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	01/10/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to provide treatment and care in accordance with professional standard of practice for one of three sampled residents (Resident 1). For Resident 1 who reported on 12/8/24 that he had a fall on 12/8/24 at 4 a.m., the facility failed to: 1.Assess Resident 1 immediately after he reported that he had a fall. 2.Notify Resident 1's physician immediately after Resident 1 reported he had a fall on 12/8/24. 3.Ensure the Magnetic Resonance Imaging (MRI, test that produces clear images of the organs and structures inside the body to diagnose a variety of conditions) ordered by the physician on 12/9/24 was carried out as ordered. These deficient practices had the potential for Resident 1 not to receive necessary treatment timely for possible injuries resulted from the fall. Findings: During a review of the Admission Record, the Record indicated the facility originally admitted Resident 1 on 9/18/21 and readmitted on [DATE] with diagnoses including respiratory failure (a condition that causes problems with breathing), chronic pain syndrome (pain that lasts longer than three months) and anxiety disorder (experience of fear and worry that is both intense and excessive). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 6/14/24, the MDS indicated Resident 1 was cognitively intact. Resident 1 needed supervision with eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear and independent with personal hygiene. During a review of Nursing Progress Note (late entry) dated 12/8/24 at 2:59 p.m., the Note indicated Resident 1 informed licensed vocational nurse (LVN 1) that .he fell from the bed sliding at night and . verbalized he was ok. The Note indicated will continue to monitor. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Change in Condition (Known as change of condition-COC) dated 12/9/24 at 3:39 p.m., the COC indicated Resident 1 reported to registered nurse supervisor (RNS 1) that he had a fall yesterday (12/8/24) at around 4 a.m. The COC indicated Resident 1 stated he slipped off the bed because the mattress slipped from the bed frame. Resident 1 further added .he called his own doctor and his doctor put in new orders for him . The COC indicated Resident 1's nurse practitioner (NP, a registered nurse who had additional training and education in how to diagnose and treat disease) was notified. During a review of the Nursing Progress Note dated 12/9/24 at 3:10 p.m., the Note indicated Resident 1's NP gave an order for x-ray of the lumbar (lower back) and thoracic spine (midback). During a review of the x-ray report dated 12/10/24 at 2:54 p.m., the report indicated no fracture or dislocation of the lumbar and thoracic spine. The Report indicated if Resident 1's pain persists to follow-up the x-ray with MRI. During an interview on 12/7/24 at 12:07 p.m., Resident 1 stated he had a fall on 12/8/24 and reported the fall incident to the nurse, but he did not remember who the nurse was - only that she was a female nurse. Resident 1 stated no one assessed me, and I had to call my own doctor. Resident 1 stated an x-ray of the spine was done and he had no injury. Resident 1 stated he continue to have back pain and .I feel something is moving in my back . Resident 1 stated Resident 1's physician came on 12/9/24 and the physician informed Resident 1 that the physician placed an order for MRI. Resident 1 stated the facility did not do anything about the MRI order. Resident 1 stated the MRI was done on 1/6/25, 19 days after the physician order was placed. Resident 1 stated the result of the MRI was with the physician and staff had not told Resident 1 about the result yet. During a concurrent interview and record review on 1/10/25 at 12:58 p.m., the Nursing Progress Note dated 12/8/24 at 2:59 p.m., was reviewed with licensed vocational nurse (LVN 1). LVN 1 stated on 12/8/24, Resident 1 reported to her that Resident 1 slid off the bed and fell on the floor during the night (12/8/24). LVN 1 stated Resident 1 complained of pain in his back and was given Norco 5-325 (medication used to relieve moderate to severe pain) milligrams (mg., metric unit of measurement used for medication dosage and/or amount) two tablets for pain. LVN 1 further added she notified Resident 1's physician by text message and the physician texted back that the physician will talk with the Resident 1 about the fall. LVN 1 stated it is important to assess Resident 1 after the fall and to notify Resident 1's physician to obtain orders that may include x-ray to find out if Resident 1 had an injury due to the fall. However, LVN 1 stated she did not document in the progress notes what she did for Resident 1. LVN 1 stated if it is not documented, it was not done. During a concurrent interview and record review with the registered nurse supervisor (RNS 1) and director of nursing (DON), on 1/10/25 at 1:29 p.m., the physician order for MRI dated 1/2/25 for Resident 1 was reviewed. RNS 1 stated Resident 1's physician entered the MRI order for Resident 1 directly in the computer on 12/9/24. RNS 1 stated she saw the order on 12/9/24 but the .order disappeared. The DON stated the MRI order was sent to the business office to get authorization from Resident 1's health insurance but the authorization was not obtained. The DON stated the order was stuck in the business office. The DON stated as soon as the order was received, the authorization from the health insurance should be done right away. The DON further added when Resident 1 had a fall, assess Resident 1, notify the physician for any orders the physician may give. Any assessment and follow-up done should be documented in the nurses' notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility Policy titled Change in a Resident's Condition or Status reviewed on 3/24, the Policy indicated the facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental condition and/or status. The same Policy indicated the nurse will notify the resident's attending physician or physician on call that includes when there has been an accident or incident involving the resident. The same Policy indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. During a review of the facility Policy titled Assessing Falls and Their Causes, revised on 5/24, the Policy indicated when a resident falls, the following information should be recorded in the resident's medical record that included: 1.Assessment data including vital signs (measurement of the body's most basic functions) and any obvious injuries. 2.Interventions, first aid or treatment administered. 3.Notification of the physician and family as indicated.