

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to promptly notify the physician of a change in condition (COC) regarding multiple medications refused for one of three sampled residents (Resident 2).</p> <p>This deficient practice resulted in delayed treatment and placed Resident 2 at risk of harm.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2 ' s diagnoses included severe dementia (a progressive state of decline in mental abilities) with behavioral disturbance (any pattern of behavior that was persistently disruptive, inappropriate, or causes problems for the individual or those around them), schizophrenia (a mental illness that was characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that ranged from the lows of depression to elevated periods of emotional highs).</p> <p>During a review of Resident 2 ' s History and Physical (H&amp;P), dated 3/6/2025, the H&amp;P indicated Resident 2 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 2 ' s Medical Administration Record (MAR) for 3/2025, the MAR indicated Resident 2 had at least ten episodes of roaming around facility daily.</p> <p>During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think and reason) for daily decision making. The MDS indicated Resident 2 had behavior of rejecting care that was necessary to achieve his goals for health and well-being daily. The MDS indicated Resident 2 required setup assistance with eating and required supervision with chair/bed-to-chair transferring and walking. The MDS indicated Resident 2 required maximal assistance (helper did more than half the effort) with oral hygiene and was dependent (helper did all the effort) with toileting hygiene and showering/ bathing self. The MDS indicated Resident 2 had lower extremities impairment and used a wheelchair for mobility. The MDS did not indicate Resident 2 had wandering behavior.</p> <p>(continued on next page)</p>		

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2 's Situation, Background, Assessment, Recommendation (SBAR -a communication tool used by healthcare workers when there was a change of condition among the residents), dated 5/28/2025 at 2:40 p.m., the SBAR indicated on 5/28/2025, staff (the Payroll Director [PD]) observed Resident 2 in Resident 1's room and Resident 2 touched Resident 1 on the breast. The SBAR indicated on 5/28/2025, Resident 2 thought Resident 1 was his wife.</p> <p>During an observation on 5/29/2025 at 9:58 a.m., in facility ' s hallway, Resident 2 was observed in his wheelchair, wandering outside of room [ROOM NUMBER]. During an observation on 5/29/2025 at 10:18 a.m. , in facility ' s hallway, Resident 2 was observed in his wheelchair, wandering outside of room [ROOM NUMBER].</p> <p>During an observation on 5/29/2025 at 1:12 p.m., in facility ' s hallway, Resident 2 was observed in his wheelchair, wandering outside the facility conference room.</p> <p>During a review of Resident 2 ' s Order Summary Report, dated 5/29/2025, the report indicated Resident 2 had active order of the following:</p> <ul style="list-style-type: none"> <li>-Donepezil HCL (medication used to treat dementia) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime for dementia.</li> <li>-Quetiapine fumarate (medication used to manage schizophrenic symptoms) 400mg by mouth two times a day (BID) for schizophrenia manifested by (m/b) constantly roaming around the facility in circles.</li> <li>-Depakote (medication used to treat bipolar disorder) 750 mg by mouth BID for schizophrenia related to bipolar disorder m/b constant talking to self.</li> <li>-Trazodone HCl (a medication used to treat major depressive disorder) 50mg by mouth at bedtime for inability to sleep.</li> </ul> <p>During a review of Resident 2 ' s Medical Administration Record (MAR) for 5/2025, the MAR indicated the following:</p> <ul style="list-style-type: none"> <li>-Resident 2 refused 16 out of the 28 doses of donepezil HCl in 5/2025.</li> <li>-Resident 2 refused 17 of 57 doses of quetiapine fumarate in 5/2025.</li> <li>-Resident 2 refused 17 of 57 doses of depakote in 5/2025.</li> <li>-Resident 2 refused 14 of 28 doses of trazodone HCl in 5/2025.</li> </ul> <p>-The MAR indicated Resident 2 had increased episodes of constantly roaming around the facility from 5/24/2025 to 5/28/2025.</p> <p>During an interview on 5/29/2025 at 10:20 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 wandered around the facility and liked to go to Resident 1 ' s room. CNA 1 stated Resident 2 was very non-compliant with care and needed frequent redirection.