

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  06/06/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on, interview and records review, the facility failed to notify the Resident ' s physician when 1 of three sampled residents, Resident 1 refused to go for hemodialysis treatment (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/s have failed).</p> <p>This deficient practice had the potential to delay other alternative treatment and placed Resident 1 at risk for medical complications like fluid overload, leading to hospitalization or death.</p> <p>Findings:</p> <p>During a review of Resident 1 admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (a condition where the heart cannot pump enough blood to meet the body ' s needs), chronic kidney disease (occurs when the kidneys are no longer able to effectively remove waste and excess fluid from the blood), Resident 1 was on hemodialysis therapy.</p> <p>During a review of Resident ' s 1 Minimum Data Set ([MDS] a comprehensive resident assessment and care-screening too) dated 6/7/2025, the MDS indicated Resident 1 had the capacity to understand and can make his needs known.</p> <p>During a review of Resident 1 ' s physician ' s order sheet dated 4/10 2025, the order indicated hemodialysis 3 times a week, every Monday, Wednesday and Friday.</p> <p>During a review of dialysis communication form and Resident 1 ' s nurses ' progress notes, with the RN supervisor, indicated that Resident 1 did not get his hemodialysis treatment on 6/19/2025, 6/21/2025 and 6/22/2025.</p> <p>During a review of the SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) for Resident 1 dated 6/21/2025, indicated that Resident 1 ' s primary physician was notified of Resident 1 refusing to go for his hemodialysis on 6/21/2025, there was no indication that Resident 1 physician was notified that Resident 1 did not get his hemodialysis treatment on 6/19/2025 and 6/22/2025.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/6/2025 at 12:30 p.m., with the dialysis clinic nurse, the dialysis Nurse stated that Resident 1 did not come for his hemodialysis treatment on 6/19/2025, 6/21/2025 and on 6/22/2025. The dialysis clinic Nurse stated that she tried to get in touch with the facility to know why Resident 1 did not show up for dialysis three times consecutively. The dialysis clinic Nurse stated that none of the staff in the facility could tell her the reasons Resident 1 keep missing his dialysis. The dialysis clinic Nurse stated that knowing how important it is for Resident 1 to get his dialysis, she has to report the incident to California Department of Public Health (CDPH) because she do not want the resident to keep missing his dialysis.</p> <p>During interview on 6/6/2025 at 1:25 p.m., with Resident 1, Resident 1stated that he missed his dialysis on 6/19/2025, 6/21/2025 and on 6/22/2025 because he was having diarrhea, and he do not like going to dialysis when he is having diarrhea.</p> <p>During an interview on 6/10/2025 at 12:05 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated that she did not know that Resident 1 missed his dialysis on 5/19/2025 and was not informed by the night shift nurse that Resident 1 refused to go for his dialysis. Resident 1 did not tell her (LVN 1) that he did not go for his dialysis. LVN 1 stated that Resident 1 usually goes to dialysis around 4 am and comes back around 7 am. By 7:30 am when she was doing her initial round, Resident 1 was already in bed and she asked him how his dialysis was, Resident 1 stated that it went well. She then went ahead and did the post dialysis evaluations on Resident.</p> <p>During an interview on 6/10/2025 at 12:32 p.m., with LVN 2, LVN 2 stated he prepared Resident 1 for dialysis on 5/19/2025, and when the transportation came to pick Resident 1 up, Resident 1 refused to go for his dialysis. LVN 2 stated that he forgot to endorse to the oncoming nurse that Resident 1 refused to go for his dialysis. LVN 2 stated he did not call the dialysis clinic and did not inform Resident 1 ' s physician about Resident 1 refusing to go for his dialysis.</p> <p>During an interview on 6/10/2025 at 1:40 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that when a resident missed dialysis appointment, the staff shouldnotify the dialysis clinic so that they can reschedule the dialysis. The ADON stated the staff should notify the resident ' s physician and document on the Situation, Background, Assessment, and Recommendation ([SBAR] a structured way to communicate to the care team about a resident ' s change in condition), and endorse to the incoming staff. The ADON stated that Resident 1 should be monitored for any signs and symptoms of fluid overload, that could happen as a result of resident missing his dialysis.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Change of Condition, dated 8/2017, the P&amp;P indicated that it is the policy of the facility to promptly notify the resident attending physician and the representative of any change in the resident ' s medical/mental condition. The P&amp;P indicated that the Licensed Nurse should notify the physician, using the interact tool SBAR to notify physicians for all signs and symptoms manifested by the patient. The form will be used to initiate change of condition documentation for any decline or improvement.</p> <p>Based on, interview and records review, the facility failed to notify the Resident's physician when 1 of three sampled residents, Resident 1 refused to go for hemodialysis treatment (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/s have failed).</p> <p>(continued on next page)</p>		

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