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	06/15/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement it's policy and procedures (P&Ps) titled Injuries of Unknown Origin - Investigation and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, for one of two sampled residents (Resident 1), following the identification of swelling to Resident 1's right eye. This failure resulted in delayed notification of the State Agency (SA), and a subsequent delay in the initiation of the facility's investigation. The failure also increased the potential for additional incidents of injury of unknown origin to occur or abuse to occur.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 1 had severe cognitive impairment (a significant deterioration in intellectual capacity that prevents independent living). The MDS indicated Resident 1 was dependent on staff for toileting and personal hygiene, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 was dependent on staff for all mobility while in and out of bed. During a review of Resident 1's progress note, dated 5/29/2026 at 7:40 a.m., written by Registered Nurse (RN) 1, the progress note indicated on 5/29/2026, Resident 1 was noted with a bump above his right eye while. The progress note indicated staff were to monitor Resident 1 for 72 hours regarding abuse. During a review of Resident 1's Change of Condition (COC) assessment, dated 5/29/2026, the assessment indicated on 5/29/2026, Resident 1 was found with a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) above his right eye and swelling to the right eye. Staff applied an ice pack to help reduce pain and swelling. During a review of Resident 1's progress note, dated 5/29/2026 at 11:28 a.m., written by the Director of Nursing (DON), the progress note indicated report was received from the licensed nurse regarding a hematoma noted to the resident's [Resident 1] right eye. The progress note indicated Resident 1 was unable to provide a clear or consistent explanation for the cause of the injury. The progress note indicated Resident 1 later reported an unidentified person struck him in the eye. During an attempted interview on 6/8/2026 at 10:30 a.m., with Resident 1, Resident 1 was unable to recall the injury to his right eye or how it happened. During an interview on 6/8/2026 at 12:35 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that on 5/29/2026, around 7:10 a.m., she saw Resident 1 exiting his room in his wheelchair. CNA 1 stated because she was familiar with Resident 1 she noticed the resident had a new injury to his right eye. CNA 1 stated his right eye was swollen and stated it was not like that the day before. CNA 1 stated she reported the injury to the Charge Nurse (Licensed Vocational Nurse [LVN] 1) right away. During an interview on 6/8/2026 at 12:50 p.m., with LVN 1, LVN 1 stated CNA 1 notified her Resident 1 had a bump on his eye. LVN 1 stated the area above Resident 1's eye was swollen and Resident 1 could not fully open his right eye. LVN 1 stated Resident 1 could not state how it happened. LVN 1 stated she reported the injury to Registered Nurse (RN 1) right away because that was the facility protocol when an injury was identified. During an interview on 6/8/2026 at 11:07 a.m., with RN 1, RN 1 stated Resident 1's injury was first identified around on 5/29/2026 between 7:20 a.m. to 7:30 a.m. RN 1 stated staff informed him Resident 1 had a bump above his right eye. RN 1 (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he assessed Resident 1 and saw a bulge above his right eye and Resident 1 could not state how the injury happened. RN 1 stated he immediately notified the DON via telephone and notified the Administrator (ADM) in person. RN 1 stated the facility policy was to report any suspected abuse or injuries immediately. RN 1 stated prompt reporting was to ensure that investigations could be initiated timely, and to prevent any repeat incidents of abuse. During an interview on 6/8/2026 at 1:35 p.m., with the DON, the DON stated RN 1 called him on 5/29/2026 at 7:37 a.m. The DON stated RN 1 informed him that Resident 1 had swelling to his right eye and could not report how it happened. The DON stated he did not consider Resident 1's swollen eye as an injury of unknown origin because it was not reported that there was discoloration, pain, or a skin tear. The DON stated that swelling to the right eye was not enough to classify it as an injury of unknown origin. The DON stated other causes needed to be ruled out first, prior to reporting. The DON stated Resident 1 later reported, around 9:30 a.m., that the swelling was the result