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/29/2025 at 11:29 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s MAR for 5/2025 was reviewed. The MAR indicated Resident 2 refused multiple medications on multiple shifts in 5/2025. LVN 1 stated the MAR indicated Resident 2 refused the donezepiril HCl 10mg for six consecutive shifts from 5/19/2025 to 5/24/2025 at 8 p.m. LVN 1 stated Resident 2 had dementia, and it was important for Resident 2 to take the donezepiril to prevent any sexual allegation. LVN 1 stated the donezepiril was to manage Resident 2 ' s wandering behavior and the nurse should notify the physician when Resident 2 continued to refuse his medications. LVN 1 stated the nurse should do a change of condition documentation for Resident 2 ' s medication refusals, notify the physician of the residents ' condition, and maybe the physician could order an alternative to encourage Resident 2 to take the medications. LVN 1 stated it was a delay of necessary care for Resident 2. LVN 1 stated the LVNs, charge nurse, and the Registered Nurses (RN) were responsible for notifying the physician about Resident 2 ' s medication refusal.</p> <p>During a concurrent interview and record review on 5/29/2025 at 11:52 a.m. with RN 1, Resident 2 ' s Nursing Progress Note for 5/2025 was reviewed. The note did not indicated documentation regarding Resident 2 ' s medication refusals in 5/2025. RN 1 stated the nurse should have documented Resident 2 ' s medication refusals on the Nursing Progress Note. RN 1 stated Resident 2 took donezepiril to manage dementia behavior. RN 1 stated the nurse should notify the physician and the responsible party about Resident 2 ' s medication refusals. RN 1 stated the purpose of notifying the physician was for alternative medications for Resident 2, and to update the physician about Resident 2 ' s condition. RN 1 stated the physician might order to transfer Resident 2 for further evaluation due to medication refusal. RN 1 stated the potential risk was that Resident 2 ' s wandering and dementia behavior would be worsened. RN 1 stated it was possible for Resident 2 to wander into the female residents ' room and cause unwanted sexual interaction. RN 1 stated it was a delay of necessary care for Resident 2.</p> <p>During an interview on 5/29/2025 at 1:16 p.m. with the Assistant Director of Nursing (ADON), the ADON stated staff should monitor medication compliance for the dementia residents. The ADON stated the dementia residents were forgetful, had wandering behavior, and could be aggressive at the late stage of dementia. The ADON stated the potential risks of not taking medication for the dementia residents, was a worsening wandering behavior and aggressive behavior toward self, other residents, and staff. The ADON stated the nurses needed to notify the resident ' s physician and responsible party, do the change of condition documentation, and update the care plan when the resident refused medications. The ADON stated the purpose of notifying the physician was for an alternative medication and care intervention. The ADON stated it also kept the physicians updated on the residents ' conditions, so staff could provide the appropriate care. The ADON stated it was a delay of necessary care for Resident 2 because it was important for Resident 2 to take his medications.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 5/29/2025 at 4:09 p.m. with Resident 2 ' s Nurse Practitioner (NP), Resident 2 ' s NP stated he expected the nurse to notify him or the primary physician when the residents refused medications. Resident 2 ' s NP stated it was to prevent withdrawal (abnormal physical or psychological features after the abrupt discontinuation of a drug) from the medication and prevent unwanted behavior. Resident 2 ' s NP stated it was important for Resident 2 to take donepezpril and quetiapine furnarate as ordered. Resident 2 ' s NP stated one of the side effects (an effect of a drug or other type of treatment that was in addition to or beyond its desired effect) of refusing donepezpril and quetiapine furnarate was the increased risks of wandering into other residents ' rooms and possibly increased hypersexual activities for Resident 2. Resident 2 ' s NP stated Resident 2 was disorganized manifested by wandering off and did not make any sense. Resident 2 ' s NP stated it was possible that Resident 2 ' s behavior would be more manageable if he was aware of Resident 2 ' s medication refusal. Resident 2 ' s NP stated it was possible to avoid this sexual allegation if the facility had notified him about Resident 2 ' s medication refusal.