

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/20/2025
NAME OF PROVIDER OR SUPPLIER  California Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>36395</p> <p>Based on interview and record review the facility failed to implement their Policy in reporting unusual occurrences for one of three sample residents (Resident 1). The facility failed to report to the state survey agency (SSA) when Resident 1 eloped (the act of leaving a facility unsupervised and without prior authorization) on 5/18/25.</p> <p>This deficient practice resulted in a delay in the investigation of the elopement of Resident 1 and to ensure Resident 1 was safe.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility admitted Resident 1 on 5/14/25 with diagnoses including encephalopathy (a disease that affects the function or structure of the brain) and anoxic brain damage (serious types of brain injuries characterized by a lack of oxygen to the brain).</p> <p>During a review of Resident 1 ' s History and Physical (H&amp;P, a comprehensive formal assessment by a healthcare provider) dated 5/17/25 indicated Resident 1 required close supervision at all times when out of bed to ensure safety secondary to impaired cognition and poor safety awareness. The H&amp;P indicated Resident 1 continues to be an elopement risk.</p> <p>During a review of the Change in Condition (COC) Evaluation dated 5/18/25 at 3:12 p.m., indicated Resident 1 eloped on 5/18/25 at around 11 a.m. The COC indicated Resident 1 was confused and forgetful. The notes indicated Resident 1 eloped while licensed vocational nurse (LVN 1) was temporarily assisting another resident. Facility searched for Resident 1 but was unable to locate Resident 1. The COC indicated the police, Resident 1 ' s family, the director of nursing and the administrator were notified.</p> <p>During an interview a telephone interview on 5/20/25 at 12:03 p.m., the director of nursing (DON) stated Resident 1 ' s elopement was not reported to the SSA.</p> <p>During an interview on 5/20/25 at 12:27 p.m., the administrator (ADM) stated he was notified when Resident 1 eloped from the facility on 5/18/25. ADM stated he did not report the elopement to the SSA because Resident 1 was eventually found.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility' policy and procedures (P&amp;P) titled Unusual Occurrence Reporting revised on 5/24, the P&amp;P indicated as required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety or welfare of our residents, employees or visitors. The same Policy indicated the facility will report the following events to appropriate agencies that included occurrences that interfere with facility operations and affect the welfare, safety or health of residents, employees or visitors. Unusual occurrences shall be reported by telephone to appropriate agencies as required by current law and/or regulations within 24 hours of such an incident or otherwise required by federal and state regulations.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36395</p> <p>Based on interview and record review the facility failed to prevent elopement (the act of leaving a facility unsupervised and without prior authorization) for one of three sampled residents (Resident 1). Resident 1 who was identified as an elopement risk, the facility failed to provide one-to-one sitter (staff member that provide one-to-one care and observation to ensure resident ' s safety) to prevent elopement.</p> <p>This deficient practice resulted in Resident 1 eloping from the facility on 5/18/25 at 11 a.m., exposing Resident 1 to danger while out in the community.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility admitted Resident 1 on 5/14/25 with diagnoses including encephalopathy (a disease that affects the function or structure of the brain) and anoxic brain damage (serious types of brain injuries characterized by a lack of oxygen to the brain).</p> <p>During a review of the Progress Notes Admission Summary dated 5/14/25 at 9:53 p.m., indicated safety measures were implemented due to Resident 1 ' s repeated intent to go home and to avoid elopement. The Admission Summary indicated a one-to-one sitter was provided for the incoming shift.</p> <p>During a review of Resident 1 ' s Care Plan initiated on 5/15/25, indicated Resident 1 was placed on elopement precaution. The Care Plan goal indicated Resident 1 will have no episode of escaping from the facility daily in the next 90 days. The care plan interventions included constant monitoring of Resident 1 ' s whereabouts and to maintain a safe and hazard free environment.</p> <p>During a review of Resident 1 ' s History and Physical (H&amp;P, a comprehensive formal assessment by a healthcare provider) dated 5/17/25 indicated Resident 1 required close supervision at all times when out of bed to ensure safety secondary to impaired cognition and poor safety awareness. The H&amp;P indicated Resident 1 continues to be an elopement risk.</p> <p>During a review of the Change in Condition (COC) Evaluation dated 5/18/25 at 3:12 p.m., indicated Resident 1 eloped on 5/18/25 at around 11 a.m. The COC indicated Resident 1 was confused and forgetful. The notes indicated Resident 1 eloped while licensed vocational nurse (LVN 1) was temporarily assisting another resident. Facility searched for Resident 1 but was unable to locate Resident 1. The COC indicated the police, Resident 1 ' s family, the director of nursing and the administrator were notified.</p> <p>During an interview on 5/20/25 at 10:11 a.m., LVN 1 stated Resident 1 was supposed to have a one-to-one sitter on 5/18/25, but no one-to-one sitter was provided to Resident 1. LVN 1 stated he left Resident 1 in the facility ' s front entrance to help another resident. LVN 1 stated when he returned after about five minutes, Resident 1 was already gone. LVN 1 stated the facility searched for Resident 1 but was unable to find Resident 1. LVN 1 stated the police, administrator, Resident 1 ' s family and DON were notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/20/25 at 10:20 a.m., the social service designee (SSD) stated Resident 1 eloped on 5/18/25 and the police found Resident 1 at Resident 1 ' s home. SSD stated Resident 1 ' s home was located 6.4 miles from the facility.</p> <p>During an interview on 5/20/25 at 10:58 a.m., the director of staff development (DSD) stated Resident 1 was forgetful, needed frequent redirection and Resident 1 stated he wanted to go home. DSD stated Resident 1 needed a one-to-one sitter but there was no one-to-one sitter provided to Resident 1 on 5/18/25. DSD stated when Resident 1 eloped, Resident 1 can get lost, get injured and anything can happen to Resident 1.</p> <p>During an interview on 5/20/25 at 11:38 a.m., the registered nurse supervisor (RNS 1) stated based on the report from the general acute hospital prior to Resident 1 ' s admission to the facility, Resident 1 needed a one-to-one sitter. RNS 1 stated the facility should have anticipated that Resident 1 needed a one-to-one sitter .staff should be available to be the sitter.</p> <p>During a telephone interview on 5/20/25 at 11:49 a.m., Resident 1 ' s next of kin (NOK) stated the facility notified her that Resident 1 eloped from the facility. NOK stated she was very upset with the facility and was worried about Resident 1. Resident 1 ' s NOK stated Resident 1 walked from the facility and when Resident 1 arrived at home, Resident 1 was very thirsty.</p> <p>During a review of the facility's policy and procedures (P&amp;P) titled Wandering and Elopements reviewed on 4/25, the P&amp;P indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>During a review of the facility's P&amp;P titled Safety and Supervision of Residents reviewed on 4/25, the P&amp;P indicated resident safety and supervision and assistance to prevent accidents are facility wide priorities. The same Policy indicated resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs and identified hazards in the environment.</p>		