of someone hitting him. The DON stated he reported this allegation to the ADM, but all staff were capable in reporting allegations of potential abuse or injury of unknown origin, including himself. The DON stated timely reporting ensured investigations were carried out and pertinent interventions were implemented. The DON stated it also helped prevent any further harm to the affected resident or other facility residents. The DON stated the incident should have been reported to the State Agency sooner. During an interview on 6/8/2026 at 2:42 p.m., with the ADM, the ADM stated the DON did not notify him of Resident 1's allegation of being hit. The ADM stated he was not made aware of Resident 1's injury until around 10:00 a.m. on 5/29/2026. The ADM stated that when he observed the swelling to Resident 1's right eye, the swelling looked like an obvious injury and should have been identified as reportable right away. The ADM stated Resident 1 was confused and had no information about how it happened, therefore it was reported. The ADM stated timely reporting in situations of an injury of unknown origin helped to keep the facility residents safe. The ADM stated there was nothing in the facility's policies indicating staff were to verify the validity of an allegation or suspicion before they can report it. The ADM stated that if there was swelling and the source was unknown, the expectation is that it was reported right away. During a review of the facility's record titled Follow-Up Investigation Report, dated 6/2/2026, the record indicated Resident 1 had a bump above his eyebrow and the cause of the swelling was unknown. The record did not include Resident 1's allegation that he was hit by an unidentified individual. The record indicated the ADM was made aware of the injury on 5/29/2026 at 10:15 a.m. The record indicated Resident 1's injury was reported to the State Agency on 5/29/2026 at 12:00 p.m. During a review of the facility's policy and procedure (P&P) titled Injuries of Unknown Origin - Investigation, dated 1/2018, the P&P indicated it was the facility's policy to protect the health and safety of resident by ensuring that all unexplained injuries were promptly and thoroughly investigated and addressed to ensure that resident safety was not compromised, and action was taken to avoid future occurrences. The P&P indicated an injury of unknown source was defined as an injury that was not observed or could not be explained by the resident and was suspicious because of the extent of the injury. During a review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 1/2026, the P&P indicated all reports and/or suspicions of resident abuse (including injuries of unknown origin) were to be reported immediately to the ADM, local, state and federal agencies.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three (3) sampled residents (Resident 4), did not develop a stage 3 pressure ulcer (a severe skin injury with full-thickness skin loss where the underlying fat is exposed) at the facility. The facility failed to:1). Ensure Resident 4's pressure points (sacrum [triangular-shaped bone at the base of the spine], coccyx [tailbone], ischium [the lower and back part of the hip bone], trochanter [hip]) were inspected daily, as indicated in its policy and procedure (P&P) titled, Prevention of Pressure Injuries (injuries to the skin over bony areas), which indicated, the facility will inspect residents' pressure points daily, for the presence of erythema (redness), skin temperature and soft tissue edema (swelling), during residents care. 2). Implement Resident 4's care plan titled Impaired Skin Integrity related to immobility, incontinence (no control of bowel and bladder function), poor perfusion (reduced or not enough blood flow to body parts), malnutrition as evidenced by stage two ([2] a partial-thickness skin loss involving damage to the outer layers of the skin [the epidermis and dermis]) on the left thigh, which indicated the facility will reposition the resident every 2 hours and as needed, and assess the resident's skin every shift for skin breakdown (open areas or changes in skin). 3). Ensure the Certified Nurse Assistants (CNAs) observed and documented Resident 4's skin condition during showers and bed baths, on the Skin Monitoring: Comprehensive Certified Nurse Assistant Shower Review form for timely identification of new skin breakdown and providing intervention. 4). Turn Resident 4 every 2 hours, change the resident when soiled and keep the resident clean and dry, per Resident 4's Situation, Background, Assessment, Recommendation Communication Form (SBAR- a communication tool used by healthcare workers when there is a change in a resident's condition). 