</p> <p>During a review of the facility ' s policy andpProcedure (P&amp;P) titled, Physician Notification, dated 12/2016, the P&amp;P indicated Attending physician will be promptly informed of the change of condition for residents.</p> <p>During a review of the facility ' s P&amp;P titled, Medication Administration-General Guidelines, dated 1/2022, the P&amp;P indicated Medication refusal must be reported to the prescriber after 3 doses are refused and there must be documentation of prescriber notification of such.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to protect resident's right to be free from sexual abuse for one of three residents (Resident 1), who was subjected to Resident 2's sexual advancements. The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Follow its policy and procedure (P&amp;P) titled Abuse and Neglect Prohibition Policy, which indicated the facility should be identifying, correcting, and intervening in situations in which abuse was more likely to occur.</li> <li>2. Follow its P&amp;P titled Wandering Behavior Management, which indicated each resident who was a wandering risk was provided the appropriate intervention and adequate supervision.</li> <li>3. Address Resident 2's refusals of quetiapine fumarate (medication used to manage schizophrenic [mental illness that was characterized by disturbances in thought] symptoms) and donepezil (medication used to treat dementia [a progressive state of decline in mental abilities]).</li> </ol> <p>These deficient practices resulted in Resident 2 wandering into Resident 1's room and touching Resident 1's left breast. These deficient practices also violated Resident 1's right to be free from sexual abuse. Cross Reference F580.</p> <p>Findings:</p> <p>a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included cataracts (a common age-related eye condition that could affect vision in older adults) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 1 had severely impaired cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 1 had impaired vision. The MDS indicated Resident 1 required setup assistance with eating. The MDS indicated Resident 1 required supervision with oral hygiene. The MDS indicated Resident 1 required moderate assistance with (helper did less than half the effort) personal hygiene. The MDS indicated Resident 1 was dependent (helper did all the effort) with toileting hygiene, showering/bathing self, and tub/shower transferring.</p> <p>During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there was a change of condition among the residents) form, dated 5/28/2025 at 3:04 p.m., the SBAR indicated on 5/28/2025, Resident 1 exposed her breast to Resident 2. The SBAR indicated Resident 2 was seen moving his hand away from Resident 1's breast.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included severe dementia (a progressive state of decline in mental abilities) with behavioral disturbance (any pattern of behavior that was persistently disruptive, inappropriate, or causes problems for the individual or those around them), schizophrenia (a mental illness that was characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that ranged from the lows of depression to elevated periods of emotional highs).</p> <p>During a review of Resident 2's History and Physical (H&amp;P), dated 3/6/2025, the H&amp;P indicated Resident 2 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 had a behavior of rejecting care that was necessary to achieve his goals for health and well-being daily. The MDS indicated Resident 2 required setup assistance with eating. The MDS indicated Resident 2 required supervision with chair/bed-to-chair transferring and walking. The MDS indicated Resident 2 required maximal assistance (helper did more than half the effort) with oral hygiene. The MDS indicated Resident 2 was dependent with toileting hygiene and showering/ bathing self. The MDS indicated Resident 2 had impairment to the lower extremities (legs) and used a wheelchair for mobility.</p> <p>During a review of Resident 2's care plan titled Has a behavior problem and desires r/t (related to) schizophrenia, constant walking in the hallway for no apparent reason, initiated 8/4/2021, the care plan indicated staff were to administer medication as ordered, monitor/ document for side effects and effectiveness, and intervene as necessary to protect the rights and safety of others.