| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055052 | A. Building<br>B. Wing | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| California Post-Acute Care | 3615 E. Imperial Hiwy<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect resident's right to be free from verbal abuse for one of five residents (Resident 1), who was subjected to Certified Nursing Assistant (CNA) 1's yelling on 8/25/2025. The facility failed to:1. Follow its Policy and Procedure (P&P) titled Abuse and Neglect Prohibition Policy, which indicated the facility would identify, correct, and intervene in situations in which abuse was more likely to occur.2. Follow its P&P titled Quality of Life - Dignity, which indicated residents shall be treated with dignity and respect at all times. 3. Honor Resident 1's rights to choose his preferred CNA on 8/24/2025. These deficient practices resulted in Resident 1 being subjected to CNA 1's verbal abuse. It also negatively impacted Resident 1's psychosocial 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 cataracts (a common age-related eye condition that could affect vision in older adults), legal blindness, and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/12/2025, the MDS indicated Resident 1 had intact cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 1 required setup assistance with eating. The MDS indicated Resident 1 required supervision with oral hygiene, toileting hygiene, showering/bathing, personal hygiene, bed-to-chair transferring, and walking. The MDS indicated Resident 1 had adequate hearing and impaired vision. During a review of Resident 1's History and Physical (H&P), dated 9/14/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. 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 8/25/2025 at 5:55 a.m., the SBAR indicated on 8/25/2025 at 4:30 a.m., Resident 1 was agitated (feeling or appearing nervous, upset, or disturbed) with Certified Nursing Assistant (CNA) 1 and accused CNA 1 of violating his (Resident 1)'s patient rights. The SBAR indicated Resident 1 requested CNA 1 to pull his curtain back, turn off the light, and close the door. The SBAR indicated Resident 1 stated CNA 1 left the room without doing so, disrespected his space, and disturbed his peace. The SBAR indicated CNA 1 called Resident 1 names and escalated the verbal altercation. The SBAR indicated CNA 1 refused to leave. The SBAR indicated that CNA 1 was Mistakenly assigned to Resident 1. During a review of Resident 1's care plan titled He wanted to also control who can enter his room for example CNA and LVN (licensed vocational nurse), initiated on 3/22/2025, the care plan indicated staff were to assess and anticipate Resident 1's needs. The care plan indicated to intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk away calmly and approach later. During a review of the facility's Nursing Staff Assignment and Sign-In Sheet, dated 8/24/2025, the assignment sheet indicated CNA 1 was assigned to Resident 1 on 8/24/2025 night shift. During an interview on 9/4/2025 at 9:51 a.m. with Resident 1, Resident 1 stated he was legally blind and differentiated staff by their voice and using his peripheral vision (what you saw on the sides when you're looking straight ahead.) Resident 1 stated on 8/25/2025, CNA 1 left the bathroom light on after providing care to his roommate (Resident 2) and left the room. Resident 1 stated he walked to the hallway and asked CNA 1 to put everything back the way it should be in the room. Resident 1 stated CNA 1 became verbally and physically aggressive toward him. Resident 1 stated he did not remember what CNA 1 said exactly but CNA 1 used curse words and called him names. Resident 1 stated CNA 1 was coming at him like a gang member. Resident 1 stated Registered Nurse (RN) 1 stepped in-between him and CNA 1 to stop CNA 1 from getting close to Resident 1. Resident 1 stated CNA 1 was not professional and yelled at him. Resident 1 stated CNA 1 made him feel like he was in the hood with his aggressive behavior and intimidation. Resident 1 stated he should not feel this way from a nurse. Resident 1 stated he did not get along with CNA 1 for at least six months and did not want CNA 1 to be assigned to him. Resident 1 stated he informed LVN 2 and the Administrator (ADM) to not assign CNA 1 to him before the verbal altercation on 8/25/2025. Resident 1 stated continuing to have CNA 1 assigned to his care made him feel bad and as if the facility did not care about him. Resident 1 stated his rights were not protected when the administrative staff were off duty. During a telephone interview on 9/5/2025 at 10:20 a.m. with CNA 1, CNA 1 stated she was assigned to Resident 1 on the evening shift of 8/24/2025. CNA 1 stated on 8/24/2025 at 11 p.m., she informed LVN 2 that Resident |