5). Ensure Resident 4's name was included in the Activities of Daily Living (ADL) Repositioning Rounds Monitoring log on 5/3/2026 (afternoon shift) and 5/3/2026 to 5/4/2026 (night shift). These failures resulted in Resident 4 acquiring a stage 3 pressure ulcer on the sacrum area on 5/4/2026.Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis affecting one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, muscle weakness, muscle wasting (muscle thinning) and atrophy (muscle tissue loses mass and shrinks), severe protein-calorie malnutrition (a severe form of undernutrition caused by insufficient intake of both protein and calories, leading to muscle wasting, fat loss, and impaired bodily functions), absence of left leg below knee, peripheral vascular disease (a common condition characterized by narrowed arteries that reduce blood flow to the limbs, primarily the legs, leading to symptoms like leg pain and cramping) and dysphagia (difficulty swallowing). During a review of Resident 4's admission Skin assessment dated [DATE], the admission skin assessment indicated Resident 4 had an ulcer on the left hip (no measurement or other descriptions indicated). During a review of Resident 4's Braden Scale (a standardized tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers, or bedsores) dated 4/7/2026 and 4/14/2026, the Braden scale indicated Resident 4 was at risk for developing pressure ulcers. During a review of Resident 4's Care Plan titled Impaired Skin Integrity related to immobility, incontinence poor perfusion malnutrition as evidenced by stage 2 on the left thigh, dated 4/7/2026, the interventions indicated to reposition every 2 hours and as needed, assess skin every shift for skin breakdown (open areas or changes in skin), keep skin clean and dry after each incontinence episode, offload pressure to bony areas. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 4/11/2026, the MDS indicated Resident 4 was usually able to understand and be understood by others. The MDS indicated Resident 4 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) (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 0686 Level of Harm - Actual harm Residents Affected - Few	on staff for ADL such as eating, oral hygiene, toileting, shower/bathe, and upper/lower body dressing. Resident 4 was dependent on staff on rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, chair/bed, and tub/shower transfer. Resident 4 had an indwelling catheter (thin, flexible tube inserted into the bladder to continuously drain urine) and was always incontinent of bowel. Resident 4 was at risk of pressure/injuries and had one or more unhealed pressure ulcers /injuries. During a review of Resident 4's Nursing Weekly Summary (a document containing records of vital signs, skin assessment, bowel and bladder function, pain management, cognitive patterns, ADL function, nutrition and hydration status), dated 4/8/2026, 4/15/2026, 4/22/2026 and 4/29/2026, the Nursing Weekly Summary did not indicate Resident 4 was included on the turning and repositioning program or that the resident's skin was assessed. During a review of Resident 4's Skin Monitoring: Comprehensive CNA Shower Review form, dated 4/7/2026 to 5/5/2026, the form indicated to perform a visual assessment of the resident's skin during showers, report any abnormal looking skin to the charge nurse immediately, by describing and graphing all abnormalities by number, using the body chart (in the form). The section subtitled visual assessment dated 4/7/2026 to 5/5/2026 were blank. During a review of the ADL Repositioning Rounds Monitoring log dated 5/3/2026, for the evening shift (3pm-11pm) and 5/3/2026 to 5/4/2026, for the night shift (11pm to 7pm), the log did not indicate Resident 4 was included in the repositioning schedule and was not turned or repositioned every 2 hours. During a review of Resident 4's every shift Documentation Survey Report for the month of 5/2026, the sections subtitled, Monitor- Resident turned and repositioned every 2 hours, unless otherwise indicated, and Monitor- skin observation, were blank on 5/3/2026 and 5/5/2026 day shifts (7a.m. to 3p.m.). During a review of Resident 4's SBAR dated 5/4/2026 at 3:29 p.m., the SBAR indicated Resident 4 had a stage 3 pressure injury at the sacrum/coccyx area. The SBAR indicated resident not being repositioned every 2 hours or changed when soiled, made the condition worse, and repositioning the resident every 2 hours and keeping the resident clean and dry, could have made the