</p> <p>During a review of Resident 2's SBAR, dated 5/28/2025 at 2:40 p.m., the SBAR indicated on 5/28/2025, Payroll Director (PD 1) observed Resident 2 in Resident 1's room. The SBAR indicated PD 1 observed Resident 2 touching Resident 1's breast. The SBAR indicated Resident 2 thought Resident 1 was his wife.</p> <p>During a review of Resident 2's Physician's Order dated 6/12/2023, the order indicated to administer Donepezil HCL (medication used to treat dementia) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime for dementia.</p> <p>During a review of Resident 2's Physician's Order dated 2/3/2025, the order indicated to administer Quetiapine Fumarate (medication used to manage schizophrenic symptoms) 400 mg by mouth two times a day for schizophrenia manifested by constantly roaming around the facility in circles.</p> <p>During a review of Resident 2's Medication Administration Record (MAR) for 5/2025, the MAR indicated Resident 2 refused 16 out of the 28 doses of donepezil. The MAR indicated Resident 2 refused 17 of 57 doses of quetiapine fumarate. The MAR indicated Resident 2 had increased behavior episodes from 5 episodes to 15 episodes of constantly roaming around the facility from 5/24/2025 to 5/28/2025.</p> <p>During observations on 5/29/2025 at 9:58 a.m., 10:18 a.m., and 1:12 p.m., Resident 2 was observed in the hallways wandering around the facility in his wheelchair unsupervised.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/29/2025 at 10:20 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 5/28/2025 around 2:15 p.m., Resident 2 was observed by PD 1 in Resident 1's room touching Resident 1's breast. CNA 1 stated on 5/28/2025 around 2:16 p.m., she observed Resident 2 coming out of Resident 1's room pushing his wheelchair with one hand and pulling up his pants with the other hand. CNA 1 stated it was not Resident 2's first time entering Resident 1's room. CNA 1 stated Resident 2 wandered around the facility and liked to go to Resident 1's room. CNA 1 stated she was instructed by an unidentified charge nurse to remove Resident 2 from Resident 1's room, and to provide frequent redirection to Resident 2 because the resident kept passing by Resident 1's room. CNA 1 stated Resident 2 was very non-compliant with care and needed frequent redirection.</p> <p>During an interview on 5/29/2025 at 10:37 a.m. with PD 1, PD 1 stated on 5/28/2025 around 2:15 p.m., she observed Resident 2's hand on Resident 1's left breast in Resident 1's room. PD 1 stated Resident 2 immediately removed his hand and PD 1 instructed Resident 2 to leave the room. PD 1 stated Resident 2 told her that Resident 1 was his wife.</p> <p>During a concurrent interview and record review on 5/29/2025 at 11:29 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's MAR for 5/2025 was reviewed. The MAR indicated Resident 2 refused donepezril and quetiapine fumarate on multiple shifts in 5/2025. LVN 1 stated the MAR indicated Resident 2 refused donepezril for six consecutive days from 5/19/2025 to 5/24/2025 at 8 p.m. LVN 1 stated Resident 2 had dementia, and it was important for Resident 2 to take his donepezril to prevent any sexual allegation. LVN 1 stated the donepezril was to manage Resident 2's wandering behavior. LVN 1 stated the nurse should have notified the physician when Resident 2 continued to refuse his medications.</p> <p>During a concurrent interview and record review on 5/29/2025 at 11:52 a.m. with Registered Nurse (RN) 1, Resident 2's Nursing Progress Notes for 5/2025 were reviewed. The notes did not indicate documentation regarding Resident 2's refusals of donepezril and quetiapine in 5/2025. RN 1 stated the nurse should have documented and notified Resident 2's physician of Resident 2's medication refusals. RN 1 stated the purpose of notifying the physician was to provide updates of Resident 2's condition and possibly receive an alternative medication order. RN 1 stated the physician might have ordered to transfer Resident 2 to the hospital for further evaluation due to medication refusal. RN 1 stated there was a risk for Resident 2's wandering and dementia behavior to worsen. RN 1 stated it was possible for Resident 2 to wander into the female residents' room and cause unwanted sexual interactions. RN 1 stated it was inappropriate for Resident 2 to touch Resident 1's breast because it violated Resident 1's rights to be free from abuse. RN 1 stated Resident 2 touching Resident 1's breast was considered sexual abuse. RN 1 stated staff should have provided constant monitoring on Resident 2's movement and redirected the resident to prevent any sexual abuse.</p> <p>c. 