STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post Acute	909 S Lake Street Los Angeles, CA 90006

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observations, interviews, and record reviews the facility failed to ensure one out of three sampled residents (Resident 1) were free from physical abuse (an act where one person uses their body to inflict intentional harm or injury upon another person) from staff by failing to acknowledge and investigate allegations, assess monitor, and implement allegations of Resident 1 being slapped by Certified Nursing Assistant (CNA) 1 This deficient practice had the potential to result in the continued physical abuse to Resident 1 and resident sin the facility. Findings: During a review of Resident 3's admission record indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-high blood pressure). During a review of a history and physical (H&P-a term used to describe a physician's examination of a patient. In an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) dated 1/19/2024 indicated, Resident 1 had the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 8/22/2024, indicated Resident 1 had moderate cognitive impairments (a stage of cognitive decline where a person has significant difficulty with complex tasks and may become confused about their surroundings). The same MDS indicated Resident 1 was mostly depended on staff for most of his Activities of Daily Living such as: (ADLs- routine tasks/activities such as bathing, dressing, toileting hygiene). During a review of Resident 4's admission record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which including depression, acute kidney failure (the rapid [less than 2 days] loss of your kidneys' ability to remove waste and help balance fluids and electrolytes in your body), and generalized muscle weakness (a decrease in muscle strength that can make it difficult to move your body). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's H&P indicated Resident 4 had the capacity to make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 was cognitively intact (mental action or process of acquiring knowledge and understanding). The same MDS indicated Resident 4 required between partial/maximal assistance and staff dependency for ADLs. During an interview with Resident 1 on 11/26/24 at 1:05 pm, Resident 1 stated, That CNA just came in and slapped me. During an interview with Resident 4 on 11/26/24 at 11:31 am, Resident 4 stated that CNA 1 (whom she had identified in the hallway) came in to perform some personal care a few weeks ago (did not remember exact date) for Resident 1. Resident 4 stated that CNA 1 came to their room, went to Resident 1's side of the room, closed the privacy curtain and heard a slap sound, then heard Resident 1 ask why CNA 1 had slapped her. During an interview with CNA 2 on 11/26/23 at 2:54 pm, CNA 2 stated that on 11/9/2024 while passing lunch trays in the room that is adjacent to Resident 1's room, she heard a slap sound and heard Resident 1 scream. CNA 2 stated that she noticed that CNA 2 was in Resident 1's room with Resident 1. CNA 2 stated that she reported the incident to Registered Nurse (RN) 1. During an interview with RN 1 on 11/26/24 at 3:12 pm, RN 1 stated that CNA 1 reported the slap incident which was then reported to the Director of Nursing (DON). RN 1 admitted and stated the slap incident should have been reported as suspected abuse, investigated, reported to the police, ombudsman as well as Department of Public Health. RN 1 stated that the implications of not reporting may result in continued abuse. During an interview with the Social Services Director (SSD) on 11/26/24 at 3:36 pm, the SSD stated the incident with Resident 1 should have been suspected as physical abuse even though it was not witnessed based on the information provided. SSD acknowledged that the incident should have been reported because it needs to be investigated. During an interview with the Facility Administrator (FA), the FA stated that he was aware about that Resident 1 had alleged that she was slapped. The FA stated that nursing had assessed, and incident investigated but was unable to provide documented evidence of the investigation. FA stated that he thought that the designee (DON) had investigated the incident. FA admitted that he was the abuse coordinator. During a review of a Policy and Procedures (P&P) titled Abuse Prevention Program - Abuse Prohibition, revised 5/2024 indicated, The facility shall uphold resident's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Facility shall ensure thorough and extensive investigation of different types of incidents including but not limited to those that may constitute abuse, and identification of a staff member, who would be responsible for the initial reporting, investigation of alleged violations and reporting of results to facility administrator and/or facility abuse coordinator, who shall, in return, report such incident to required agencies. a) Facility administrator shall be responsible for appointing staff member(s) who would be responsible for the initial reporting and investigation of alleged. Necessary steps are to be taken to prevent reoccurrence of violations which may include in service training, suspension of involved individuals, or other measures as appropriate.

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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** 45524 Based on observation, interview, and record review, the facility failed to: 1. Ensure Certified Nursing Assistant (CNA) 2 did not release a hoyer lift (a medical device use to transfer patients with limited mobility from one place/surface to another) control quickly when transferring one of four sampled residents (Resident 2). 2. Inspect the hoyer lift for any malfunction or operational concerns before using it to transfer dependent residents including Resident 2. These deficient practices resulted in the hoyer lift control hitting Resident 2 in the face and the resident sustaining a bruise (an injury appearing as an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) to the right eye, and had the potential for further injuries to the residents. Findings: During a review of the admission record for Resident 2 indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), morbid obesity. During a review of a history and physical (H&P-a term used to describe a physician's examination of a patient. In an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) for Resident 2 dated 12/11/2024 indicated, Resident 2 had the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 8/30/2024, indicated Resident 2 was cognitively intact (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The same MDS indicated Resident 2 was mostly depended on staff for most of the resident's Activities of Daily Living such as: (ADLs- routine tasks/activities such as bathing, dressing, toileting hygiene). During a review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 11/9/2024 at 10:05 pm indicated, skin discoloration/swelling on top of right eyebrow. - no full assessment. During a review of Resident 2's Nurse Progress Notes dated 11/10/2024 at 3:15 pm, indicated, on monitoring for discoloration to upper right side of the eyelid. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 2 on 11/26/2024 at 1:20 pm, Resident 2 was observed to have a bruise to her right eye which was purple bluish in color. The bruise was localized to the outer side of the resident's right eye. Resident 2 stated that during a transfer from her bed to the wheelchair using a lift, a piece of the lift equipment hit her head on. During an interview with CNA 2 on 11/26/23 at 2:54 pm, CNA 2 stated that a few weeks ago, she (CNA 2) and another CNA (unidentified) were transferring Resident 2 from the bed to the wheelchair. CNA 2 stated that when Resident 2 was positioned to be placed in the chair, CNA 2 pushed a button on the lift's controller which is supposed to slowly lower Resident 2 into the chair, the lift quickly lowered the resident. Resident 2 had leaned forward in the process and hit her head onto the metal bar. CNA 2 stated that she reported the incident to the charge nurse. During an interview with Registered Nurse (RN) 1 on 11/26/24 at 3:12 pm, RN 1 stated that she observed Resident 2 with a bruise but did not follow up on how the resident had sustained the bruise because there was a progress note which indicated that Resident 2 had some discoloration to her right eye. RN 1 admitted and stated that further investigating on what had happened could help prevent further occurrences/incidents with the hoyer lift. During an interview with the Facility Administrator (FA) on 11/26/24 3:56 pm, the FA stated Resident 2 had reported that she (Resident 2) had bumped her head on the lift and did not probe any further because he thought that nursing her investigated. The FA admitted and stated that the facility did not inspect the hoyer lift was not for malfunction after the incident with Resident 2.