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	09/23/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 1) preferences were honored when the following occurred: 1. Certified Nursing Assistant (CNA) 1 was assigned to Resident 1's care despite Resident 1's prior documented and verbal refusal of care from CNA 1 due to a previously reported past traumatic experience with CNA 1. 2. Resident 1's preference for longer showers due to his extensive physical limitations and medical diagnoses were not honored. These deficient practices demonstrated a failure to honor Resident 1's preferences and person-centered care, and had the potential to result in feelings of loss of trust, ongoing emotional distress, diminished self-worth, and re-traumatization. Cross reference F656.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), spinal stenosis (a condition where the spinal canal, the bony tunnel that surrounds and protects the spinal cord, becomes narrowed), spastic diplegic cerebral palsy (a neurological disorder that causes muscle stiffness) , muscle weakness and anxiety (an overwhelming feeling of worry, fear and nervousness). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 9/5/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's History and Physical (H&P), dated 8/12/2025, the H&P indicated Resident 1 had the capacity to make and understand medical decisions. During an interview on 9/23/2025 at 8:45 a.m. with Resident 1, Resident 1 stated, approximately two years ago, the facility's previous Administrator and the Quality Assurance Nurse (QAN) implemented a 15-to-20-minute shower rule for Resident 1 because he was known to take long showers. Resident 1 explained that his showers often exceeded thirty minutes because he was a quadriplegic, who was entirely dependent on staff to perform his showers. Resident 1 stated, approximately two years ago, Resident 1 had a traumatic experience with Certified Nursing Assistant (CNA) 1 during his shower. Resident 1 stated CNA 1 abruptly told him she had to complete his shower within 15 minutes. CNA 1 proceeded to rush through his shower, ignored his requests, quickly raised his arms, flipped him over, and used one towel to wash his genitals and his face. Resident 1 stated, ever since that day, he had been very vocal and clear about refusing care from CNA 1, but the facility failed to listen to his request and continued to assign her to his care two or three times and he felt forced to deal with it. Resident 1 stated he recalled providing details of his traumatizing encounter to the QAN and provided the QAN a CNA preference list about a month ago. Resident 1 stated he was recently re-traumatized once he learned CNA 1 was assigned to his care again on 9/18/2025, his scheduled shower day. Resident 1 stated, on 9/18/2025, CNA 1 walked into his room and proceeded to empty the contents of his urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). Resident 1 stated he could not take it [her being his assigned CNA] anymore and refused CNA 1 for the remainder of the shift. Resident 1 stated he felt sad and frustrated that the facility continued to assign CNA 1 as his CNA. 1. During an interview on 9/23/2025 at 9:24 a.m. with the QAN, the QAN stated she was one of the nurses responsible for doing the CNA assignments while the Director of Staff Development (DSD) was on medical leave. The QAN stated she recalled, about a year ago, Resident 1 expressed dissatisfaction with CNA 1's care because she used one wash cloth to wipe his genitals and face during his shower. The QAN stated, during that time, Resident 1 expressed wanting a break from CNA 1 and CNA 1 was removed from Resident 1's rotation of assigned CNAs. The QAN stated shortly after, she resigned from her position at the facility and verbally told the incoming DSD Resident 1's wishes. The QAN stated she was recently re-employed at the facility (8/2025) and was the nurse responsible for making the CNA assignments on 9/18/2025. The QAN stated she assigned CNA 1 to the care of Resident 1 because there were no other available nurses. The QAN stated she did not ask or notify Resident 1 that CNA 1 was assigned to his care before the assignment was made because Resident 1 usually accepted the CNAs assigned to his care. The QAN stated she should have done so because Resident 1 had the right to be involved in decisions that affected his care and well-being. The QAN stated the potential outcome of excluding Resident 1 from his patient care assignment would lead to Resident 1 feeling uncomfortable and did not align with the facility's goal of providing dignified care to the residents. During an interview on

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the care plan interventions developed by the Interdisciplinary Team (IDT- a group of different disciplines working together towards a common goal of a resident) were implemented for one of three sampled residents (Resident 1), when Resident 1 had preferences to not be assigned to Certified Nursing Assistant (CNA) 1's care due to a past traumatic experience.This deficient practice resulted in CNA 1 being assigned to Resident 1, contrary to the resident's care plan interventions. This deficient practice also had the potential for Resident 1 to exhibit re-traumatization, distress, and psychosocial harm. Cross Reference F558.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), spinal stenosis (a condition where the spinal canal, the bony tunnel that surrounds and protects the spinal cord, becomes narrowed), spastic diplegic cerebral palsy (a neurological disorder that causes muscle stiffness) , muscle weakness and anxiety (an overwhelming feeling of worry, fear and nervousness). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 9/5/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's History and Physical (H&P), dated 8/12/2025, the H&P indicated Resident 1 had the capacity to make and understand medical decisions. During a review of Resident 1's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Note, dated 7/10/2025, the IDT Note indicated Resident 1 expressed dissatisfaction with the Certified Nursing Assistant (CNA) assignment when CNA 1 was assigned to Resident 1 a few days ago. The IDT note indicated Resident 1 had a preference list for CNAs. The IDT Note indicated, two years ago, Resident 1 experienced a traumatic experience while CNA 1 provided care while showering Resident 1. The note indicated Resident 1 chose not to disclose specific details of the incident. The IDT Note indicated, a few weeks ago, Resident 1 verbalized not wanting CNA 1 to be assigned to him. The IDT Note indicated CNA 1 was inadvertently assigned Resident 1 again a few days ago which led to his complaint. The IDT Note indicated the IDT reassured Resident 1 his preferences were important and would be honored as staffing allows moving forward. The IDT Note indicated the CNA assignment list and care preference documentation would be reviewed and updated accordingly and facility staff would continue to monitor resident satisfaction and ensure care assignments were appropriate. During a review of Resident 1's Preferences Care Plan, initiated 7/10/2025, the Care Plan indicated Resident 1 expressed a clear preference for care to be provided by specific CNAs. The Care Plan indicated Resident 1 had a history of discomfort when he was assigned to a particular CNA due to a prior undisclosed traumatic experience. The Care Plan interventions indicated to ensure communication amongst all nursing staff and scheduling coordinators of Resident 1's CNA preference and to ensure that assignments are reviewed before each shift. The Care Plan indicated the facility was to document CNA preferences, monitor Resident 1's satisfaction with care daily, address and document any further deviations from preference immediately, support Resident 1's emotional well-being and provide opportunities for Resident 1 to express concerns about care. During a review of Resident 1's IDT Note, dated 9/18/2025 (two months after the previous IDT meeting), the IDT Note indicated Resident 1 expressed dissatisfaction with the CNA assignment and Resident 1 preferred certain CNAs. The IDT note indicated Resident 1 had experienced a traumatic experience while CNA 1 showered Resident 1. The IDT Note indicated the CNA assignment list and care preference documentation [would] be reviewed and updated accordingly and the facility would continue to monitor resident satisfaction and ensure care assignments were appropriate. During an interview on 9/23/2025 at 8:45 a.m. with Resident 1, Resident 1 stated, approximately two years ago, the facility's previous Administrator and Quality Assurance Nurse (QAN) implemented a 15-to-20-minute shower rule for Resident 1 because he was known to take long showers. Resident 1 explained that his showers often exceeded thirty minutes because he was a quadriplegic, who was entirely dependent on staff to perform his showers. Resident 1 stated, approximately two years ago, Resident 1 had a traumatic experience with CNA 1 during his shower. Resident 1 stated CNA 1 abruptly told him she had to complete his shower within 15