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 DM and generalized muscle weakness.</p> <p>During a review of Resident 3's H&amp;P, dated 10/17/2024, the H&amp;P indicated Resident 3 had the capacity to understand and make decisions.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 3 had adequate vision and was able to understand others.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/29/2025 at 10:03 a.m. with Resident 3 (Resident 1's roommate), Resident 3 stated on 5/28/2025 (unable to recall time), she called staff to assist when Resident 2 entered the room for the second time that day. Resident 3 stated she was unable to see what was happening between Resident 1 and Resident 2 because Resident 1's privacy curtain was closed. Resident 3 stated Resident 2 had been coming inside Resident 1's room since 10/2024. Resident 3 stated staff would come into the room and take Resident 2 away.</p> <p>During an interview on 5/29/2025 at 11:52 a.m. with RN 1, RN 1 stated Resident 3 was alert. RN 1 stated nurses should report to the charge nurse when a male resident was observed going into a female resident's room to avoid sexual abuse.</p> <p>During an interview on 5/29/2025 at 1:16 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 2 propelled around the facility in his wheelchair. The ADON stated staff should have monitored the behaviors and medication compliance for the dementia residents. The ADON stated the dementia residents were forgetful and had wandering behaviors. The ADON stated the residents could be aggressive at the late stage of dementia. The ADON stated the risks of not taking medication for the dementia residents were worsening wandering behavior and aggressive behavior toward self, residents, and staff. The ADON stated when residents refused medications, the nurses needed to inform resident's physician, complete a change of condition, and update the care plan. The ADON stated the purpose of notifying the physician was for an alternative medication regimen and care interventions. The ADON stated it also kept the physicians updated on the residents' conditions so staff could provide the appropriate care. The ADON stated it was a delay of necessary care because it was important for Resident 2 to take his medications. The ADON stated staff should have closely monitored Resident 2 to ensure his whereabouts. The ADON stated there was potential for sexual interaction when Resident 2 wandered into the other residents' rooms. The ADON stated Resident 2 refusing his medications contributed to Resident 2's thinking Resident 1 was his wife. The ADON stated Resident 2 touching Resident 1's breast violated Resident 1's rights and was considered sexual abuse.</p> <p>During a telephone interview on 5/29/2025 at 4:09 p.m. with Resident 2's Nurse Practitioner (NP 1), NP 1 stated he expected the nurse to notify him or the primary physician when Resident 2 refused his medications. NP 1 stated it was important for Resident 2 to take donepezil and quetiapine fumarate as ordered to prevent unwanted behavior. NP 1 stated one of the side effects (an effect of a drug or other type of treatment that was in addition to or beyond its desired effect) of refusing donepezil and quetiapine fumarate was the increased risk of wandering into other residents' rooms and increased hypersexual activities for Resident 2. NP 1 stated Resident 2 was disorganized manifested by wandering and confusion. NP 1 stated if he was aware Resident 2 touched Resident 1's breasts on 5/28/2025, he would have increased Resident 2's medication for safety. NP 1 stated Resident 2's behavior would be more manageable.</p> <p>During a review of the facility's P&amp;P titled Wandering Behavior Management, dated 12/2016, the P&amp;P indicated to ensure that each resident who was a wandering risk was provided the appropriate intervention and adequate supervision. The P&amp;P indicated the facility was to modify the plan of care as needed to address the wandering risk behaviors by monitoring for any type of medical causes that increases wandering.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	During a review of the facility's P&P titled Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated to ensure that facility staff were doing all that was within their control to prevent occurrences of abuse for all the residents. The P&P indicated that the facility should be identifying, correcting, and intervening in situations in which abuse was more likely to occur, and it included analysis of the supervision of staff to identify inappropriate behaviors. The P&P indicated that the facility should analyze the assessment, care planning, and monitoring of the residents with needs and behaviors which might lead to conflict, such as the residents who have behaviors such as entering other residents' rooms. The P&P further indicated that sexual abuse was non-consensual sexual contact of any type with a resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was accurately coded to reflect the resident ' s wandering behavior for one of three sampled residents (Resident 2).