condition or symptoms better. During a review of Resident 4's Physician Assistant's Wound Progress Note dated 5/4/2026, the progress notes indicated Resident 4 had a newly developed sacral pressure ulcer acquired on 5/4/2026. The progress notes indicated the pressure ulcer was a stage 3, measured 4 centimeters (cm- unit of measurement [unspecified]) by 4 cm (unspecified), with a 0.10 cm depth, 51 to 75 percent (%) granulation (new tissues) and 1 to 25 % slough (dead tissue, yellowish, or white stuff that forms inside a cut or wound while it heals). During a concurrent interview and record review on 6/11/2026 at 2:53 p.m., with the Licensed Vocational Nurse (LVN) 3, Resident 4's SBAR dated 5/4/2026, was reviewed. The SBAR dated 5/4/2026 3:30 p.m., indicated a stage 3 pressure injury at the sacrum coccyx area likely related to prolonged pressure and inadequate repositioning. The LVN 3 stated the SBAR indicated on 5/4/2026, Resident 4 developed a stage 3 pressure ulcer on the sacrum. The LVN 3 stated Resident 4's sacral wound developed due to lack of turning and prolonged pressure. Resident 4 was bedridden, could not turn on his own, did not have diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and had an intact skin at the sacral area. LVN 3 stated Resident 4 had a healed surgical left stump (below the knee amputation [removal of part of the limb]) wound, a pressure ulcer on the left hip, skin tear on the inner left thigh, and a skin tear to the right buttock but no wound on the sacrum area. LVN 3 stated before a wound progresses to a stage 3, the wound would have started as a stage 1 (the earliest form of skin damage caused when a certain spot on the body is squeezed by sitting or lying down for too long, causing the skin to turn red or change color and get a little sore), then stage 2 , then stage 3 where the wound would become deep into fat or muscle. LVN 3 stated Resident 4's stage 3 pressure ulcer did not develop overnight. LVN 3 stated that when CNAs provided residents with ADL care, the CNAs did not check Resident 4's skin and report skin changes to charge nurses so the resident could be treated right away to prevent the skin from becoming worse. During a concurrent interview and record review on 6/15/2026 at 2:08 p.m., with the Director of Nursing (DON), Resident 4's Skin Monitoring: Comprehensive CNA Shower Review dated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4/11/2026, 4/14/2026, 4/18/2026, 4/21/2026, 4/25/2026, 4/28/2026, and 5/1/2026, Resident 4's ADL Repositioning Rounds Monitoring report dated 5/3 to 5/4/2026 p.m. (evening) and the 5/3/2026 to 5/4/2026 noc (night shift) and Resident 4's care plan titled Impaired Skin Integrity related to immobility, incontinence, poor perfusion, malnutrition as evidenced by stage 2 on the left thigh, dated 4/7/2026, were reviewed. The Skin Monitoring: Comprehensive CNA Shower Review indicated to perform a visual assessment of Resident 4's skin during showers, document and report any abnormal looking skin to the charge nurse immediately. The DON stated the licensed nurses were not documenting resident's daily skin assessments. The DON stated Resident 4 had multiple skin issues (unspecified), however the CNAs did not indicate the resident's skin condition in the skin monitoring reports dated 5/1/2026 and 5/5/2026. Resident 4's ADL Repositioning Rounds Monitoring reports did not indicate Resident 4 was included in the repositioning schedule to be turned or repositioned every 2 hours. Resident 4's care plan interventions indicated to reposition the resident every 2 hours and as needed, assess the skin every shift for skin breakdown, and keep Resident 4's skin clean and dry. The DON stated there was no indication Resident 4's skin was assessed or the resident was turned or repositioned every 2 hours. The DON stated any care not document meant it was not done and led to unidentified skin problems. During a phone interview on 6/25/2026 at 9:39 a.m. with CNA 4, CNA 4 stated Resident 4 was supposed to be turned every two hours. CNA 4 stated the facility had a folder for titled Repositioning Rounds Monitoring and the CNAs would log in when they turned residents and the LVN would co sign. CNA 4 stated she did not know if Resident 4's name was missing on 5/3 to 5/4/2026 from the list. CNA 4 stated CNAs document turning every 2 hours on the Kiosk (small electronic device to document tasks) and she did not know why it was not documented for Resident 4 on 5/3/2026. CNA 4 stated they are supposed to document any new skin changes on the skin monitoring shower sheet. CNA 4 stated she was assigned to Resident 4 a