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	06/23/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 1) was not held down by Certified Nursing Assistants (CNA 1 and CNA 2) during care. This failure resulted in Resident 1 experiencing psychosocial distress and physical pain after being held down despite Resident 3's refusal of care.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 malignant neoplasm (cancer) of the ovary, liver, and bile duct, and morbid obesity (a serious, chronic disease diagnosed in individuals who are severely overweight). During a review of Resident 1's record titled Physician's Certification for Hospice Benefit, dated 5/20/2026, the record indicated Resident 1 had a PleurX catheter (a small, flexible silicone tube surgically placed under the skin into the chest or abdomen) to the right side of her abdomen. The record indicated Resident 1 complained of moderate pain at the catheter site. The record indicated Resident 1 was bedbound and had widespread metastatic disease (when cancer cells break away from the original tumor and form new tumors in other parts of the body) and generalized weakness. The record indicated Resident 1 had severe debility (a state of physical weakness, feebleness, or loss of strength) and required extensive assistance (when a resident is totally dependent or requires hands on assistance more than half the time while performing part of an activity) with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 1 had clear speech and was able to make herself understood. The MDS indicated Resident 1 had no cognitive impairment (problems with memory, thinking, learning, or decision-making) or disorganized thinking. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half of the work to complete the activity) from staff to roll side to side while in bed and was dependent on staff (helper does all of the work) for toileting hygiene. During a review of Resident 1's Change of Condition (COC) assessment, dated 6/13/2026 at 5:00 a.m., the assessment indicated on 6/13/2026, Resident 1 became aggressive while being turned by two certified nursing assistants (CNAs).During a review of Resident 1's COC assessment, dated 6/13/2026 at 8:43 a.m., the assessment indicated on 6/13/2026, Resident 1 alleged she was abused by the CNAs who were providing her care during the 11:00 p.m. to 7:00 a.m. shift on 6/13/2026. During a review of the facility record titled Written Statement Regarding Resident Care Incident, dated 6/13/2026, authored by CNA 1, the record indicated that on 6/13/2026, between 4:30 a.m. and 5:00 a.m., CNA 1 and CNA 2 entered Resident 1's room to provide perineal care (the cleansing of the genital and anal areas) and change her incontinent brief (adult diaper). The record indicated that while cleaning Resident 1, the resident became increasingly agitated and began yelling they (CNA 1 and CNA 2) were killing her. The record indicated that CNA 1 continued to hold Resident 1 in a side-lying position as Resident 1 struck CNA 1. The record indicated Resident 1's behavior continued to escalate and CNA 2 attempted to prevent further strikes by controlling one of the resident's hands. The record indicated that Resident 1 displayed continued physical aggression and made repeated requests that [they] leave her alone. The (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record indicated that after care was stopped, Resident 1 continued to request that CNA 1 and CNA 2 not touch her and that they leave the room. The record indicated that after the incident, Resident 1 reported that CNA 1 and CNA 2 physically assaulted her and requested for law enforcement to be notified. During a review of Resident 1's progress note, dated 6/15/2026, the progress note indicated on 6/13/2026, Resident 1 reported that two CNAs attempted to hold her down while providing care. During an interview on 6/17/2026 at 3:02 p.m., with Resident 1, Resident 1 stated she had multiple areas on her body that required staff to be sensitive, work at a slower pace, and handle gently due to the significant amount of pain the areas cause her. Resident 1 stated she also had a surgical wound on the right side of her abdomen that caused her a lot of pain. Resident 1 stated on 6/13/2026 around 4:30 a.m., two unidentified staff were assisting her into a side lying position. Resident 1 stated she told the staff she could not turn further because the repositioning was causing pain. Resident 1 stated the two staff continued what they were doing, and the pain became so extreme that she demanded that they stop touching her. Resident 1 stated they did not listen to her request and continued to provide care. Resident 1 stated that she began to strike at them and scream because they were not listening to her requests to discontinue care. Resident 1 stated she did not feel safe in the facility, and stated the facility told her she was the perpetrator (a person who carries out a harmful, illegal, or malicious act) for defending herself. Resident 1 stated that after the staff discontinued their care, her pain, on a scale of one to 10 (with 10 being the worst pain), was a billion. During a telephone interview, on 6/18/2026 at 8:39 a.m., with CNA 