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	06/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure feeding assistance at eye-level was provided to one of nine sampled residents (Resident 6). This deficient practice had the potential to result in affecting Resident 6's self-esteem and self-worth. Cross Reference F689. Findings: During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 6's cognition (process of thinking) was severely impaired. The MDS indicated Resident 6 required set up and clean-up assistance with eating. The MDS indicated Resident 6 was on a mechanically altered diet (change in texture of food or liquids). During a review of Resident 6's History and Physical (H&P), dated 10/17/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Orders, dated 6/11/2025, the Orders indicated to give Resident 6 No Added Salt (NAS), Consistent Carbohydrate (CCHO, diet used for individuals with diabetes to manage blood sugar levels) diet, pureed texture (food consistency that does not require chewing, often for individuals with swallowing difficulties). During an observation on 6/11/2025 at 9:33 a.m. in Resident 6's room, Certified Nursing Assistant (CNA) 2 was standing to the side of Resident 6's bed while providing feeding assistance to Resident 6. Resident 6's head of the bed was elevated, and the base of the bed was close to the floor. CNA 2 and Resident 6 were not at eye-level. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 9:39 a.m., with CNA 2, CNA 2 stated Resident 6 required feeding assistance with his meals. CNA 2 stated when providing feeding assistance, she was supposed to be at eye-level with Resident 2. CNA 2 stated being at eye-level with Resident 2 provided a more comfortable dining experience. During an interview on 6/11/2025 at 11:35 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated when providing feeding assistance to a resident, the CNA was expected to either sit next to the resident's bedside or raise the resident's bed to be at eye-level with the resident. LVN 2 stated being at eye-level was important to provide dignity to the resident. LVN 2 stated by not being at eye-level with Resident 2, Resident 2 may feel embarrassed and could affect Resident 2's self-esteem. During an interview on 6/11/2025 at 2:28 p.m., with the Assistant Director of Nursing (ADON), the ADON stated dignity during a meal was maintained when the CNA was eye-level with the resident. The ADON stated Resident 6 required feeding assistance due to his medical conditions. The ADON stated with CNA 2 standing next to Resident 2 and not being eye-level, Resident 2 could feel uncomfortable and could affect his self-worth. During a review of the facility's policy and procedure (P&P) titled, Resident Dignity and Personal Privacy , dated 12/2016, the P&P indicated, All activities and interactions with residents by any staff, temporary agency staff, or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. During a review of the facility's P&P titled, Assisting the Impaired Patients with In-Room Meals , dated 4/2018, the P&P indicated, The facility shall provide assistance for all patients with meals in a manner that meets the individual needs of each patient. The P&P indicated, if you are going to be seated during the feeding, position a chair where it will be convenient for you and the patient.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident's privacy for one of nine sampled residents (Resident 9), when Resident 9 was undressed sitting on a shower chair in the room without the privacy curtain drawn or door closed. This deficient practice violated Resident 9's rights and dignity. This deficient practice also had the potential to negatively impact Resident 9's physical and psychosocial wellbeing. Findings: During a review of Resident 9's admission Record, the record indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and presence of urogenital implants (medical devices surgically placed within the body to help treat various conditions affecting the urinary or genital system). During a review of Resident 9's Minimum Data Set (MDS – a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 9 had moderately impaired cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 9 required setup assistance with eating and oral hygiene. The MDS indicated Resident 9 required maximal assistance (helper did more than half the effort) with toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated Resident 9 was dependent (helper did all the effort) with bed-to-chair transfer. The MDS indicated Resident 9 had impairment to the extremities (arms and legs) and used a wheelchair for mobility. During a review of Resident 9's History and Physical (H&P), dated 8/18/2024, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a concurrent observation and interview on 6/11/2025 at 8:50 a.m. with Certified Nursing Assistant (CNA) 5, outside Resident 9's room, Resident 9 was observed undressed and sitting on a shower chair inside the room with CNA 6. The privacy curtain was not drawn nor the door closed. CNA 5 stated staff should close the door for privacy during care. CNA 5 stated it was important to protect the residents' privacy. CNA 5 stated Resident 9 had no clothes on because the resident just came from the shower. CNA 5 stated staff should cover Resident 9 with a blanket for dignity. During an interview on 6/11/2025 at 8:55 a.m. with CNA 6, CNA 6 stated she should close the door for Resident 9's privacy but forgot. During an interview on 6/11/2025 at 11:55 a.m. with Registered Nurse (RN) 1, RN 1 stated the facility staff needed to respect the residents' privacy and dignity. RN 1 stated staff should cover the residents after showers for privacy. RN 1 stated staff should pull the privacy curtain and/ or close the door to make sure no one saw the resident's undressed body. RN 1 stated this violated Resident 9's rights of privacy when Resident 9's undressed body was exposed. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Resident Dignity & Personal Privacy, revised in 12/2016, the P&P indicated Each resident has the right to be treated with dignity and respect. The P&P indicated Examine and treat residents in a manner that maintains their privacy. Use a closed door, a drawn curtain, or both, to shield the resident during all personal care and treatment procedures.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan (a document that outlined a resident's health needs and the care they required) for one out of nine residents (Resident 1), when the facility did not address Resident 1's preference of having a female certified nursing assistant (CNA) to provide showers. This deficient practice had the potential to delay and negatively affect the delivery of care for Resident 1's overall wellbeing. Findings: 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 depression (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and anxiety (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that could interfere with daily life). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/14/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 1 required setup assistance with eating. The MDS indicated Resident 1 required maximal assistance (helper did more than half the effort) with oral hygiene. The MDS indicated Resident 1 was dependent (helper did all the effort) with toileting hygiene, personal hygiene, showering/ bathing, and bed-to-chair transfer. The MDS indicated Resident 1 had impairments to the upper extremity (arm) and used a wheelchair for mobility. During a review of Resident 1's History and Physical (H&P), dated 5/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Psychosocial Progress Note, dated 6/5/2025, the note indicated Resident 1 did not want a male nurse to care for him. During an interview on 6/10/2025 at 8:43 a.m. with Resident 1, Resident 1 stated he preferred to have female staff shower him. Resident 1 stated he informed an unidentified staff about his care preference after he moved to his current room. During an interview on 6/10/2025 at 11:05 a.m. with CNA 4, CNA 4 stated on 5/29/2025, Resident 1 refused his shower because Resident 1 preferred a female CNA to shower him. During an interview on 6/10/2025 at 12:14 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was aware of Resident 1's preference to have female CNAs care for him. LVN 2 stated the facility should have a care plan to address Resident 1's care preferences of female CNAs. LVN 2 stated the purpose of the care plan was to develop interventions for staff to follow, to set a goal to help the residents, and to address the residents' needs. LVN 2 stated the charge nurse who took care of the resident should initiate a care plan for the resident's preference. LVN 2 stated the care plan was a standard of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 6/11/2025 at 11:55 a.m. with Registered Nurse (RN) 1, Resident 1's care plans, as of 6/11/2025, were reviewed. There were no care plans to address Resident 1's care preferences of female CNAs. RN 1 stated she was made aware of Resident 1's care preference of female CNAs on 5/29/2025, [FB1] [JL2] and the facility should have a care plan to address it. RN 1 stated the risk was delayed necessary care for Resident 1. During a review of the facility's Policy and Procedure (P&P), titled, Care Planning - Interdisciplinary Team, dated 1/2018, the P&P indicated A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by a care planning/interdisciplinary team. During a review of the facility's P&P, titled, Quality of Care, dated 11/2019, the P&P indicated The resident must receive a comprehensive assessment to provide direction for the development of the resident's care plan to address the choices and preferences of the resident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer one of nine sampled residents (Resident 8) showers. This deficient practice resulted in Resident 8 not receiving showers and had the potential to result in infection. Findings: During a review of Resident 8's admission Record (Face Sheet), the Face Sheet indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), neuromuscular dysfunction of the bladder (lacking bladder control leading to difficulty empty the bladder), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 8's cognition (process of thinking was