</p> <p>This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS) and a potential to negatively affect Resident 2 ' s plan of care and delivery of necessary services.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2 ' s diagnoses included severe dementia (a progressive state of decline in mental abilities) with behavioral disturbance (any pattern of behavior that was persistently disruptive, inappropriate, or causes problems for the individual or those around them), schizophrenia (a mental illness that was characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that ranged from the lows of depression to elevated periods of emotional highs).</p> <p>During a review of Resident 2 ' s History and Physical (H&amp;P), dated 3/6/2025, the H&amp;P indicated Resident 2 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 2 ' s Medical Administration Record (MAR) for 3/2025, the MAR indicated Resident 2 had at least ten episodes of roaming around facility daily.</p> <p>During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think and reason) for daily decision making. The MDS indicated Resident 2 had behavior of rejecting care that was necessary to achieve his goals for health and well-being daily. The MDS indicated Resident 2 required setup assistance with eating and required supervision with chair/bed-to-chair transferring and walking. The MDS indicated Resident 2 required maximal assistance (helper did more than half the effort) with oral hygiene and was dependent (helper did all the effort) with toileting hygiene and showering/ bathing self. The MDS indicated Resident 2 had lower extremities impairment and used a wheelchair for mobility. The MDS did not indicate Resident 2 had wandering behavior.</p> <p>During an observation on 5/29/2025 at 9:58 a.m., in facility ' s hallway, Resident 2 was observed in his wheelchair, wandering outside of room [ROOM NUMBER]. During an observation on 5/29/2025 at 10:18 a.m. , in facility ' s hallway, Resident 2 was observed in his wheelchair, wandering outside of room [ROOM NUMBER].</p> <p>During an observation on 5/29/2025 at 1:12 p.m., in facility ' s hallway, Resident 2 was observed in his wheelchair, wandering outside the facility conference room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2025
NAME OF PROVIDER OR SUPPLIER  California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3615 E. Imperial Hiwy Lynwood, CA 90262	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/29/2025 at 10:20 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 wandered around the facility and liked to go to Resident 1 ' s room. CNA 1 stated Resident 2 was very non-compliant with care and needed frequent redirection.</p> <p>During a concurrent interview and record review on 5/29/2025 at 11:29 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s MDS dated [DATE] was reviewed. LVN 1 stated the MDS assessment for wandering behavior was inaccurate because Resident 2 wandered around the facility daily. LVN 1 stated the MDS assessment should have been coded as Occurred daily.</p> <p>During a concurrent interview and record review on 5/29/2025 at 11:52 a.m. with Registered Nurse (RN) 1, Resident 2 ' s MDS dated [DATE] was reviewed. RN 1 stated the MDS assessment for wandering behavior was not accurate. RN 1 stated the potential risk of having an inaccurate MDS assessment was that staff was unable to manage the wandering behavior and it could delay necessary care.</p> <p>During an interview on 5/29/2025 at 1:16 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the potential risk of inaccurate MDS assessment would be the wrong care plan and possibly a delay in necessary care for Resident 2. The ADON stated the MDS nurse was responsible for completing and auditing the MDS assessments.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Certifying Accuracy of the Resident Assessment, dated 1/2018, the P&amp;P indicated Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. The P&amp;P further indicated, The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.</p>		