1, CNA 1 stated that on 6/13/2026, they turned Resident 1 onto her left side. CNA 1 stated that once Resident 1 was turned onto her left side, she was combative within seconds. CNA 1 stated Resident 1 was moving around a lot and attempting to return to lying on her back. CNA 1 stated she placed one of her hands behind Resident 1's right shoulder to keep her on her left side. CNA 1 stated Resident 1 then struck her with her left arm, while screaming, You're killing me, you're gonna kill me! CNA 1 stated CNA 2 used her hand to restrain Resident 1's left arm. CNA 1 stated that while Resident 1's left arm was restrained by CNA 2, Resident 1 then struck her again with her right arm. CNA 1 stated Resident 1 was still screaming and using profanity. CNA 1 stated Resident 1 kept saying, I'm gonna die. CNA 1 stated Resident was saying, Stop touching me!, using profanity, and telling CNA 1 and CNA 2 to get out of her room. CNA 1 stated that after she was hit, CNA 2 made the decision to stop care. During a telephone interview on 6/18/2026 at 2:01 p.m., with CNA 2, CNA 2 stated that the morning of 6/13/2026, CNA 1 was assisting her to provide perineal care and a brief change to Resident 1. CNA 2 stated they informed Resident 1 they needed to turn her onto her side to perform perineal care on her backside. CNA 2 stated that while turning Resident 1 onto her left side, Resident 1 repeatedly said no, but they continued to turn her onto her side. CNA 2 stated CNA 1 began cleaning Resident 1's backside, and Resident 1 leaned back and hit CNA 1 with one of her hands. CNA 2 stated she grabbed Resident 1 by the wrist to restrain her. CNA 2 stated that while restraining one of Resident 1's arms, Resident 1 began to move her other, unrestrained arm. CNA 2 stated she assumed Resident 1 was going to hit her or CNA 1, so she grabbed Resident 1's other arm to restrain it. CNA 2 stated that while restraining both of Resident 1's arms, she tried to use her body to push Resident 1 back onto her back. CNA 2 stated Resident 1 kept saying they [CNA 1 and CNA 2] were trying to kill her and that she [Resident 1] was going to die. CNA 2 stated that while Resident 1 was saying, You're gonna kill me, she assumed it was due to Resident 1 being in pain. CNA 2 stated Resident 1 had a right to refuse care. CNA 2 stated she and CNA 1 did not stop what they were doing when Resident 1 was repeatedly saying no while being turned. When asked why they did not honor Resident 1's request for care to be stopped, CNA 2 stated they were focused on cleaning her and did not want to fall behind on their patient care tasks. CNA 2 stated she felt that they were short-staffed during that shift. During an interview on 6/18/2026 at 3:29 p.m., with the Administrator (ADM), the ADM stated that if a resident was refusing care, or saying No, no, no! while care was being attempted, staff should respect the resident's refusal. The ADM stated if the resident appeared to not want the care being provided, the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should stop. The ADM stated that pausing care would allow staff to identify why the resident was refusing. The ADM stated that continuing to provide care, and ignoring the resident's requests, was a violation of their right to refuse care, and was going against the resident's wishes. The ADM stated if the CNA felt staffing was an issue, they should have asked their charge nurse, or gotten additional help. During a review of the facility's policy and procedure (P&P) titled Use of Restraints, dated 1/2026, the P&P defined restraints as including any manual method that restricts freedom of movement or restricts normal access to one's body. The P&P indicated restraints were only to be used for the safety and well-being of the resident, and only after other alternatives have been tried unsuccessfully. The P&P indicated restraints should not be used for staff convenience. During a review of the facility's P&P titled Abuse and Neglect Clinical Protocol, dated 1/2018, the P&P defined abuse as the willful infliction of.unreasonable confinement.resulting in physical harm, pain or mental anguish. The P&P defined willful as the individual acting deliberately, not that the individual must have intended to inflict injury or harm. During a review of the facility's P&P titled Resident Rights, dated 1/2018, the P&P indicated that federal and state laws guaranteed basic rights to all facility residents, including:A dignified existenceBeing treated with respect, kindness, and dignityBeing free from physical restraintsSelf-determinationBeing supported by the facility in exercising their rights During a review of the facility's P&P titled Dignity, dated 1/2026, the P&P indicated each resident was to be cared for in a manner that promotes and enhances his or her sense of well-being. The P&P indicated staff were to treat residents with dignity and respect at all times. The P&P indicated that when assisting a resident with care, the resident was to be supported in exercising their rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate abuse prevention for one of two sampled residents (Resident 5) by failing to provide Resident 5 with 1:1 supervision (one-to-one, a high level of patient monitoring where a single healthcare staff member is assigned exclusively to one patient to observe, protect, and assist them continuously), as ordered by the physician, following Resident 5's involvement as the aggressor in a resident-to-resident altercation on 6/16/2026. This failure resulted in Resident 5 wandering the facility unsupervised, placing her at risk of involvement in another altercation with and abuse of another facility resident.Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included left-sided hemiplegia (inability to move one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain), schizophrenia (mental illness that is characterized by disturbances in thought), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 5 had no cognitive impairment (ability to think and reason). The MDS indicated Resident 1 required supervision/touch assistance from staff to wheel her wheelchair. During a review of Resident 5's Change of Condition (COC) assessment, dated 6/16/2026 at 10:59 a.m., the assessment indicated on 6/16/2026, Resident 5 was aggressive towards others and involved in an altercation with another resident resulting in her pulling the other resident to the floor. During a review of Resident 5's physician order, dated 6/16/2026, the physician order indicated Resident 5 was to have 1:1 supervision due to a physical altercation that occurred on 6/16/2026. During a review of the facility staffing record, dated 6/16/2026, for the 3:00 p.m. to 11:00 p.m. (evening shift) and 11:00 p.m. to 7:00 a.m. on 6/17/2026 (NOC shift), the staffing record did not indicate Resident 5 was assigned 1:1 supervision. During a review of the facility staffing record, dated 6/17/2026 to 6/22/2026, the staffing did not indicate Resident 5 was assigned 1:1 supervision. During an interview on 6/18/2026 at 10:17 a.m., with the Director of Staff Development (DSD), the DSD stated she was responsible for creating the staffing assignment for the certified nursing assistants (CNAs) and stated that a CNA would typically be the staff assigned to provide 1:1 supervision. The DSD stated the facility had enough staff to ensure that if 1:1 supervision was ordered it could be provided. During an interview on 6/23/2026 at 10:39 a.m., with the Director of Nursing (DON), the DON stated 1:1 supervision required a pre-designated staff to be with the resident at all times. The DON stated he was responsible for notifying the DSD of any 1:1 supervision orders, as soon as they were entered, to ensure the DSD designated a staff to provide 1:1 supervision. During a concurrent interview and record review, on 6/23/2026 at 10:41 a.m., with the DON, Resident 5's physician order dated 6/16/2026 was reviewed. The order indicated 1:1 supervision from 6/16/2026 to 6/22/2026. The DON stated the 1:1 supervision was indicated due to Resident 5's physical altercation with another resident. The DON stated it was important for the 1:1 supervision to be implemented, as ordered, to ensure the safety of the facility's residents was maintained. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Program, dated 1/2018, the P&P indicated the facility was to develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of our residents. The P&P indicated staff were to protect residents during abuse investigations. During a review of the facility's P&P titled Safety and Supervision of Residents, dated 1/2018, the P&P indicated resident safety and supervision to prevent accidents were facility-wide priorities. The P&P indicated the interdisciplinary team (group of different disciplines working together towards a common goal of a resident) was to analyze information obtained from assessments and observations to identify specific resident risks and develop interventions. The P&P indicated that implementation of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	these interventions was to be accomplished by communicating the specific interventions to all relevant staff, and ensuring they were implemented.

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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 provide one of one sample resident (Resident 3) with a daily bath or shower, as indicated in her care plan. This failure did not honor Resident 3's care preferences, and placed her at risk of not having her care needs met.Findings: 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]. Resident 3's diagnoses included generalized muscle weakness, morbid obesity (a serious, chronic disease diagnosed in individuals who are severely overweight), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 3 had no cognitive impairment (ability to think and reason). The MDS indicated Resident 3 required substantial to maximal assistance from staff for showering and bathing and mobility while in bed. During a review of Resident 3's care plan titled The resident has an activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) self-care performance deficit related to limited mobility, musculoskeletal impairment, ., created 9/22/2025 and revised 1/8/2026, the care plan indicated Resident 3 was totally dependent on one staff to provide a bath/shower daily and as necessary. During a