference F-tag F740.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 47286 Based on interview and record review, the facility failed to ensure the posted nurse staffing information: 1. Included the facility's name and actual direct hours provided. 2. Was documented on the State-specific nursing hours per patient day (NHPPD) form. This created the potential for possible inaccuracy in calculating the required number of nursing hours, and for facility residents/visitors to not receive clear information about the daily facility staffing. Findings: During an observation on 4/16/2025 at 10:14 a.m., an untitled document indicating the nurse staffing information for 4/16/2025 was posted next to nurse's station A. The nurse staffing information was not printed on a State-specific NHPPD form, did not indicate the facility's name, and did not indicate if the posted hours were projected direct care hours or actual direct hours provided. During a concurrent interview and record review, on 4/16/2025 at 12:45 p.m. with Payroll Staff 1, the untitled nurse staffing posting, dated 4/16/2025 was reviewed. Payroll Staff 1 stated the untitled nurse staffing posting dated 4/16/2025, did not indicate the facility's name, and stated it was not printed on a State-specific NHPPD form. Payroll Staff 1 also stated the posting did not indicate if the hours were projected direct care hours or actual hours. Payroll Staff 1 stated she was responsible for updating the daily nurse staffing posting, and could not recall if the document ever included the facility's name or was ever printed on a State-specific NHPPD form. During a concurrent interview and record review, on 4/16/2025 at 2:46 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Staffing Sufficiency Requirements, dated 2/2017, and the untitled nurse staffing posting dated 4/16/2025, were reviewed. The DON stated the P&P indicated the nurse staffing posting was to include the facility name and the actual direct care hours provided, and was to be documented on State specific nursing hours per patient day (NHPPD) forms. The DON stated the nurse staffing posting dated 4/16/2025, was not in accordance with the facility's P&P. During a concurrent observation and interview, on 4/16/2024 at 2:51 p.m., with the DON, the nurse staffing postings at all three facility nursing stations were observed. The DON stated none of the nurse staffing postings were in accordance with the facility's P&P and stated there were no other postings available to facility residents and visitors indicating the information missing from the current postings. The DON stated it was the facility residents' (and their families/responsible parties') right to know the staffing levels in the facility as staffing affected the quality of care provided.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure behavioral health services were provided to one of four sampled residents (Resident 3) by failing to: Ensure Resident 3's Level I Preadmission Screening and Resident Review (PASRR, a preliminary assessment completed for all individuals prior to admission to a Medicaid-certified Nursing Facility) accurately reflected Resident 3's multiple diagnoses of serious mental illness and prescribed psychotropic medications (any drug that affects brain activities associated with mental processes and behavior). Develop and implement resident-specific care plans for Resident 3's diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and anxiety disorder (a condition characterized by excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life). Monitor and document behavioral manifestations of Resident 3's diagnoses of anxiety disorder, schizophrenia, and psychosis while administering psychotropic medications. These deficient practices placed Resident 3 at risk for not receiving the care and services needed for his diagnosed mental illnesses, including placement at an appropriate facility, and prevention of adverse effects associated with administration of psychotropic medications such as falls and excessive sedation. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted on [DATE]. Resident 3's admitting diagnoses included schizophrenia, psychosis, and anxiety disorder. During a review of Resident 3's Nursing Admission Assessment, dated 4/7/25, the assessment indicated Resident 3 was disoriented, could sometimes understand others, and was sometimes understood by others. The assessment indicated Resident 3 could ambulate without any problems with a device. During a review of Resident 3's active physician orders, dated 4/7/2025, the orders indicated Resident 3 was receiving: Ativan (lorazepam, a medication that acts on the brain and nerves to produce a calming effect that relieves symptoms of anxiety), one (1) milligram (mg, a unit of dose measurement) every six (6) hours as needed for anxiety Ativan (lorazepam) two (2) mg every six (6) hours as needed for excessive anxiety (continued on next page)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Chlordiazepoxide HCl (a sedative and hypnotic medication used to treat anxiety) 25 mg every 12 hours for anxiety During review of Resident 3's Level I PASRR, dated 4/8/2025, the Level I PASRR did not indicate Resident 3's diagnoses of serious mental illness, such as schizophrenia, anxiety disorder, and psychosis. The Level I PASRR did not indicated Resident 3 had prescriptions for psychotropic medications. During a review of Resident 3's record titled Notice of PASRR Level I Screening Results, dated 4/8/2025, the record indicated a Level II Mental Health Evaluation was not required because the Level I PASRR screening indicated Resident 3 did not have diagnoses of serious mental illness. During a concurrent interview and record review, on 4/16/2025 at 12:26 p.m., with the Director of Nursing (DON), Resident 3's Admission Record, physician orders dated 4/7/2025, and Level I PASRR screening, dated 4/8/25, were reviewed. The DON stated the Admission Record, and physician orders dated 4/7/25, indicated Resident 3 had diagnoses of serious mental illness and was receiving psychotropic medications. The DON stated the Level I PASRR did not indicate Resident 3's diagnoses of serious mental illness, or his orders for psychotropic medications. The DON stated an inaccurate Level I PASRR screening placed Resident 3 at risk of being placed in a facility that could not meet his behavioral health needs, and could prevent him from receiving the mental health services he required. During a concurrent interview and record review, on 4/16/2025 at 12:31 p.m., with the DON, Resident 3's current physician orders were reviewed. The DON stated Resident 3 did not have orders for monitoring the behaviors for which he was receiving psychotropic medications. The DON stated Resident 3 should have orders for behavioral monitoring to assess the effectiveness of the psychotropic medications being administered, and to determine if adjustments were needed to meet the resident's needs. During an interview, on 4/16/2025 at 12:33 p.m., with the DON, the DON stated Resident 3 did not have care plans for his diagnoses of schizophrenia, anxiety disorder, or psychosis. The DON stated Resident 3 did not have care plans for the psychotropics being administered for his diagnoses of schizophrenia, anxiety disorder, or psychosis. The DON stated it was important to have care plans for psychotropic medications because the medications could cause side effects such as altered mental status and increased risk for falls. The DON stated care plans for the diagnosed serious mental illnesses were important to identify and implement non-pharmacologic (non-medication) interventions that could be attempted to address the resident's behavioral manifestations, prior to or instead of administering additional psychotropic medications. The DON stated non-pharmacologic interventions should always be attempted first before the addition of pharmacologic interventions. During a review of the facility policy and procedure (P&P) titled Psychoactive Medication Management, dated 7/2017, the P&P indicated residents were to have an individualized care was to be developed for residents with behavioral and psychotropic medications. The P&P indicate the care plan was to include the mood or behavior problem and its manifestations, and non-drug interventions. The P&P indicated residents were to be monitored for behaviors every shift. During a review of the facility P&P titled Behavioral Health Services, dated 1/2023, the P&P indicated it was the facility's policy to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The P&P indicated these behavioral health services included a PASRR screening, ongoing monitoring of mood and behavior, and development and implementation of a care plan.