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| California Post-Acute Care | 3615 E. Imperial Hiwy<br>Lynwood, CA 90262 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not implement their care plan interventions for three out of three sampled residents (Resident 2, 4, and 5) by failing to ensure staff:1. Separated Resident 2 and Resident 4 after an alleged sexual abuse; and2. Monitored Resident 5's location. These deficient practices potentially exposed Resident 2 to further sexual abuse and allowed Resident 5 to leave the facility without notifying staff.Findings:1. During an observation on 9/3/2025 at 2:48 p.m. in the lobby, Resident 2 and Resident 4 were sitting close to each other and talking. Resident 4 stood up and went to Resident 2 to place a pillow under Resident 2's legs. Resident 2 lifted his legs and Resident 4 placed a pillow underneath Resident 2's legs and gently pushed Resident 2's legs down.During a review of Resident 2's admission Record, dated 9/4/2025, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included Tourette's syndrome (disorder characterized by repetitive, involuntary movements or vocalizations) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 2's History and Physical (H&P) dated 5/17/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 5/22/2025, the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required supervision for eating. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for eating. The MDS indicated Resident 2 was dependent on staff for personal hygiene, toileting hygiene, dressing, oral hygiene and shower/bathing.During a review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR), dated 9/1/2025, the SBAR indicated Resident 2 reported allegations of sexual abuse when Resident 4 touched Resident 2's legs during lunch on 8/31/2025. The SBAR indicated there was an order to separate the residents and educate the residents on proper behavior.During a review of Resident 2's Care Plan titled, This resident has vulnerability from other residents crossing his boundaries, actual allegation of abuse on 9/1/2025, dated 9/1/2025, the care plan indicated the goal was for the Resident to be safe in the facility's environment. The care plan indicated the interventions included separating the residents.During a review of Resident 4's admission Record, dated 9/4/2025, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnosis included cerebral infarction (loss of blood flow to a part of the brain) and human immunodeficiency virus ([HIV] a virus that attacks the body's immune system).During a review of Resident 4's H&P dated 10/21/2024, the H&P indicated Resident 4 was alert, awake and oriented X3 (mental status, indicating they are awake, alert, and aware of their person, place, and time). The H&P indicated Resident 4 had mental capacity.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was intact. The MDS indicated Resident 4 was independent for dressing and toileting hygiene. The MDS indicated Resident 4 required set-up assistance for eating and oral hygiene. The MDS indicated Resident 4 required supervision for shower/bathing and personal hygiene.During a review of Resident 4's Care Plan titled, Inappropriate Statements and Touching, dated 5/1/2025, the care plan indicated on 9/1/2025, Resident 4 touched the legs of another resident. The care plan indicated the goal for Resident 4 was to reduce the frequency of inappropriate verbal and physical behaviors. The care plan indicated the interventions included separating the residents from each other and increasing supervision in common areas. During an interview on 9/3/2025 at 3:04 p.m. with Registered Nurse (RN) 1, RN 1 stated he developed the care plan after the alleged abuse between Resident 2 and Resident 4 on 9/1/2025. RN 1 stated Resident 2 and Resident 4 must be separated to prevent the alleged abuse from happening again and to prevent recurring trauma to Resident 2. RN 1 stated Resident 2 and Resident 4 must not sit next to each other to keep Resident 2 safe during alleged abuse investigation. The RN stated Resident 2 and Resident 4 should be monitored for at least 72 hours.During an interview on 9/3/2025 at 3:35 p.m. with Resident 4 in the lobby, Resident 4 stated RN 1 came to wheel Resident 2 away from him and RN 1 told him he could not sit with or talk to Resident 2. Resident 4 stated he did not know he could not talk to or be close to Resident 2. Resident 4 stated he and Resident 2 hung out together and talked daily in the lobby and no one told them they could not do that.During an interview on 9/4/2025 at 12:50 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she did not monitor Resident 4 to see if he was close to Resident 2 because she was not aware there was an abuse allegation between Resident 2 and Resident 4. LVN 1 stated if there was |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a care plan for one of two sampled residents (Resident 4) after the resident was observed touching another resident. This deficient practice increased the risk of Resident 4 inappropriately touching another resident. Findings:During a review of Resident 2's admission Record, dated 9/4/2025, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included Tourette's syndrome (disorder characterized by repetitive, involuntary movements or vocalizations) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 4's History and Physical (H&P) dated 10/21/2024, the H&P indicated Resident 4 was alert, awake and oriented times 3 (mental status, indicating they are awake, alert, and aware of their person, place, and time). During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool), dated 6/11/2025, the MDS indicated Resident 4's cognitive skills for daily decision making was intact. The MDS indicated Resident 4 was independent for dressing and toileting hygiene. The MDS indicated Resident 4 required set up assistance for eating and oral hygiene. The MDS indicated Resident 4 required supervision for shower/bathing and personal hygiene. During