review of the facility record titled Documentation Survey Report, dated 5/1/2026 to 5/31/2026, and 6/1/2026 to 6/30/2026, the records indicated the Certified Nursing Assistants' (CNAs) were to provide baths/showers to Resident 3. The records did not indicate Resident 3 was provided with a daily bath/shower from 5/1/2026 to 5/31/2026, or 6/1/2026 to 6/23/2026. During an interview on 6/22/2026 at 2:46 p.m., with the Director of Nursing (DON), the DON stated Resident 3's care plan indicated Resident 3 was to receive a daily bath. The DON stated provision of a daily bath was important to meet Resident 3's needs. The DON stated frequent baths/showers aided in prevention of skin breakdown, and was important for maintaining the resident's dignity and overall well-being. During an interview on 6/22/2026 at 2:56 p.m., with the DON, the DON stated the documentation in Resident 3's medical record did not indicate staff provided Resident 3 with a daily bath as indicated in her care plan. During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), Supporting, dated 1/2018, the P&P indicated staff were to provide care and services for residents who are unable to carry out ADLs independently, in accordance with the resident's plan of care. During a review of the facility's P&P titled Bath/Shower, dated 1/2018, the P&P indicated that the purpose of the P&P was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. The P&P indicated staff were to document the date and time the shower/bath was performed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were updated for one of two sampled residents (Resident 5) to reflect the physician's orders for 1:1 supervision (one-to-one, a high level of patient monitoring where a single healthcare staff member is assigned exclusively to one patient to observe, protect, and assist them continuously), following Resident 5's involvement as the aggressor in a resident-to-resident altercation. This failure resulted in Resident 5's care plan not reflecting the interventions needed to prevent further altercations, and placed the safety of Resident 5, and other facility residents, at risk.Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included left-sided hemiplegia (inability to move one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain), schizophrenia (mental illness that is characterized by disturbances in thought), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 5 had no cognitive impairment (ability to think and reason). The MDS indicated Resident 1 required supervision/touch assistance from staff to wheel her wheelchair. During a review of Resident 5's Change of Condition (COC) assessment, dated 6/16/2026 at 10:59 a.m., the assessment indicated on 6/16/2026, Resident 5 was aggressive towards others and was involved in an altercation with another resident resulting in her pulling the other resident to the floor. During a review of Resident 5's physician order, dated 6/16/2026, the physician order indicated Resident 5 was to have 1:1 supervision due to a physical altercation that occurred on 6/16/2026. During an interview on 6/23/2026 at 10:43 a.m., with the Director of Nursing (DON), the DON stated care plans were revised after resident-to-resident altercations. The DON stated these revisions would include adding interventions necessary in response to the altercation. The DON stated including the interventions on the care plan would ensure staff were aware of the intervention and ensure it was implemented. The DON stated Resident 5's intervention for 1:1 supervision was not included in her care plan. During a concurrent interview and record review, on 6/23/2026 at 10:41 a.m., with the DON, Resident 5's physician order dated 6/16/2026 was reviewed. The order indicated 1:1 supervision from 6/16/2026 to 6/22/2026. The DON stated the 1:1 supervision was indicated due to Resident 5's physical altercation with another resident. The DON stated it was important for the 1:1 supervision to be implemented, as ordered, to ensure the safety of the facility's residents was maintained. During a review of the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered, dared 1/2018, the P&P indicated the resident's comprehensive, person-centered care plan was to describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated the resident's comprehensive care plan was also to incorporate risk factors associated with identified problems.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide one of one sample resident (Resident 3) with her required level of assistance during provision of activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). This failure placed Resident 3's safety at risk from not having the required assistance and supervision during care.Findings: 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]. Resident 3's diagnoses included generalized muscle weakness, morbid obesity (a serious, chronic disease diagnosed in individuals who are severely overweight), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 3 did not have cognitive impairment (ability to think and reason). The MDS indicated Resident 3 required substantial to maximal assistance from staff (staff does more than half of the