STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER: California Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from unnecessary psychotropic medications (medications that affect the mind, emotions, and behavior) when: a. Resident 1's order for Depakote (a prescription anticonvulsant and mood-stabilizing medication), started 3/18/2026, did not indicate a documented behavior for use. b. Resident 1 was not monitored for the effectiveness of her use of Depakote. This deficient practice placed Resident 1 at risk for experiencing potential adverse effects from continued Depakote use, including liver failure and severe inflammation of the pancreas (an organ of the digestive system and endocrine system of vertebrates).Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and was most recently readmitted to the facility on [DATE]. Resident 1's diagnoses included metabolic encephalopathy (a non-structural brain dysfunction caused by systemic illness, organ failure, or chemical imbalances) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment (a profound loss of mental capacity, including memory, reasoning, and communication, that prevents independent living). The MDS indicated Resident 1 required supervision or touch assistance from staff for eating, personal hygiene, and walking in areas outside of her room. During a review of Resident 1's physician order, dated 3/18/2026, the order indicated staff were to administer Depakote 250 milligrams (mg, a unit of dose measurement) twice a day as a mood stabilizer related to her diagnosis of schizophrenia. The order did not indicate the specific mood or behavior the Depakote was indicated to treat or manage. During an interview on 4/16/2026 at 4:05 p.m., with the Director of Nursing (DON), the DON stated physician orders for psychotropics should include the specific behavior the medication is intended to treat or manage. The DON stated this allowed the staff to monitor the effectiveness of the medication and identify if it was still necessary. The DON stated Resident 1's Depakote order did not identify the specific quantifiable behavior staff were to monitor. The DON stated this resulted in Resident 1 receiving the medication without any behavior monitoring. During a review of the facility's policy and procedure (P&P) titled Antipsychotic Medication Use, dated 1/2018, the P&P indicated that the attending physician, with input from other disciplines, was to identify and document symptoms that may warrant the use of antipsychotic medications. The P&P also indicated diagnoses alone were not enough to warrant the use of antipsychotic medication.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) accurately reflected the visual and clinical status for one of two sampled residents (Resident 1). This deficient practice resulted in Resident 1 not having a care plan developed to address her impaired visual status and created the potential for the severity of her visual impairment to be unidentified. This deficient practice also created the potential for Resident 1 to not receive the necessary care and interventions for the medications she was receiving.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 1's diagnoses included metabolic encephalopathy (a non-structural brain dysfunction caused by systemic illness, organ failure, or chemical imbalances). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment (a profound loss of mental capacity, including memory, reasoning, and communication, that prevents independent living). The MDS indicated Resident 1 required supervision or touch assistance from staff for eating and personal hygiene. The MDS indicated Resident 1 had impaired vision. The MDS did not indicate the level of Resident 1's visual impairment. The MDS did not indicate Resident 1 was receiving anticonvulsant medications (used to prevent or treat seizures by controlling abnormal electrical activity in the brain). a. During an observation on 4/16/2026 at 8:58 a.m., in the dining room, Resident 1 was observed seated on a wheelchair next to the window. Resident 1 did not make eye contact, and was unable to track objects in the environment. Two fingers were held up at eye-level less than two feet from Resident 1. When asked how many fingers were held up, Resident 1 responded Five. When three fingers were held up, Resident 1 could not state the number. Resident 1 identified a black blouse as red. During an interview on 4/16/2026 at 11:43 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she knew Resident 1 could barely see because of the way the resident navigated through the facility. CNA 1 stated Resident 1 walked into things. CNA 1 stated she had to ensure Resident 1's walkways were clear to prevent accidents. CNA 1 stated that Resident 1 would often reach in front of her to feel her way around the environment. During an interview on 4/16/2026 at 2:13 p.m., with the Social Services Assistant (SSA), the SSA stated she completed the vision assessment portion of Resident 1's MDS dated [DATE]. The SSA stated she was never trained on how to complete the vision assessment of the MDS, and stated she was not sure what the purpose of the MDS was. The SSA stated she indicated Resident 1 had vision impairment due to her inability to track objects in her environment, and her observation of Resident 1 displaying minimal blinking when spoken to. The SSA stated she did not ask Resident 1 to read any text or printed material to determine the severity of Resident 1's visual impairment. b. During a review of Resident 1's physician's order, dated 12/19/2026 to 3/3/2026, the order indicated Resident 1 was to receive divalproex sodium (Depakote, used to treat certain types of seizures) twice a day. During a review of Resident 1's Medication Administration Record (MAR), dated 1/1/2026 to 1/31/2026, the MAR indicated