a review of Resident 4's care plan titled, Inappropriate Statements and Touching, dated 5/1/2025, the care plan indicated Resident 4's goal was to reduce the frequency of inappropriate verbal and physical behaviors. The interventions indicated to increase Resident 4's supervision in common areas and resident education on use of appropriate language and touching. The care plan was revised on 9/1/2025 due to Resident 4 touching the legs of another resident. The care plan indicated no new goals or interventions were developed on 9/1/2025. During a review of Resident 4's Situation, Background, Assessment, Recommendation form ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) , dated 9/1/2025, the SBAR indicated Resident 4 was observed touching the legs of another resident. The SBAR indicated there was a new order to educate Resident 4 on proper behavior and to separate the residents. During an interview on 9/3/2025 at 3:08 p.m. with Registered Nurse (RN) 1, RN 1 stated residents had to be separated to prevent alleged abuse from happening again. During an interview on 9/5/2025 at 2:42 p.m. with the Director of Nursing (DON), the DON indicated she expected licensed staff to revise care plans when residents have a new issue. The DON stated a revision to the care pan meant a new intervention was developed. The DON stated a new intervention must be developed because the existing interventions did not work and it outlined the plan of care. The DON stated if a care plan was not revised the resident would not have an up-to-date plan of care and staff would practice the previous interventions that did not work. During a review of the facility's Policy and Procedure (P&P) titled Care plans, Comprehensive Person-Centered, dated 1/2018, the P&P indicated staff must review and update the care plan when there has been a significant change in the resident's condition. The P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure titled Resident on Pass for one of three sampled residents (Resident 5) when the facility failed to ensure, 1. The licensed nurse completed the Out On Therapeutic Pass/Leave of Absence form when Resident 5 left and returned back to the facility from out on pass. This deficient practice did not ensure Resident 5's safe release from the facility. This deficient practice also did not provide a system to ensure Resident 5's safe return back to the facility. Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnosis included schizophrenia (a mental illness that can affect thoughts, mood, and behavior) and epilepsy (chronic brain disorder characterized by recurrent, unprovoked seizures [uncontrolled electrical discharges in the brain]). During a review of Resident 5's History and Physical (H&P) dated 1/26/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool), dated 6/26/2025, the MDS indicated Resident 5's cognitive skills for daily decision making was intact. The MDS indicated Resident 5 required supervision for toileting hygiene and lower body dressing. The MDS indicated Resident 5 required moderate assistance (helper does less than half the effort) for shower/bathing and lower body dressing. The MDS indicated Resident 5 needed set up assistance for personal hygiene and upper body dressing. The MDS indicated Resident 5 was independent for oral hygiene and eating. During a record review of Resident 5's Out On Therapeutic Pass/Leave of Absence forms dated 5/23/2025, 5/30/2025, 6/7/2025, 6/13/2025, 6/22/2025, 6/25/2025, 7/4/2025, 8/1/2025, 8/7/2025, 8/17/2025, and 8/19/2025, the forms did not indicate a signature of a licensed nurse. The forms did not indicate the date and time Resident 5 returned to the facility and it did not have the signature of the licensed nurse that accepted Resident 5 back into the facility. The forms did not indicate the name of the person signing Resident 5 back into the facility upon return. During an interview on 9/4/2025 at 12:50 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated all residents that leave the facility must be signed out by a licensed nurse. LVN 1 stated a licensed nurse signature on the Out On Pass Therapeutic Pass/Leave of Absence form indicated the resident was assessed by the nurse and was stable enough to leave the facility. LVN 1 stated when a resident returned to the facility a licensed nurse must sign the form indicating they accepted the resident back into the facility. LVN 1 stated the Out On Therapeutic Pass/Leave of Absence form must be filled out completely. LVN 1 stated if the form was not signed there was no proof the resident was stable enough to leave the facility. LVN 1 stated the Out On Therapeutic Pass/Leave of Absence form required a licensed nurse to sign when a resident returned to the facility. During an interview on 9/5/2025 at 9:37 a.m. with LVN 3, LVN 3 stated a licensed nurse must document the time the resident left the facility, the estimated time of arrival back to the facility, where the resident was going, and the name of the person picking up the resident on the Out On Therapeutic Pass/Leave of Absence form. LVN 3 stated a licensed nurse must sign the form to indicate the resident was stable to leave the facility and witnessed the resident leave the facility. LVN 3 stated licensed nurses were responsible for completing the form upon the residents return to the facility to indicate the resident returned in stable condition. LVN 3 