effort) for showering and bathing herself. The MDS indicated Resident 3 required substantial to maximal assistance for toileting hygiene. During a review of the facility record titled Documentation Survey Report, dated 5/1/2026 to 5/31/2026, and 6/1/2026 to 6/30/2026, the records indicated the Certified Nursing Assistants' (CNA) were to document baths/showers and toileting hygiene provided to Resident 3. The records did not indicate staff provided substantial to maximal assistance for bathing or toileting hygiene. During an interview on 6/22/2026 at 2:40 p.m., with the Director of Nursing (DON), the DON stated Resident 3's MDS indicated she required substantial to maximal assistance from staff for bathing/showering and toileting hygiene. The DON stated the MDS guided the plan of care and staff should provide the level of care indicated in the MDS. The DON stated it was important to provide the required level of assistance to ensure that the resident's care needs were being met and to ensure the resident's safety. The DON stated failure to provide the required level of assistance could result in the resident not being adequately cleaned, which could result in a urinary tract infection (UTI, a bacterial infection in any part of your urinary system), skin breakdown, or negatively impact her dignity. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument Process (RAI), dated 1/2018, the P&P indicated the Resident Assessment Instrument (MDS) was used to provide the caregiving staff with ongoing assessment information necessary to provide the appropriate care and services for each resident. During a review of the facility's P&P titled Activities of Daily Living (ADLs), Supporting, dated 1/2018, the P&P indicated staff were to provide care and services for residents who are unable to carry out ADLs independently, in accordance with the resident's plan of care.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled Trauma Informed Care, dated 1/2026, by ensuring staff received training and/or in-services to ensure they were equipped to provide all facility residents with trauma-informed care (an organizational and clinical framework requiring skilled nursing and long-term care facilities to recognize, understand, and respond to the effects of trauma). This failure placed the facility residents at risk of not receiving care to meet their behavioral health needs, including person-centered care approaches designed to meet their individual goals.Findings: During a review of the facility document titled In Service Schedule 2026, dated 2026, the document did not indicate in-services related to trauma (effects from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being), trauma-informed care, post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), or trauma assessments were provided to or scheduled for facility staff. During a review of the employee files for five sampled staff (Certified Nursing Assistant [CNA] 1, CNA 2, Licensed Vocational Nurse [LVN] 1, Registered Nurse [RN] 1, and RN 2), the employee files did not contain any records that training related to trauma, trauma-informed care, PTSD, or trauma assessments was received. During an interview on 6/17/2026 at 12:46 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she did not receive training or in-services related to trauma, PTSD, or trauma-informed care training. During an interview on 6/18/2026 at 1:02 p.m., with the Social Services Director (SSD), the SSD stated she or the Social Services Assistant (SSA) were primarily responsible for completing the Brief Trauma Questionnaire (a short assessment designed to assess traumatic exposure). The SSD stated that to her knowledge, there were no other staff who were trained to complete the brief trauma questionnaire or assess residents for trauma and/or identify triggers. During an interview on 6/18/2026 at 1:34 p.m., with the Director of Staff Development (DSD), the DSD stated she had been the DSD since 11/2025. The DSD stated in-services/training related to trauma-informed care or PTSD were not conducted for staff. The DSD stated that to her knowledge these training topics had never been on the training calendar. The DSD stated that in-services and training related to trauma-related training/in-services were important for CNAs to ensure they knew how to address the residents and could identify behavior patterns or triggers while providing care. The DSD stated that a history of trauma or PTSD could impact the resident's plan of care and willingness to participate or accept care. During an interview on 6/18/2026 at 1:49 p.m., with the Director of Nursing (DON), the DON stated he had not provided any in-services related to trauma, trauma-informed care, or PTSD. The DON stated that to his knowledge, this was also not a topic that was included as part of routine onboarding for new hires, or as part of ongoing training in the facility. The DON stated that a history of trauma can result in staff unknowingly triggering a resident if the trigger was not previously identified. The DON stated that this can impact the resident both emotionally and/or physically depending on their history. During a review of the facility's policy and procedure (P&P) titled Trauma Informed Care, dated 1/2026, the P&P indicated trauma-informed care was culturally sensitive and person-centered. The P&P indicated that all staff were to be provided in-service training about trauma, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting. The P&P indicated nursing staff were to be trained on screening tools, trauma assessments, and how to identify triggers associated with re-traumatization.

