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	12/12/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 report to the California Department of Public Health (CDPH), when Certified Nurse Assistant (CNA) 1 allegedly yelled at one of four residents, Resident 1.This deficient practice resulted in a delay of investigation by the CDPH and placed Resident 1 at risk for abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being).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 diagnoses included hypertension (high blood pressure), and legal blindness (a specific level of vision impairment defined by government standards. Visual acuity of 20/200 or less in the good eye).During a review of Resident 1's History and Physical (H&P) dated 9/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/12/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance which may be provided throughout the activity, or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 1 required setup assistance (helper sets up or cleans up; resident completes activity/ helper assists only prior to or following the activity) for oral hygiene, toileting hygiene, shower/bathe self and personal hygiene. The MDS indicated Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sitting to standing, for chair/bed to chair transfer, walking 10 feet, walk 50 feet with two turns and to walk 150 feet. The MDS indicated Resident 1 needed set up for toilet transfer, and tub/shower transfer. During a review of Resident 1's Progress Notes dated 12/11/2025 at 3:00 a.m., the progress notes indicated Resident 1 showed signs of aggression (not specified [violent behavior]) when Resident 1 went to the nurses' station. The progress notes indicated Resident 1 had an argument (not specified) with Certified Nurse Assistant (CNA) 1. The progress notes indicated Resident 1 and CNA 1 used indecent (unacceptable) words (not specified) towards each other.During an interview on 12/12/2025 at 10:45 a.m., with Resident 1, Resident 1 stated that around 2:30 a.m. on 12/11/2025, he was asking Registered Nurse (RN) 1 at the nurse's station about a medical issue. Resident 1 stated CNA 1 interrupted his conversation with RN 1 and asked CNA 1 not to butt (interrupt) in his conversation. Resident 1 stated CNA 1 yelled at him and told him that she was going to get some raid on his ass. Resident 1 stated CNA 1 needed to behave professionally, instead of yelling. Resident 1 stated CNA 1 talked like she was on the streets.During a phone interview on 12/12/2025 at 12:26 p.m., with RN 1, RN 1 stated Resident 1 came around 3 a.m. on 12/11/2025, to the nurse's station and asked to switch CNA 1 with another CNA because he (Resident 1) did not like black women. RN 1 stated CNA 1 said something (not sure what was said) to Resident 1 while she (RN 1) was assisting the resident. RN 1 stated Resident 1 started to insult CNA 1 and CNA 1 started to talk loudly to the resident. RN 1 stated she reported the incident (CNA 1 talking loudly at Resident 1) to the incoming morning shift RN 2 (time not specified). RN 1 stated yelling at residents could be a form of abuse because the resident could feel threatened. RN 1 stated she should have reported the incident (staff yelling at resident) to the Department of Health by filing the Report of Suspected Dependent Adult/Elder Abuse (SOC 341- documentation of information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult). RN 1 stated, at that moment, she thought reporting it to the incoming RN 2 on 12/11/2025 7am- 3pm shift was enough. During a phone interview on 12/12/2025 at 1:46 p.m. with CNA 1, CNA 1 stated she did not yell or call Resident 1 names, disrespected nor said anything inappropriate (spraying bug killer) to Resident 1 on 12/11/2025 at around 2:30 a.m. CNA 1 stated she intervened when Resident 1 started to yell and insulted (unspecified) RN 1. CNA 1 stated Resident 1 started to yell at both CNA 1 and RN 1 and Resident 1 waived his hands at CNA 1. CNA 1 stated Resident 1 called RN 1 names (unspecified), [NAME] b bi h and disliked black women. CNA 1 stated staff should never yell at a resident.During an interview on 12/12/2025 at 2:40 p.m., with RN 2, RN 2 stated RN 1 did not report any incident about CNA 1 yelling at Resident 1 on 12/11/2025. RN 2 stated if it was reported to him, he would have reported it to the Administrator (ADM) and the Director of Nursing (DON.)During a phone

