

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Lomita Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1955 Lomita Blvd Lomita, CA 90717	

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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092</b></p> <p>Based on interview and record review, the facility failed to manage pain for one out of three residents (Resident 2), when Resident 2 informed the Certified Nursing Assistant (CNA) 1 she had left arm and hand pain.</p> <p>This deficient practice had the potential to cause Resident 2's pain to worsen, become uncontrolled, create discomfort, and cause fear of receiving treatment/services due to anticipated pain.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including cerebrovascular accident (CVA - stroke, loss of blood flow to a part of the brain) and left side hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).</p> <p>During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/7/2025, the MDS indicated Resident 2 had severe cognitive (ability to think and reason) impairment and was dependent on staff for toileting hygiene, showering/bathing, personal hygiene, and dressing the upper/lower body.</p> <p>During a review of Resident 2's untitled Clinical Record (Care Plan section) initiated 9/10/2023, the Care Plan indicated Resident 2 has acute/chronic pain. Under this Care Plan, the goals indicated Resident 2 will not have an interruption in normal activities due to pain. The Care Plans interventions included administering pain medication as ordered 30 minutes prior to care, to anticipate pain relief, and respond immediately to any complaints of pain.</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/18/2025 at 11:31 a.m., in Resident 2's room, Resident 2 was observed awake, alert, lying in bed flat on her back, and noted to have a straight stiff left arm and left hand in a fist position. Resident 2 stated she had a stroke and was unable to move her left arm/hand. Resident 2 stated she was scared to be transferred out of bed or receive care because earlier that day when she was being showered with the assistance of CNA 1, she informed CNA 1 her left-hand got caught in the shower chair, was in pain, and needed to be repositioned. Resident 2 stated CNA 1 told her to wait until after the shower. Resident 2 stated after her shower was completed, she was put back to bed with a mechanical lift (a lift that provides support to residents to lift them up and transfer them) when her left-hand got stuck behind her on the sling as she was being lifted. Resident 2 stated she was still in pain and had not been given medication to help relieve the pain.</p> <p>During an interview on 4/18/2025 at 11:47 p.m., with CNA 1, CNA 1 stated Resident 2 informed her about her left-hand pain when being transferred back to bed, and she informed the Licensed Vocational Nurse (LVN) 1 right away.</p> <p>During an interview on 4/18/2025 at 11:54 a.m. with LVN 1, LVN 1 stated he was not aware that Resident 2 was in any pain but should have been informed right away to provide interventions for Resident 2's comfort.</p> <p>During an interview on 4/18/2025 at 12:01 p.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated she was assisting CNA 1 transfer Resident 2 back to bed after her shower when Resident 2 complained of having pain in her left arm/hand. RNA 1 stated she did not report Resident 2's pain to anyone.</p> <p>During an interview on 4/22/2025 at 2:21 p.m. with the DON, the DON stated when Resident 2 reported pain to CNA 1 it should have been reported to a licensed nurse right away so the licensed nurse could assess Resident 2 and intervene appropriately. The DON stated since Resident 2 had a known history of frequent pain in her left hand/arm she should have been premedicated prior to showering or other activities since pain could be anticipated to keep her comfortable and control pain.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Pain Management, dated 4/2022, the P&amp;P indicated screening should be done to determine if the resident has been or is experiencing pain, identifying circumstances when pain can be anticipated, and implementing pharmacological and non-pharmacological interventions to manage the pain, per the resident's care plan.</p>