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	055052	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the need for specialized rehabilitation services was determined for one of one sample resident (Resident 3) following a decline in Resident 3's ability to perform activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility. This failure delayed the opportunity for Resident 3's care team to determine if Resident 3 could benefit from physical and/or occupational therapy (healthcare specialties that help individuals reduce pain, restore mobility, and regain functional independence). Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. Resident 3's diagnoses included generalized muscle weakness, morbid obesity (a serious, chronic disease diagnosed in individuals who are severely overweight), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 6/10/2026, the MDS indicated Resident 3 was independent in daily decision making. The MDS indicated Resident 3 required substantial to maximal assistance from staff (staff does more than half of the effort) for showering and bathing herself. The MDS indicated Resident 3 required substantial to maximal assistance to roll from side to side in bed, and to transition from a lying position to a sitting position. During a review of Resident 3's record titled Occupational Therapy Discharge Summary, dated 10/7/2025 to 12/11/2025, the record indicated Resident 3 received physical therapy from 10/7/2025 to 12/11/2025. The record indicated that upon discharge from occupational therapy services, Resident 3 was able to complete hygiene and grooming tasks with standby assistance from staff (a caregiver or therapist remains within arm's reach of an individual to ensure safety during a task). The record indicated Resident 3 had achieved her maximum potential. During a review of Resident 3's record titled Physical Therapy Discharge Summary, dated 10/7/2025 to 12/11/2025, the record indicated Resident 3 received physical therapy from 10/7/2025 to 12/11/2025. The record indicated that upon discharge from physical therapy services, Resident 3 was able to roll from side to side in bed with standby assistance from staff. The record indicated Resident 3 was able to transition from a lying position to a sitting position with minimal assistance from staff (the resident performs at least 75% of a physical or daily living task). The record indicated Resident 3 had achieved her maximum potential. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 required substantial to maximal assistance from staff (staff does more than half of the effort) for toileting hygiene. The MDS indicated Resident 3 required substantial to maximal assistance from staff to roll side to side in bed, and to transition from a lying to sitting position in bed. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 continued to require substantial to maximal assistance from staff for toileting hygiene. The MDS indicated Resident 3 continued to require substantial to maximal assistance from staff to roll side to side in bed, and to transition from a lying position to a sitting position in bed. During an interview on 6/22/2026 at 11:40 a.m., with the Rehabilitation Coordinator (RC), the RC stated she was not notified of Resident 3's decline in ability to perform hygiene tasks, or mobility while in bed, identified in her MDS dated [DATE] and 3/27/2026. The RC stated prompt notification was important to ensure that interventions could be implemented. The RC stated that failure to identify a decline increased the risk for further decline and placed Resident 3 at risk for complications related to ADL and mobility decline, such as pressure injuries, poor circulation, and blood clots. During an interview on 6/22/2206 at 12:35 p.m., with the RC, the RC stated that upon discharge from physical and occupational therapy services on 12/11/2025, Resident 3 was at her highest level of functioning. The RC stated that if there were a decline following her discharge from therapy services, Resident 3 would have benefited from renewed services. The RC stated that if there were an observed decline, Resident 3's physician could be notified to determine if orders for new physical and (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occupational therapy evaluations were appropriate. During an interview on 6/22/2026 at 3:05 p.m., with the Director of Nursing (DON), the DON stated there was no documentation in Resident 3's medical record indicating her physician was notified of her decline in ability to perform ADLs and mobility, identified in her MDS on 12/26/2025 and 3/27/2026. The DON stated staff should have notified Resident 3's physician of the change to ensure that her care plan could be revised and to address the change of condition. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument Process (RAI), dated 1/2018, the P&P indicated the Resident Assessment Instrument (MDS) was used to provide the caregiving staff with ongoing assessment information necessary to provide the appropriate care and services for each resident. During a review of the facility's P&P titled Changes in Resident Condition, dated 4/2005, the P&P indicated that the attending physician was to be notified when a change in condition occurred, including a significant change in the resident's physical status or when there was a need to alter the treatment plan. The P&P indicated this information was to be documented in the medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician completed the Physician Discharge Summary assessment for two of two sampled residents (Resident 3 and Resident 4). This failure placed Residents 3 and 4 at risk of being discharged without a physician assessment or a physician-guided plan of care upon discharge.Findings: 1. 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]. Resident 3's diagnoses included congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), generalized muscle weakness, morbid obesity (a serious, chronic disease diagnosed in individuals who are severely overweight), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees. During a review of Resident 3's Discharge Minimum Data Set (MDS, a resident assessment tool), dated 6/10/2026, the MDS indicated Resident 3 was independent in making daily decisions. The MDS indicated Resident 3 required substantial to maximal assistance from staff for showering and bathing herself and mobility while in bed. During a review of Resident 3's progress note, dated 6/10/2026, the progress note indicated Resident 3 was transferred to the hospital via emergency medical services on 6/10/2026 due to low blood pressure, low blood oxygen levels, and a flushed appearance (sudden increase of blood flow to your cheeks, neck or upper chest). During a review of Resident 3's Electronic Medical Record (EMR), the EMR indicated a Physician's Discharge Summary assessment was completed for Resident 3 on 6/10/2026. 2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE]. Resident 4's diagnoses included generalized muscle weakness, abnormal gait (manner of walking) and mobility, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), delusional disorders (a psychiatric condition where a person experiences fixed, false beliefs (delusions) that persist for at least one month), anxiety disorder (a group of mental health conditions that cause intense, persistent, and excessive fear or worry out of proportion to actual situations), major depressive disorder (a serious mood disorder characterized by persistent sadness, hopelessness, and a profound loss of interest in activities), and inability to move the right side of her body following a cerebral infarction (loss of blood flow to a part of the brain). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no cognitive impairment (ability to think and reason). The MDS indicated Resident 4 required set-up/clean-up assistance from staff for most activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's EMR, the EMR indicated a Physician's Discharge Summary assessment was completed for Resident 3 on 6/10/2026. During a review of Resident 4's progress note, dated 6/16/2026, the progress note indicated on 6/16/2026, Resident 4 was transferred to the hospital due to an altercation with another facility resident. During an interview on 6/22/2026 at 8:57 a.m., with Registered Nurse (RN) 3, RN 3 stated the Physician's Discharge Summary was an assessment completed when a resident was transferred out of the facility. RN 3 stated he was not sure of the assessment's purpose and stated he figured it's information that someone would need to know. RN 3 stated the assessment was not completed by a physician and was completed by an RN. RN 3 stated that in the section indicated for the physician's electronic signature, the RN would type in in the physician's name. RN 3 stated it was rare that the physician came in to see the resident before they were transferred out of the facility, and it was rare that they completed documentation related to the transfer. During an interview on 6/22/2026 at 1:07 p.m., with the Director of Nursing (DON), the DON stated the Physician's Discharge Summary was an assessment completed by the registered nurse performing the resident's transfer. During a concurrent interview and record review, on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/22/2026 at 1:16 p.m., with the DON, the facility's policy and procedure (P&P) titled Preparing a Resident for Transfer or Discharge, dated 12/2016, was reviewed. The P&P indicated the nurse was responsible for obtaining the Physician's Discharge Summary. The DON stated the nurse was responsible not completing the physician discharge summary. The DON stated it was not appropriate for the nurse to complete an assessment intended to be completed by a physician. The DON further stated that the physician's signature should not be filled in by a nurse. The DON stated the physician should be completing and signing off on the assessment.