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 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 investigate the allegation of abuse for one of three residents (Resident 1), within 24 hours, as indicated in the facility's policy and procedure (P&P) titled, Abuse and Neglect Prohibition Policy.This failure placed the Resident 1 at risk for potential verbal abuse. This failure resulted in the facility to not protect the residents from potential abuse. 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 diagnoses included hypertension (high blood pressure), and legal blindness (a specific level of vision impairment defined by government standards. Visual acuity of 20/200 or less in the good eye).During a review of Resident 1's History and Physical (H&P) dated 9/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/12/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance which may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 1 required setup assistance (helper sets up or cleans up; resident completes activity/ helper assists only prior to or following the activity) for oral hygiene, toileting hygiene, shower/bathe self and personal hygiene. The MDS indicated Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sitting to standing, for chair/bed to chair transfer, walking 10 feet, walk 50 feet with two turns and to walk 150 feet. The MDS indicated Resident 1 needed set up for toilet transfer, and tub/shower transfer. During a review of Resident 1's Progress Notes dated 12/11/2025 at 3:00 a.m., the progress notes indicated Resident 1 showed signs of aggression (not specified [violent behavior]) when Resident 1 went to the nurses' station. The progress notes indicated Resident 1 had an argument (not specified) with Certified Nurse Assistant (CNA) 1. The progress notes indicated Resident 1 and CNA 1 used indecent (unacceptable) words (not specified) towards each other. The progress notes did not indicate an investigation was initiated regarding the verbal incident between Resident 1 and CNA 1. During an interview on 12/12/2025 at 10:45 a.m., with Resident 1, Resident 1 stated that around 2:30 a.m. on 12/11/2025, he was asking Registered Nurse (RN 1) at the nurse's station about a medical issue. Resident 1 stated CNA 1 interrupted his conversation with RN 1 and asked CNA 1 not to butt (interrupt) in his conversation. Resident 1 stated CNA 1 yelled at him and told him that she was going to get some raid on his ass. Resident 1 stated CNA 1 needed to behave professionally, instead of yelling. Resident 1 stated CNA 1 talked like she was on the streets. During a phone interview on 12/12/2025 at 1:18 p.m., with RN 1, RN 1 stated yelling at residents could be a form of abuse because the resident could feel threatened. RN 1 stated she should have reported the incident (staff yelling at resident) to the Administrator (ADM) immediately on 12/11/2025 so the incident could have been investigated and determined what interventions to implement to keep Resident 1 protected. RN 1 stated not reporting the incident to the ADM delayed the investigation and could have led to another verbal incident and physical confrontation. During a phone interview on 12/29/2025 at 11:02 a.m. with the ADM, the ADM stated the verbal altercation between CNA 1 and Resident 1 occurred on 12/11/2025 between 2:30 a.m. to 3:00 a.m. The ADM stated he was not aware of the verbal altercation between Resident 1 and CNA 1 until 12/12/2025 around 11:00 a.m. and that was the reason the facility did not start the investigation within 24 hours as per the facility's P&P. The ADM stated the delay in the investigation put Resident 1 at risk for further verbal abuse.During a review of the facility's P&P titled, Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated the facility must initiate an investigation within 24 hours of an allegation of abuse and thoroughly document in the facility's investigation form and log.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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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 0641 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 skin assessment was performed for one of three sampled residents (Resident 1), who was readmitted back to the facility on [DATE].This deficient practice resulted in a delay in identifying wounds and delayed in providing the care necessary to ensure good wound healing process and to prevent wound complications.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 diagnoses included urinary tract infection (UTI - infection in the urine) and muscle weakness.During a review of Resident 1's skin assessment on readmission on [DATE], Resident 1's clinical record did not indicate a skin assessment was conducted on readmission.During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 11/23/2025, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 1 was dependent on staff with rolling left to right, sitting to lying, sitting on side of bed, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. The MDS indicated Resident 1 was always incontinent of bowel. During a review of Resident 1's Order Listing Report dated 11/19/2025, revised 11/20/2025, the orders indicated the following: 1). Bilateral (both) lateral (side) feet- deep tissue injury (DTI- damage to soft tissues underneath intact skin, caused by