stated it was important to fill out the form completely to communicate the residents' whereabouts and for the residents' safety. During an interview on 9/5/2025 at 2:42 p.m. with the Director of Nursing (DON), the DON stated all residents that leave the facility out on pass must be signed out by a licensed nurse. The DON stated the nurse's signature on the Out On Therapeutic Pass/Leave of Absence form meant a nurse witnessed the resident leave the facility. The DON stated if there was not a signature on the form it indicated a nurse did not witness the resident leaving the facility and there was no way of verifying when the resident left. The DON stated the purpose of the form was to communicate which resident left the facility and to indicate what time they would be back. The DON stated if the form was not filled out correctly it could affect the residents safety During a review of the facility's policy and procedure (P&P) titled Resident on Pass dated 1/2018, the P&P indicated all residents leaving the premises must be signed out. The P&P indicated a sign-out register (therapeutic leave form) was located at each nurse's station. Registers must indicate the resident's expected time of return. The P&P indicated residents must be signed in upon return to the facility. |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.<br><br>(continued on next page) |

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|---|---|
| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to address the psychosocial needs (emotional, social, and cultural factors that influence an individual's well-being and mental health) for two of two sampled residents (Resident 2 and Resident 4) after an allegation of abuse when, 1. The Social Services Director (SSD) failed to assess Resident 2 after an alleged abuse incident. 2. The SSD failed to develop a care plan to address Resident 2 and 4's psychosocial needs. These deficient practices had the potential to negatively impact Resident 2's psychosocial needs. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included Tourette's syndrome (disorder characterized by repetitive, involuntary movements or vocalizations) and psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality). During a review of Resident 2's History and Physical (H&P) dated 5/17/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 5/22/2025, the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required supervision for eating. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for eating. The MDS indicated Resident 2 was dependent on staff for personal hygiene, toileting hygiene, dressing, oral hygiene and shower/bathing. During a review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR), dated 9/1/2025, the SBAR indicated Resident 2 reported allegations of sexual abuse when Resident 4 touched Resident 2's legs during lunch on 8/31/2025. The SBAR indicated there was an order to separate and educate the residents on proper behavior. During a review of Resident 2's electronic medical record, unable to locate a social services note indicating Resident 2 was seen by the Social Services Designee (SSD) after the alleged abuse incident. During a review of Resident 2's electronic medical record, unable to locate a social services care plan addressing Resident 2's psychosocial needs after an alleged sexual abuse. 2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnosis included cerebral infarction (loss of blood flow to a part of the brain) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's H&P dated 10/21/2024, the H&P indicated Resident 4 was alert, awake and oriented times 3 (x3) (mental status, indicating they are awake, alert, and aware of their person, place, and time). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was intact. The MDS indicated Resident 4 was independent with dressing and toileting hygiene. The MDS indicated Resident 4 required set up assistance with eating and oral hygiene. The MDS indicated Resident 4 required supervision with shower/bathing and personal hygiene. During a review of Resident 4's electronic medical record, unable to locate a social services note indicating Resident 4 was seen by the SSD after the alleged abuse incident. During a review of Resident 4's electronic medical record, unable to locate a social services care plan addressing Resident 4's psychosocial needs after an alleged sexual abuse incident. During an interview on 9/5/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated when there was an alleged abuse incident, she expected the SSD to review the documentation, interview the residents and document their findings right away. The DON stated if residents' psychosocial needs (emotional, social, and cultural factors that influence an individual's well-being and mental health) were not met it would make residents become more apprehensive, they might feel no one wanted to talk to them about the situation, and they might feel isolated. The DON stated the SSD should have visited Resident 2 and Resident 4 and asked what happened and how they felt about the situation and refer them to see a psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness), if needed. The DON stated the SSD should have documented their visit with the residents and developed a care plan and implemented interventions. During an interview on 9/9/2025 at 10:00 a.m. with the SSD, the SSD stated part of his job duties was to assist residents with their psychosocial needs by developing care plans, performing psychosocial evaluations and referring residents to see a doctor to talk about their psychosocial concerns. The SSD stated to assist residents with their psychosocial needs he must visit residents and find out if they have any concerns. The SSD stated for alleged sexual abuse he must make sure residents were safe and away from the abuser. The SSD stated he would make sure there was no additional contact between the two |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055052 | A. Building<br>B. Wing | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| California Post-Acute Care | 3615 E. Imperial Hiwy<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