intact. The MDS indicated Resident 8 required maximal assistance (helper does more than half the effort) with bathing, upper body dressing, and personal hygiene). During a review of Resident 8's History and Physical (H&P), dated 1/21/2025, the H&P indicated Resident 8 had the capacity to understand and make decisions. During a review of the facility's Shower Schedule, undated, the Showe Schedule indicated the following shower days based on bed locations: Bed A showered Mondays and Thursdays, Bed B showered Tuesdays and Fridays, Bed C and D showered Wednesday and Saturday. During a review of Resident 8's Care Plan titled, Resistive to Care Refusing Shower or Bed Bath , dated 3/27/2024, the Care Plan indicated Resident 8's goal to cooperate with care. The Care Plan indicated staff interventions to provide resident with opportunities for choice during care provision and to negotiate a time for showers so Resident 8 could participate in the decision-making process. During an interview on 6/11/2025 at 9:43 a.m., with Resident 8, Resident 8 stated he preferred to shower at night. Resident 8 stated he could not recall the last time he had a bed bath or went to the shower room. Resident 8 stated the certified nursing assistants (CNAs) do not offer him a shower or bed bath. During an interview on 6/11/2025 at 12:06 p.m. with CNA 3, CNA 3 stated Resident 8 was known to refuse showers because Resident 8 preferred specific staff members to bathe him and had a preference to shower at nighttime. CNA 3 stated although Resident 8 had staff preferences, Resident 8 should be offered baths routinely to provide choices and allow Resident 8 to make his own decisions. CNA 3 stated per the shower schedule, Resident 8 was scheduled to shower on Wednesdays and Saturdays, but Resident 8 could shower on any day if he requested. CNA 3 stated whether a shower or bath was provided or refused, the CNA was responsible for documenting on Resident 8's Task sheet on the electronic health record (eHR). (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/11/2025 at 12:15 p.m., with CNA 3, Resident 8's Bathing Task, dated 5/14/2025 through 6/7/2025, was reviewed. CNA 3 stated the Bathing Task indicated Not Applicable was documented to answer the question, Did the resident have a bed bath or shower on 5/14/2025, 5/21/2025, 5/24/2025, 5/28/2025, and 6/7/2025. CNA 3 stated if Resident 8 refused a bed bath or shower, there was an option to document refused . CNA 3 stated Not Applicable indicated Resident 8 was not asked to shower or a shower was not an option. CNA 3 stated documenting Not Applicable indicated the CNA did not try to see if Resident 8 wanted a shower. CNA 3 stated this was an issue because Resident 8 had the right to be given the option to shower and to decide when to shower or to refuse. CNA 3 stated by not offering a shower to Resident 8, Resident 8 did not receive a shower those days which put him at risk for infection and for self-esteem concerns. During an interview on 6/11/2025 at 12:49 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated although Resident 8 had the tendency to refuse showers, the CNAs were expected to offer showers on schedule to Resident 8. LVN 2 stated providing the choice to Resident 8 allowed him the independence to decide for himself. During an interview on 6/11/2025 at 2:35 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the CNAs were expected to offer showers to every resident on their scheduled shower day. The ADON stated the residents' preferences should be honored to ensure each resident bathe unless they refuse. The ADON stated Resident 8 should have been given the opportunity to exercise his right to decide whether he wanted to bathe. The ADON stated due to Resident 8 not being offered showers, Resident 8 was at risk for skin breakdown, dry skin, and infection due to not showering. During a review of the facility's policy and procedure (P&P) titled, Tub Baths and Showers , dated 8/2018, the P&P indicated the facility was to provide the preferred method of personal hygiene for its residents.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely input one of nine sampled residents' (Resident 6) diet order upon readmission to the facility. This deficient practice resulted in Resident 6 receiving his breakfast tray two hours after the scheduled breakfast time and could have resulted in Resident 6 becoming hypoglycemic (low blood sugar). Findings: During an observation on 6/11/2025 at 9:33 a.m. in Resident 6's room, Resident 6 had his breakfast tray on the bedside table. Certified Nursing Assistant (CNA) 2 was standing to the side of Resident 6's bed while providing feeding assistance to Resident 6. During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 6's cognition (process of thinking) was severely impaired. The MDS indicated Resident 6 required set up and clean-up assistance with eating. The MDS indicated Resident 6 was on a mechanically altered diet (change in texture of food or liquids). During a review of Resident 6's History and Physical (H&P), dated 10/17/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Orders, dated 6/11/2025, the Orders indicated on 6/10/2025 at 8:10 