| 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 | 01/06/2026 |

| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its infection prevention and control measures for three of four sampled residents (Residents 1, 2 and 3) by failing to:1.Ensure staff (Certified Nurse Assistants [CNA] 1, 3 and 4) wore Personal Protective Equipment (PPE-specialized clothing or equipment such as gloves and gown worn to minimize exposure to serious illness) while providing care to Residents 1, 2 and 3, who were on Enhanced Barrier precautions (EBP - an approach to the use of PPE to reduce transmission of Multidrug Resistant Organisms [MDRO- bacteria that are resistant to multiple antibiotics]).This failure had the potential to result in the transmission (spread) of disease-causing organisms leading to illness to residents.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included cervical (neck) spinal cord injury, neuromuscular (relating to the muscular and nervous systems) dysfunction of the bladder, and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).During a review of Resident 1's Care Plan titled Resident at risk for MDRO colonization ., dated 12/3/2024, the Care Plan indicated staff should use gown and gloves during high-contact activities with a goal to not develop signs and symptoms of MDRO infection.During a review of Resident 1's History and Physical (H&P), dated 2/4/2025, the H&P indicated Resident 1 had the capacity to make medical decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment, had an indwelling catheter, and was dependent (helper does all the effort) on staff for personal hygiene, toileting hygiene, and rolling left and right.During a review of Resident 1's Bowel and Bladder Evaluation, dated 12/19/2025, the Evaluation indicated Resident 1 had a foley catheter ([FC], a thin, flexible tube inserted into the bladder to drain urine).During a review of Resident 1's Order Summary Report, dated 1/6/2026, the Report indicated Resident 1 had an order for an indwelling FC for neurogenic bladder (dysfunction of the bladder due to muscular and nervous system issues). The Report indicated staff were to follow EBP due to the presence of Resident 1's FC.During an observation on 1/6/2026 at 8:06 a.m., in Resident 1's room, CNA 1 was observed not wearing a gown and gloves while providing care to Resident 1. CNA 1's uniform, hands, and arms touched Resident 1 and Resident 1's linens while providing mobility assistance to the resident.2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included quadriplegia, neurogenic bowel (dysfunction of the bowel due to muscular and nervous system issues), and neuromuscular dysfunction of bladder.During a review of Resident 2's Care Plan titled, Resident at risk for MDRO colonization., dated 12/3/2024, the Care Plan indicated staff should use gown and gloves during high-contact activities with the goal to not develop signs or symptoms of MDRO infection.During a review of<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 |
|---|---|---|

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 2's Order Summary Report, dated 1/15/2025, the Report indicated Resident 2 required enhanced EBP due to the presence of Resident 2's suprapubic catheter (a thin tube draining urine from the bladder through a small opening in the lower abdomen).During a review of Resident 2's H&P, dated 8/12/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had no cognitive impairment, had an indwelling catheter, and was dependent on staff for eating, oral hygiene, personal hygiene, and rolling left and right (in bed).During a review of Resident 2's Bowel and Bladder Evaluation, dated 12/23/2025, the Evaluation indicated Resident 2 had a suprapubic catheter. During an observation on 1/6/2026 at 8:43 a.m., in Resident 2's room, CNA 4 was observed not wearing a gown while feeding Resident 2 breakfast.3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3 had diagnoses including colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), cellulitis (a skin infection that causes swelling and redness), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's H&P, dated 10/1/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions.During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had severely cognitive impairment. The MDS indicated Resident 3 had an ostomy, required touching assistance (helper provides verbal cues and/or touching) to eat and was dependent on staff for toilet hygiene and showering.During a review of Resident 3's Bowel and Bladder Evaluation, dated 1/6/2026, the evaluation indicated Resident 3 had a colostomy.During a review of Resident 3's Order Summary Report, dated 1/6/2026, the Report indicated Resident 3 required EBP due to his colostomy.During an observation on 1/6/2026 at 8:18 a.m., in Resident 3's room, CNA 1 and CNA 3 were observed not wearing a gown and gloves when they moved and repositioned Resident 3. CNA 1 and CNA 3's uniforms and hands touched Resident 3 and his linens.During a concurrent observation, interview and record review on 1/6/2026 at 8:22 a.m., in Resident 3's room, CNA 3 was observed not wearing a gown and gloves while feeding Resident 3. The EBP Informational Sign, dated 9/9/2024, was reviewed. CNA 3 stated staff were required to wear a gown and gloves for all high-contact activities with Resident 3, which included feeding and repositioning the resident, to prevent infection transmission.During a concurrent interview and record review on 1/6/2026 at 8:58 a.m., with Licensed Vocational Nurse (LVN) 1, the EBP Information Sign, dated 9/9/2024, was reviewed. LVN 1 stated staff should wear gowns and gloves any time high-contact resident care activities occur, including feeding, turning, and repositioning Residents 1, 2, and 3. LVN 1 stated Residents 1, 2, and 3 were at higher risk of infection when staff did not wear gowns and gloves during high-contact care.During a concurrent interview and record review on 1/9/2026 at 2:22 p.m., with the Director of Nursing (DON), the facility's P&P titled, Enhanced Barrier Precautions, dated 6/29/2022, the facility's Enhanced Barrier Precaution Informational Sign, dated 9/9/2024, Resident 1's care plan titled Resident at risk for MDRO colonization., dated 12/3/2024, Resident 2's care plan titled Resident at risk for MDRO colonization., dated 12/3/2024, and Resident 3's Order Summary Report, dated 1/6/2026, were reviewed. The DON stated high-contact resident care activities included feeding, and mobility assistance such as turning and repositioning, due to staff's close proximity to the residents. The DON stated staff should have been wearing a gown and gloves while feeding, repositioning, and turning Residents 1, 2, and 3.During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated 6/29/2022, the P&P indicated EBP is an infection control intervention to reduce transmission of resistant organisms that employs targeted gown and glove use during high<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | contact resident care activities. EBP is indicated for residents with indwelling medical devices (e.g. feeding tube, urinary catheter) or wounds. The P&P indicated gowns and gloves are required prior to high-contact care activities. |