| 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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the licensed vocational nurse failed to:1. Document the administration of insulin (a hormone that removed excess sugar from the blood, could be produced by the body or given artificially via medication) Aspart (a fast-acting insulin used for diabetes mellitus [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing]) 35 units (a way to measure the strength or amount of a drug), for one of five residents (Resident 1), on the Medication Administration Record (MAR) on 8/16/2025 at 6:30 a.m. 2. Document the findings related to a change of condition (COC), for one of five residents (Resident 1), on the nursing progress notes for the evening shift on 8/25/2025.These deficient practices had the potential to result in lack of communication between staff, and delay and interrupt the provision of care needed to maintain the residents' highest practicable, physical, mental, and psychosocial well-being. 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 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), bipolar disorder (mood swings that ranged from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/12/2025, the MDS indicated Resident 1 had intact cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 1 required setup assistance with eating. The MDS indicated Resident 1 required supervision with oral hygiene, toileting hygiene, showering/bathing, personal hygiene, bed-to-chair transferring, and walking. The MDS indicated Resident 1 had adequate hearing and impaired vision. During a review of Resident 1's History and Physical (H&P), dated 9/14/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. a. During a review of Resident 1's Order Summary Report, dated 9/4/2025, the report indicated to administer insulin (a hormone that removed excess sugar from the blood, could be produced by the body or given artificially via medication) Aspart (a fast-acting insulin used for DM) 35 units (a way to measure the strength or amount of a drug) before meals. During a concurrent interview and record review on 9/4/2025 at 2:39 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 1's Medication Administration Record (MAR) for 8/2025 was reviewed. The MAR indicated that nurses were to administer insulin Aspart 35 units before meals, starting on 4/3/2024 at 4:30 p.m. LVN 4 stated there was no indication insulin Aspart was administrated on 8/16/2025 at 6:30 a.m. LVN 4 stated the MAR indicated the assigned licensed vocational nurse did not administer the insulin to Resident 1 on 8/16/2025 at 6:30 a.m. LVN 4 stated it was important for the licensed nurses to follow the doctor's order and to document the insulin administration on the MAR. LVN 4 stated that documentation ensured residents' safety and wellbeing and proved medication administration. LVN 4 stated the insulin Aspart was to lower Resident 1's blood sugar. LVN 4 stated that not documenting on the MAR posed the risk of hyperglycemia (high blood sugar) for Resident 1. LVN 4 stated it was not safe for Resident 1 and negatively affected quality of care and possibly delayed care. During a concurrent interview and record review on 9/4/2025 at 2:39 p.m. with LVN 4, Resident 1's care plan for DM, initiated on 6/25/2021, was reviewed. The care plan goals indicated Resident 1 would show no signs or symptoms of hyperglycemia. LVN 4 stated the care plan interventions indicated the licensed vocational nurse was to administer insulin Aspart 35 units before meals. LVN 4 stated the licensed nurse did not follow the care plan and was responsible for implementing the care plan interventions for the residents' benefits to meet their needs. During an interview on 9/5/2025 at 3:50 p. m. with the Director of Nursing (DON), the DON stated it was unacceptable not to complete the documentation on the MAR. The DON stated the licensed nurses should sign the MAR after the medication administration to verify completion. The DON stated it was the standard of practice. b. 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 8/25/2025 at 5:55 a.m., the SBAR indicated on 8/25/2025 at 4:30 a.m., Resident 1 was agitated (feeling or appearing nervous, upset, or disturbed) with Certified Nursing Assistant (CNA) 1 and accused CNA 1 of violating his (Resident 1)'s patient rights. The SBAR indicated Resident 1 requested CNA 1 to pull his curtain back, turn off the light, and close the door. The SBAR indicated Resident 1 stated CNA 1 left the room without doing so, disrespected his space, and disturbed his peace. The SBAR indicated CNA 1 called Resident 1 names and |