p.m., Resident 6's order for No Added Salt (NAS), Consistent Carbohydrate (CCHO, diet used for individuals with diabetes to manage blood sugar levels) diet, pureed texture (food consistency that does not require chewing, often for individuals with swallowing difficulties) was discontinued. The Orders indicated Resident 6's diet was reordered on 6/11/2025 at 9:27 a.m. During an interview on 6/10/2025 at 9:28 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the licensed nurses were responsible for doing room rounds during medication administration at 9 a.m. to see if residents received their breakfast trays. LVN 1 stated every resident should have received their breakfast tray and either eaten or finishing eating around 8 a.m. During an interview on 6/10/2025 at 1:58 p.m., with the Dietary Supervisor (DS), the DS stated when a resident was admitted to the facility, the licensed nurse was responsible for inputting their diet order into the electronic health record (eHR) and filling out diet slip to submit to the kitchen. The DS stated the purpose of the diet slip was to ensure the resident received their meal tray during the following mealtime. The DS stated following this process ensured the meal tray was not delayed to the resident to prevent any weight loss or complications. The DS stated the breakfast trays were sent out to the residents at 7 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 9:39 a.m., with CNA 2, CNA 2 stated Resident 2 was readmitted to the facility the night before, on 6/10/2025, and the diet slip was not sent to the kitchen, therefore Resident 2 did not have a breakfast tray sent out at the scheduled time. CNA 2 stated Resident 2 was eating breakfast two hours after the other residents. During an interview on 6/11/2025 at 11:53 a.m., with Registered Nurse (RN) 1, RN 1 stated when Resident 2 was readmitted to the facility, the licensed nurse should have inputted his diet to ensure a breakfast tray was made for him. RN 1 stated she realized Resident 2 did not have a breakfast tray and inputted the diet order that morning which resulted in Resident 2 eating later than he was supposed to. During an interview on 6/11/2025 at 2:31 p.m., with the Assistant Director of Nursing (ADON), the ADON stated when a resident was readmitted from the general acute care hospital (GACH), the resident had discharge orders to be carried out in the facility. The ADON stated the admitting nurse was responsible for inputting all the physician's orders, including the resident's diet order. The ADON stated Resident 2's diet order was not inputted in the eHR and did not receive his breakfast tray timely because the kitchen was unaware of his readmission. The ADON stated Resident 2 had diabetes and the late breakfast tray could have resulted in Resident 2 becoming hypoglycemic. During a review the facility'of s Mealtime Schedule, undated, the Mealtime Schedule indicated breakfast was served at 7:10 a.m. During a review of the facility's policy and procedure (P&P) titled, Resident Nutritional Services, dated 4/2018, the P&P indicated, Meal hours shall be scheduled at regular times to assure that each resident receives at least three meals per day.

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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** Based on observation, interview, and record review, the facility failed to ensure two of nine sampled residents (Residents 6 and 7) were free of potential accidents and hazards by failing to: 1. Provide feeding assistance to Resident 6 at eye-level. 2. Ensure Resident 7 wore non-skid socks (socks designed with special tread or grip on the bottom of the sock to provide extra traction and stability) when ambulating (walking). These deficient practices had the potential to result in Resident 6 choking and Resident 7 sustaining an avoidable fall. Findings: 1. During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 6's cognition (process of thinking) was severely impaired. The MDS indicated Resident 6 required set up and clean-up assistance with eating. The MDS indicated Resident 6 was on a mechanically altered diet (also known as a therapeutic diet which changes the texture of food or liquids). During a review of Resident 6's History and Physical (H&P), dated 10/17/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Orders, dated 6/11/2025, the Orders indicated to give Resident 6 No Added Salt (NAS), Consistent Carbohydrate (CCHO, diet used for individuals with diabetes to manage blood sugar levels) diet, pureed texture (food consistency that does not require chewing, often for individuals with swallowing difficulties). During a review of Resident 6's Care Plan titled Swallowing Problem , dated 9/22/2021, the Care Plan to monitor Resident 6 for signs and symptoms of dysphagia such as coughing, drooling, and choking. During an observation on 6/11/2025 at 9:33 a.m. in Resident 6's room, Certified Nursing Assistant (CNA) 2 was standing to the side of Resident 6's bed while providing feeding assistance to Resident 6. Resident 6's head of the bed was elevated, and the base of the bed was close to the floor. CNA 2 and Resident 6 were not at eye-level. (continued on next page)