pressure or shear, appearing as a purple or maroon area that can quickly worsen into a severe, deep wound)- cleanse with normal saline (NS - sterile saltwater that closely matches the salt and water balance in the human body), pat dry apply betadine (cleanser used to kill germs on skin prevent infections) and cover with Mepilex dressing (a type of wound dressing) daily (QD) and PRN (as needed), if soiled, every day shift2). Left medial ankle (bony inner side of ankle) abrasion (scraped)- cleanse with NS, pat dry, apply thin layer of triad cream (sterile paste used for the local management of various wounds) and cover with bordered dressing (multi-layer wound bandage with an absorbent pad in the center and an adhesive border around the edge) QD and PRN, if soiled every day shift3). Right hip abrasion- Cleanse with NS, pat dry, apply thin layer of triad cream to open wound and cover with bordered dressing QD and PRN, if soiled every dayshift.During a review of Resident 1's Order Listing Report dated 11/19/2025, revised 11/25/2025, the order indicated to cleanse the left hip pressure injury stage 2 (skin that breaks open, wears away, or forms an ulcer, which is usually tender and painful) with NS, pat dry, apply calcium alginate and cover with bordered dressing QD and PRN, if soiled every dayshift.During an interview on 12/10/2025 at 10:00 a.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated when Resident 1 was readmitted to the facility on [DATE] at 3:20 p.m., the license staff did not perform wound/skin assessment. LVN 2 stated there was no documentation that Resident 1's skin assessment was done on 11/18/2025 at 3:20 p.m. LVN 2 stated Resident 1's physician performed an assessment on 11/24/2025 (six days after the readmission date). LVN 2 stated it was important to perform skin/wound assessment immediately after admission/readmission to the facility to ensure accurate assessment of skin/skin wounds and so treatment can be started immediately. LVN 2 stated the wound care nurse started the treatment on 11/20/2025 for the new wounds at the bilateral feet (DTI), left medial ankle (abrasion), and right hip (abrasion) because Resident 1's skin was not assessed on 11/19/2025, when Resident 1 was re-admitted back to the facility.During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, dated 01/2018, the P&P indicated the facility should assess the resident on admission (within eight hours) for existing pressure injury risk factors, repeat the risk assessment weekly and upon any changes in condition. The P&P indicated to conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 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 follow professional standards of care by not talking loud at one of three sampled residents, (Resident 1).This deficient practice had the potential to result in verbal aggression and altercation, verbal abuse and can affect the resident's quality of life. This deficient practice had the potential to violate the resident's right to be free from any forms of abuse.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 diagnoses included hypertension (high blood pressure), and legal blindness (a specific level of vision impairment defined by government standards. Visual acuity of 20/200 or less in the good eye). During a review of Resident 1's History and Physical (H&P) dated 9/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/12/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance which may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 1 required setup assistance (helper sets up or cleans up; resident completes activity/ helper assists only prior to or following the activity) for oral hygiene, toileting hygiene, shower/bathe self and personal hygiene. The MDS indicated Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sitting to standing, for chair/bed to chair transfer, walking 10 feet, walk 50 feet with two turns and to walk 150 feet. The MDS indicated Resident 1 needed set up for toilet transfer, and tub/shower transfer. During a review of Resident 1's care plan titled, Resident 1 had the potential to be verbally aggressive to resident and staff related to ineffective coping skills (inability to manage stress, emotions or difficult situation) and poor impulse control (lack of self-control) indicated the following: 1). On 1/5/2023, Resident had the potential to be verbally aggressive (violent) to residents and staff related to ineffective coping skills and poor impulse control. 