couple of times, but she did not remember Resident 4 having any new skin issues. CNA 4 stated she never documented anything for Resident 4. During a concurrent phone interview and record review on 6/26/2026 at 9:58 a.m. with the DON, Resident 4's Skin Monitoring: Comprehensive CNA Shower Review document indicating to perform a visual assessment of the resident's skin during showers, was reviewed. The DON stated CNAs were not allowed to perform skin assessment because it's not within their scope of practice. The DON stated CNAs were to report new skin issues for license nurse to assess. During a review of the facility's P&P titled, Bath/ Shower, dated 01/2018, the P&P indicated all assessment data (such as reddened areas, or sores on the resident's skin) obtained during the shower/ tub bath should be documented. During a review of the facility's P&P titled, Prevention of Pressure Injuries, dated 1/2018, 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. The P&P indicated inspect presence of erythema, temperature of skin and soft tissue and edema during the skin assessment. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs, identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter). The P&P indicated to reposition resident as indicated on the care plan. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control measures, by failing to:1). Ensure the indwelling foley catheter (catheter that drains urine from bladder into a bag outside the body) and nephrostomy tube (a thin catheter inserted directly into the kidney to drain out urine) drain bags did not touch the floor, for one of three sampled residents (Resident 4).2). Ensure Resident 4's nephrostomy tube dressing was clean and not soiled. These deficient practices placed Resident 4 at risk to develop urinary tract infection (UTI) and hospitalization.Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included muscle weakness, muscle wasting (muscle thinning) and atrophy (muscle tissue loses mass and shrinks). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 4/11/2026, the MDS indicated Resident 4 was usually able to understand and be understood by others. The MDS indicated Resident 4 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) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, personal hygiene. Resident 4 was dependent with rolling from left to right, from sitting to lying position, lying to sitting on side of the bed, chair/bed to chair transfer, and tub/shower transfer. Resident 4 had an indwelling urinary catheter and was always incontinent of bowel. During a review of Resident 4's Care Plan titled, At risk for urinary [NAME] infection, catheter associated., dated 4/19/2026, some interventions indicated to change dressing per physician order and facility protocol using aseptic technique (practice by healthcare workers to be completely free of disease-causing germs to prevent infection). During a review of Resident 4's History and Physical (H&P) dated 5/27/2026, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a concurrent observation and interview on 6/9/2026 at 3:16 p.m., with Certified Nurse Assistant (CNA 2), Resident 4's nephrostomy tube (a thin catheter inserted directly into the kidney to drain out urine) gauze (type of white dressing) dressing was observed soiled, with dark/yellow/light brown color. CNA 2 stated the dressing color was beige and did not appear clean. CNA 2 stated she did not know if the dressing was supposed to be there. During a concurrent observation and interview on 6/11/2026 at 10:56 a.m., with Registered Nurse (RN 2), RN 2 stated the foley catheter and the nephrostomy tube bags were on the floor. RN2 stated it could lead to infection. RN 2 stated the bag should be below the bladder level, but off the floor. During a concurrent observation and interview on 6/11/2026 at 10:56 a.m., with Treatment Nurse (TN), the TN stated the connector of the nephrostomy tube was dirty, old and tan in color. The nephrostomy tube gauze dressing felt hard to touch. The TN stated the dressing should be changed daily or as needed when soiled because it could be a source of infection. During a concurrent observation and interview on 6/11/2026 at 2:31 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated when foley and nephrostomy tube drain bag touched the floor, it could be a source of infection that could lead to UTI and hospitalizations. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care, Urinary dated 1/2018, the P&P indicated to make sure catheter drainage bag were kept off the floor and ensure the collection bag did not touch the floor at any time.