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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post-Acute Care	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 9:39 a.m., with CNA 2, CNA 2 stated Resident 6 required feeding assistance with his meals. CNA 2 stated when providing feeding assistance, she was supposed to be at eye-level with Resident 2. CNA 2 stated being eye-level would have allowed her to ensure Resident 2 was swallowing correctly and not choking. During an interview on 6/11/2025 at 11:35 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated when providing feeding assistance to a resident, the CNA was expected to either sit next to the resident's bedside or raise the resident's bed to be at eye-level with the resident. LVN 2 stated being eye-level would have allowed CNA 2 to control the pace of the feeding to ensure Resident 2 was properly swallowing and to take any necessary breaks. During an interview on 6/11/2025 at 2:15 p.m., with the Dietary Supervisor (DS), the DS stated during feeding assistance, Resident 6 had to be monitored for any signs of choking. The DS stated the CNA providing the assistance had to be at eye-level with Resident 6 to ensure they paid attention to the resident swallowing and their cues to slow down the feeding. The DS stated being at eye-level was the necessary safety measure. The DS stated Resident 6 had dysphagia and was already at risk for choking. During an interview on 6/11/2025 at 2:28 p.m., with the Assistant Director of Nursing (ADON), the ADON stated dignity during a meal was maintained when the CNA was eye-level with the resident. The ADON stated Resident 6 required feeding assistance due to his medical conditions. The ADON stated being at eye-level with Resident 6 to ensure Resident 6 did not exhibit any signs of choking. The ADON stated if Resident 6 were to exhibit signs of choking, CNA 2 may have missed the signs and continued feeding. During a review of the facility's policy and procedure (P&P) titled, Assisting the Impaired Patients with In-Room Meals , dated 4/2018, the P&P indicated, The facility shall provide assistance for all patients with meals in a manner that meets the individual needs of each patient. The P&P indicated, if you are going to be seated during the feeding, position a chair where it will be convenient for you and the patient. 2. During a review of Resident 7's admission Record (Face Sheet), the Face Sheet indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included ataxia (loss of voluntary coordination of muscle movements) following a cerebrovascular disease (range of conditions that affect the blood vessels and blood supply to the brain), history of falls, and dementia. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognition was severely impaired. The MDS indicated Resident 7 was dependent on staff's assistance with toileting, bathing, and personal hygiene. The MDS indicated Resident 7 required supervision with walking. During a review of Resident 7's H&P, dated 3/6/2025, the MDS indicated Resident 7 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 7's Fall Risk Assessment, dated 7/13/2024, the Fall Risk Assessment indicated Resident 7 was at a high risk for falls. (continued on next page)

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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's Care Plan titled, High Risk for Falls , dated 8/4/2021, the Care plan indicated to ensure Resident 7 had non-skid socks on while ambulating. During a concurrent observation and interview on 6/11/2025 at 9:06 a.m., with CNA 1, in the hallway, Resident 7 was observed propelling himself in his wheelchair. Resident 7 was wearing white socks that did not have a grip on the bottom. Resident 7 stood up from his wheelchair and began pushing the wheelchair in front of him. CNA 1 stated any time Resident 7 was out of bed, especially when ambulating, Resident 7 was required to wear non-skid socks. CNA 1 stated Resident 7 had an unsteady gait (the way an individual walks) and was difficult for Resident 7 to walk at times. CNA 1 stated wearing normal socks put Resident 7 at risk of slipping and falling. During an interview on 6/11/2025 at 12:39 p.m., with LVN 1, LVN 1 stated Resident 7 had a history of falls and was supposed to wear non-skid socks when out of bed. LVN 1 stated Resident 7 would wear the non-skid socks or shoes when he was in the hallway or out-on-pass. LVN 1 stated Resident 7 should always wear the non-skid socks to prevent him from slipping in the hallway. During an interview on 6/11/2025 at 2:30 p.m. with the ADON, the ADON stated non-skid socks were a fall preventative measure. The ADON stated Resident 2 should always wear non-skid socks or shoes when ambulating. The ADON stated Resident 7 was at risk for further falls if he did not wear the non-skid socks. During a review of the facility's P&P titled, Fall Prevention Program , dated 12/2016, the P&P indicated, The facility will identify interventions related to the resident's specific risks and cause to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated to prevent falls, assess the resident for improper footwear.