2). On 3/3/2023, Episode of Verbal aggression.3). On 7/27/2023, Resident was noted following behind staff to take care, made staff uncomfortable, pulling SSD door and banging on window.4). On 9/9/2023, Upset and yelling at staff for keeping the bedroom door open. 5). On 10/6/2025, Episode of yelling at RN Supervisor.The interventions indicated to assess resident's understanding of the situation and allow time to express self and feelings towards the situation, discuss an agreeable plan to allow the door to be open during intervals, encourage resident to express concerns and opinions, increase rounding when resident refuses to keep the door open for roommates safety checks, redirect resident PRN (as needed), respect the residents privacy and rights. During a review of Resident 1's Progress Notes dated 12/11/2025 at 3:00 a.m., the progress notes indicated Resident 1 showed signs of aggression (not specified [violent behavior]) when Resident 1 went to the nurses' station. The progress notes indicated Resident 1 had an argument (not specified) with CNA 1. The progress notes indicated Resident 1 and CNA 1 used indecent (unacceptable) words (not specified) towards each other. During an interview on 12/12/2025 at 10:45 a.m. with Resident 1, Resident 1 stated that around 2:30 a.m. on 12/11/2025, he was asking Registered Nurse (RN 1) at the nurse's station about a medical issue. Resident 1 stated Certified Nurse Assistant (CNA 1) interrupted his conversation with RN 1 and asked CNA 1 not to butt (interrupt) in his conversation. Resident 1 stated CNA 1 yelled at him and told him that she was going to get some raid on his ass. Resident 1 stated CNA 1 needed to behave professionally, instead of yelling. Resident 1 stated CNA 1 talked like she was on the streets. During a phone interview on 12/12/2025 at 12:26 p.m., with RN 1, RN 1 stated Resident 1 came around 3 a.m. to the nurse's station and asked to switch CNA 1 with another CNA because he (Resident 1) did not like black women. RN 1 stated CNA 1 said something (not sure what was said) to Resident 1 and Resident 1 started to insult CNA 1. RN 1 stated Resident 1 told her (RN 1) CNA 1 started to talk loudly to him (Resident 1). During a phone interview on 12/12/2025 at 1:18 p.m., with RN 1, RN 1 stated Resident 1 had always been very aggressive towards staff. RN 1 stated yelling at residents could be a form of abuse because the resident might feel threatened. During a phone interview on 12/12/2025 at 1:46 p.m. with CNA 1, CNA 1 stated she did not yell or call Resident 1 names, disrespect or said anything inappropriate (spraying bug killer) to Resident 1 on 12/11/2025 at around 2:30 a.m. CNA 1 stated she intervened when Resident 1 started to yell and insulted (unspecified) RN 1. CNA 1 stated

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 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 staff was trained regarding reporting requirements on alleged resident abuse, as indicated in its policy and procedure (P&P) titled, Abuse and Neglect Prohibition Policy.This deficient practice resulted in the delay of the facility's investigation of the alleged abuse incident and delayed reporting to the Licensing and Certification (L&C) Program District Office.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 diagnoses included hypertension (high blood pressure), and legal blindness (a specific level of vision impairment defined by government standards. Visual acuity of 20/200 or less in the good eye).During a review of Resident 1's care plan titled, aggressive behavior towards staff related to bipolar (mental health condition causing extreme mood swings, from intense highs with high energy and euphoria, to deep lows with sadness and hopelessness, affecting sleep, thinking, and behavior, and making daily tasks difficult) disorder and history of aggressive behavior towards staff initiated 11/17/2024, with revision date of 12/22/2025 the care plan interventions were to approach resident calmly, using a soft tone and non-threatening body language and to ensure safety first by removing the resident or staff from immediate danger. Use a calm, non-threatening approach.During a review of Resident 1's History and Physical (H&P) dated 9/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/12/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance which may be provided throughout the activity or intermittently) for eating, upper/lower body dressing and putting off footwear. The MDS indicated Resident 1 required setup assistance (helper sets up or cleans up; resident completes activity/ helper assists only prior to or following the activity) for oral hygiene, toileting hygiene, shower/bathe self and personal hygiene. The MDS indicated Resident 1 was independent (Resident completes the activity by themself with no assistance from a helper) with rolling from left to right, for sitting to lying, lying to sitting on side of the bed, sitting to standing, for chair/bed to chair transfer, walking 10 feet, walk 50 feet with two turns and to walk 150 feet. The MDS indicated Resident 1 needed set up for toilet transfer, and tub/shower transfer. During a review of Resident 1's Progress Notes dated 12/11/2025 at 3:00 a.m., the progress notes indicated Resident 1 showed signs of aggression (not