Resident 1 received divalproex sodium within the MDS 7-day look-back period (a predetermined period from which clinical data is gathered while completing the MDS). During an interview on 4/16/2026 at 4:11 p.m., with the Director of Nursing (DON), the DON stated the facility did not currently have a nurse assigned to assist with completing MDS assessments. The DON stated the purpose of the MDS was to guide the plan of care and stated all MDS assessment should be accurate. The DON stated the Resident Assessment Instrument manual (RAI, a comprehensive, CMS-published guide for nursing homes, detailing how to use the Minimum Data Set (MDS) 3.0 to assess resident health, functional status, and care needs) should be used to guide completion of the MDS. During a review of the facility's policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment, dated 1/2026, the P&P indicated that any healthcare professionals who (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	participated in the assessment process were to be qualified to assess the medical, functional and/or psychosocial status of the resident. The P&P indicated the information captured on the assessment was to reflect the status of the resident during the observation (look-back) period for that assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was provided with one-to-one supervision (1:1, close supervision) per the care plan. This deficient practice resulted in Resident 1 wandering into another resident (Resident 2's) room multiple times, and Residents 1 and 2 having a witnessed resident-to-resident altercation in the hallway on 4/2/2026.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 1's diagnoses included metabolic encephalopathy (a non-structural brain dysfunction caused by systemic illness, organ failure, or chemical imbalances) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment (a profound loss of mental capacity, including memory, reasoning, and communication, that prevents independent living). The MDS indicated Resident 1 required supervision or touch assistance from staff for eating, personal hygiene, and walking in areas outside of her room. During a review of Resident 1's Change of Condition (COC) assessment, dated 1/1/2026, the assessment indicated on 1/1/2026, Resident 1 was entering other residents' rooms asking the resident to have sexual intercourse. During a review of Resident 1's progress note, dated 1/1/2026, the progress note indicated on 1/1/2026, Resident 1 entered multiple male resident's rooms. The progress note indicated Resident 1 approached male residents, caressing their faces and attempting to kiss them. During a review of Resident 1's progress note, dated 1/2/2026, the progress note indicated on 1/2/2026, Resident 1 was observed entering a male resident's room, and despite being asked multiple times by the male resident to leave, she continued to approach him. The progress note indicated that staff redirected Resident 1 back to her room, but the resident continued to wander throughout the facility for another hour. During a review of Resident 1's progress note, dated 1/3/2026, the progress note indicated on 1/3/2026, Resident 1 was observed making inappropriate verbal comments to other residents. The progress note indicated Resident 1 needed to be reminded of appropriate boundaries. During a review of Resident 1's COC assessment, dated 3/29/2026, the COC assessment indicated on 3/29/2026, Resident 1 touched another resident while they were in bed. The COC assessment indicated Resident 1 was redirected away from the resident by staff. The COC assessment indicated Resident 1 required 1:1 supervision to ensure the safety of other residents and prevent further intrusive behavior. During a review of Resident 1's care plan titled Risk for Injury to Others related to intrusive behavior., dated 3/29/2026, the care plan indicated nursing staff were to initiate one-on-one supervision as indicated to ensure resident safety and prevent intrusive contact with other residents. The care plan indicated staff were to provide close supervision when [Resident 1] is near other residents or in shared areas. During a review of Resident 1's COC assessment, dated 4/2/2026, the assessment indicated on 4/2/2026, Resident 1 was in the hallway near the kitchen with another resident (Resident 2). The assessment indicated Resident 2 grabbed Resident 1's hand firmly and the residents were separated. 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 generalized muscle weakness, difficulty walking, and depression (a common, serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was cognitively intact. The MDS indicated Resident 2 could eat with set-up/clean-up assistance from staff, and required supervision/touch assistance from staff for mobility while in his wheelchair. During an interview on 4/16/2026 at 9:55 a.m., with Resident 2, Resident 2 stated he was sitting in his wheelchair, in front of the kitchen, when Resident 1 approached him. Resident 2 stated Resident 1 walked up to him and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	touched his genitals without his permission. Resident 2 stated he grabbed Resident 1's wrist to move her hand away from his genitals. Resident 2 stated he did not want Resident 1 to touch him and stated the contact made him uncomfortable. During an interview on 4/16/2026 at 11:43 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 4/2/2026, she was assigned to Resident 1's care. CNA 1 stated Resident 1 was not on 1:1 supervision on 4/2/2026. CNA 1 stated Resident 1 was placed on 1:1 after the incident with Resident 2 occurred. CNA 1 stated Resident 1 had a known behavior of touching others. During an interview on 4/16/2026 at 12:00 p.m., with CNA 2, CNA 2 stated Resident 1 had a history of always touching everybody, and wandering into other residents' rooms. CNA 2 stated a lot of residents had problems with her because of this behavior. CNA 2 stated that in the days leading up to the altercation with Resident 2 on 4/2/2026, Resident 1 wandered into Resident 2's room multiple times. CNA 2 stated this upset Resident 2 and he would yell at her to leave. CNA 2 stated that Resident 1 was not on 1:1 supervision when she wandered into Resident 2's room prior to the altercation, or on 4/2/2026 when the altercation occurred. During a review of the facility's staffing document for 3/30/2026, 3/31/2026, and 4/1/2026, the document did not indicate Resident 1 was on 1:1 monitoring. During an interview on 4/16/2026 at 3:54 p.m., with the Director of Nursing (DON), the DON stated Resident 1's care plan titled Risk for Injury to Others related to intrusive behavior.,, dated 3/29/2026 was reviewed. The care plan indicated Resident 1 was to be on 1:1 monitoring due to her wandering behavior and history of touching others. The DON stated it was important for the care plan intervention of 1:1 monitoring to be followed for Resident 1's safety. The DON stated 1:1 monitoring also ensured the other facility residents' rights and dignity could be respected and maintained. The DON stated he did not know why Resident 1 was not on 1:1 monitoring as indicated in the care plan. The DON stated the lack of 1:1 monitoring created the potential for unwanted contact between Resident 1 and other residents. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, dated 1/2018, the P&P indicated the facility's individualized, resident-centered approach to safety addressed safety for individual residents. The P&P indicated the care team targeted was to target interventions to reduce individual risks, including adequate supervision. The P&P indicated staff were to ensure these interventions were implemented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accident hazards and fall risks were identified and care planned for one of two sampled residents (Resident 1) when: a. Resident 1, who was at risk for falls, did not have a care plan to address her impaired vision. b. Staff failed to conduct a fall risk assessment following Resident 1's fall on 10/6/2025. c. Staff failed to document a Change of Condition (COC) assessment following Resident 1's unwitnessed fall on 3/20/2026. These deficient practices placed Resident 1 at risk for repeat falls, with subsequent injuries and complications. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 1's diagnoses included metabolic encephalopathy (a non-structural brain dysfunction caused by systemic illness, organ failure, or chemical imbalances) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment (a profound loss of mental capacity, including memory, reasoning, and communication, that prevents independent living). The MDS indicated Resident 1 required supervision or touch assistance from staff for eating, personal hygiene, and walking in areas outside of her room. The MDS indicated Resident 1 had impaired vision. a. During an interview on 4/16/2026 at 4:21 p.m., with the Director of Nursing (DON), the DON stated Resident 1's MDS, dated [DATE], indicated Resident 1 had impaired vision. The DON stated a care plan should have been developed for Resident 1's impaired vision to ensure her safety, including possible falls. b. During a review of Resident 1's Fall Risk Assessments, Resident 1 was identified as at high risk for falls on 10/3/2026. During a review of Resident 1's progress note, dated 10/6/2025, the progress note indicated Resident 1 fell in the lobby. c. During a review of Resident 1's progress note, dated 3/20/2026, the progress note indicated on 3/20/2026, Resident 1 was found on the floor in the rehabilitation room following an unwitnessed fall. The progress note indicated Resident 1 appeared confused and had tripped on the weight scale while walking inside the rehabilitation room. During an interview on 4/16/2026 at 4:25 p.m., with the DON, the DON stated Resident 1 did not have a Fall Risk Assessment following her fall on 10/6/2025, or a COC assessment conducted following her fall on 3/20/2026. The DON stated the expectation was that a Fall Risk Assessment was to be conducted following any fall. The DON stated a Fall Risk Assessment should have been completed to identify Resident 1's fall risks and identify interventions to prevent further falls. The DON stated there should have been a COC assessment because it would prompt monitoring of the resident, assessment of any possible injuries, updating of the care plan, and would ensure all necessary parties (e.g., responsible party, physician) were notified. During a review of the facility's P&P titled Care Planning - Interdisciplinary Team, dated 1/2018, the P&P indicated a comprehensive plan of care was to be developed within seven (7) days of completion of the resident assessment (MDS), and stated the care plan was based on the MDS. During a review of the facility's P&P titled Safety and Supervision of Residents, dated 1/2018, the P&P indicated the interdisciplinary team (IDT) was to analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated staff were to then target interventions to reduce individual risks related to hazards, including adequate supervision. During a review of the facility's P&P titled Change in a Resident's Condition or Status, dated 1/2026, the P&P indicated staff were to notify the resident's attending physician promptly when there has been an accident or incident involving the resident. The P&P indicated that prior to notifying the physician, staff were to make detailed observations and gather relevant information prompted by the COC assessment form. The P&P indicated the nurse was to record in the resident's medical record information relative to changes in the resident's condition.