specified [violent behavior]) when Resident 1 went to the nurses' station. The progress notes indicated Resident 1 had an argument (not specified) with CNA 1. The progress notes indicated Resident 1 and CNA 1 used indecent (unacceptable) words (not specified) towards each other. The progress notes did not indicate the verbal incident between Resident 1 and CNA 1 was reported to the Administrator (ADM) or to the L&C or to the California Department of Public health.During an interview on 12/12/2025 at 10:45 a.m. with Resident 1, Resident 1 stated that around 2:30 a.m. on 12/11/2025, he was asking Registered Nurse (RN 1) at the nurse's station about a medical issue. Resident 1 stated Certified Nurse Assistant (CNA 1) interrupted his conversation with RN 1 and asked CNA 1 not to butt (interrupt) in his conversation. Resident 1 stated CNA 1 yelled at him and told him that she was going to get some raid on his ass. Resident 1 stated CNA 1 needed to behave professionally, instead of yelling. Resident 1 stated CNA 1 talked like she was on the streets.During a phone interview on 12/26/2025 at 11:57 a.m. with LVN 1, LVN 1 stated he witnessed CNA 1 and Resident 1 were yelling at each other. LVN 1 stated he documented the incident in Resident 1's the progress notes. LVN 1 stated he did not report the incident to the ADM because the Registered Nurse (RN) Supervisor was present during the incident. LVN 1 stated that he was not aware how soon or to whom he would report the alleged abuse. LVN 1 stated he have not received any abuse prevention training in a long time (unable to say how long ago) because he worked the night shift During a phone interview on 12/29/2025 at 11:02 a.m. with the ADM, the ADM stated all facility staff were trained on abuse and neglect but could not remember the last training was conducted. The ADM stated not training all staff, including the night shift, on abuse and neglect policy, could lead to the facility's failure to report and investigate the alleged abuse timely.During a review of the facility's policy and procedure (P&P) titled Abuse and Neglect Prohibition Policy, dated 06/2022, the P&P indicated the facility's policy prohibit abuse, mistreatment, neglect through ongoing training for all employees.

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	12/12/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 3) call light was placed within reach.This deficient practice had the potential for the resident not to be able to call when assistance is needed, or when emergency arises, resulting in the delay of care and interventions which could be life threatening.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included muscle wasting and atrophy (the shrinking, thinning, and loss of muscle tissue, leading to decreased muscle mass, weakness, and reduced strength) and muscle weakness. During a review of Resident 3's History and Physical (H&P), dated 8/11/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool), dated 10/3/2025, the MDS indicated Resident 3 required supervision for eating, and upper body dressing. The MDS indicated Resident 3 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 3 was dependent with rolling left to right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. The MDS indicated Resident 3 was always incontinent of urine. During a concurrent observation and interview on 12/9/2025 at 2:20 p.m. with Resident 3, Resident 3 stated she did not know where her call light was and she needed some lotion because her arms were very dry. Resident 3 stated it made her sad whenever she needed help and she could not find a way to call for assistance. During a concurrent observation and interview on 12/9/2025 at 2:50 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 3's the call light was stuck under the mattress and was not within Resident 3's reach. LVN stated resident's call light should be accessible. LVN 1 stated Resident 3 would need to call when needing assistance with cleaning, when thirsty, when in pain, uncomfortable or with something more urgent. LVN 1 stated Resident 3 could also attempt to get out of bed and fall. During a concurrent observation and interview on 12/9/2025 at 2:52 p.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 3 was moved an hour ago to the room (unable to recall time), and she (CNA 1) did not realize the call light was stuck under the mattress and was not accessible to Resident 3. CNA 1 stated that having the call light not within reach could make Resident 3 not call if needing cleaned. CNA 1 stated Resident 3 could have been left soiled for a long time and could have developed skin breakdown when not changed timely. During a review of the facility's policy and procedure (P&P) titled, Answering Call Lights, dated 8/2017, the P&P indicated that the call light should be placed within easy reach of resident and should be answered as soon as possible.