

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  12/18/2025
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)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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

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  12/18/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to implement its abuse policy for one of two sampled residents (Resident 1). For Resident 1, the facility failed to:1.Report to the state survey agency when Resident 1 eloped (the act of leaving a facility unsupervised and without prior authorization) on 12/13/25. The facility did not know where Resident 1 was on 12/13/25 from 6:30 a.m. to 1 p.m.2.Investigate how Resident 1 eloped from the facility on 12/13/25. These deficient practices resulted in a delay in the investigation to ensure Resident 1 was safe while out in the community. Findings; During a review of the admission Record indicated, the facility admitted Resident 1 on 5/14/25 with diagnoses including low back pain, osteomyelitis (infection in the bone) of the left shoulder and history of mental and behavioral disorders. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 11/21/25, indicated Resident 1 was cognitively intact. Resident 1 needed moderate assistance (helper does less than the effort) with lower body dressing and putting on/taking off footwear. Resident 1 needed supervision with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, personal hygiene and needed set up assistance with eating. During a review of the Nursing Progress Note dated 12/13/25 at 9:15 a.m., indicated Resident 1 left the facility without notice. The Note indicated attempts were made to contact Resident 1 by calling Resident 1's cell phone but were unsuccessful. Resident 1's physician was notified. During a review of the Nursing Progress Note dated 12/13/25 at 10:25 a.m., the police were notified. Resident 1's information was given to the police. The Notes indicated the police will continue the .missing persons investigation. During a review of the Nursing Progress Note dated 12/13/25 at 2:42 p.m., indicated that on 12/13/25 at 1 p.m., Resident 1 returned to the facility. The Note indicated Resident 1 was informed that the facility notified the police to help in the search for Resident 1. The Note indicated Resident 1 left the facility without notifying staff and Resident 1 did not have an out on pass order. The same Note indicated at 1:10 p.m., the police was notified that the .missing person has been resolved. During an interview on 12/18/25 at 7:42 a.m., licensed vocational nurse (LVN) 1 stated that on 12/13/25 at around 6:30 a.m., she was informed that Resident 1 was missing. LVN 1 stated she and other staff searched for Resident 1 around the facility including the bathroom and patio but was unable to locate Resident 1. LVN 1 further stated she and the registered nurse supervisor (RNS 1) called several hospitals to find out if Resident 1 was admitted to the hospital. LVN 1 stated Resident 1 left the facility without telling anyone. During an interview on 12/18/25 at 7:54 a.m., LVN 2 stated, on 12/13/25 at around 6:30 a.m., Resident 1 was noted to be missing. LVN 2 stated Resident 1 left the facility without telling anyone. LVN 2 stated the last time she saw Resident 1 was on 12/13/25 at around 4 a.m. in the patio and he was smoking. LVN 2 stated she does not know how Resident 1 was able to leave the facility. During a telephone interview on 12/18/25 at 9:13 a.m. Registered Nurse Supervisor (RNS) 1 stated that on 12/13/25, Resident 1 left the facility without telling anyone. RNS 1 stated he called the police to help locate Resident 1. RNS 1 further added he called the hospitals to find out if Resident 1 was admitted . RNS 1 stated at around 1 p.m., Resident 1 returned to the facility. During an interview on 12/18/25 at 10:46 a.m., the director of nursing (DON) stated that on 12/13/25 LVN 1 notified the DON that Resident 1 left the facility without staff knowledge. The DON agreed that once Resident 1 left the facility without staff knowledge, the incident is considered an elopement. The DON stated the facility did not report to the SSA when Resident 1 eloped on 12/13/25. The DON further stated does not know how Resident 1 was able to elope and did not investigate how Resident 1 eloped. During an interview on 12/18/25 at 12:10 p.m., the administrator stated Resident 1 left the facility on [DATE] and none of the staff knew that Resident 1 had left. ADM stated Resident 1 was missing and the police were notified. ADM stated when Resident 1 left the facility without telling anyone, he did not consider the incident as an elopement and did not report Resident 1's elopement to the SSA. During a review of the of the facility Policy and Procedures P&amp;P) titled Wandering and Elopement reviewed on 1/25, indicated, Elopement is a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary. The same Policy indicated the licensed nurse, and interdisciplinary team shall gather immediate information to assist in determining the root cause of the resident leaving the premises or a safe area without the facility's knowledge and supervision and potential whereabouts. The same P&amp;P indicated that, when the resident returns to the facility the licensed nurse shall complete and file applicable reports. During a review of the facility P&amp;P titled Reporting of Alleged Violations revised on 1/25 indicated The facility shall report all alleged violations and all substantiated incidents to the</p>		

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  12/18/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure that two of five exit doors (Door 1 and Door 2) were properly fitted with a functioning lock. The main entrance (Door 1) and the door near the kitchen (Door 2) had no functioning locks. This deficient practice had the potential to compromise the safety of residents, staff and the public. During observation and concurrent interview on 12/18/25 at 7:54 a.m., at the front entrance of the facility, licensed vocational nurse (LVN) 2 stated Door 1 does not lock even at night. During observation, LVN 2 tried to lock Door 1, but LVN 2 stated the front door does not lock. During observation and concurrent interview on 12/18/25 at 8:30 a.m., a short facility tour was conducted with the housekeeping (HKP). During observation, HKP tried to lock Door 1 and Door 2, using its keys. HKP stated . the locks do not work. HKP was unable to lock Door 1 and Door 2. During interview on 12/18/25 at 8:45 a.m., the receptionist stated visiting hours were from 9 a.m. to 8 p.m. daily. The receptionist stated after visiting hours, Door 1 and Door 2 should be locked because the .facility is not in a good neighborhood. During a telephone interview on 12/18/25 at 10:09 a.m., the maintenance supervisor (MS) stated Door 1 and Door 2 should be locked after visiting hours to ensure safety for residents and staff. During observation and concurrent interview on 12/18/25 at 10:46 a.m., the director of nursing (DON) tried to lock Door 1 and Door 2 by using her keys. The DON was unable to lock Door 1 and Door 2. The DON stated Door 1 and Door 2 do not latch. The DON stated Door 1 and Door 2 should be locked after visiting hours for safety. During a review of the facility Policy and Procedures (P&amp;P) titled Other Environmental Conditions revised on 1/25 indicated, The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The same P&amp;P indicated, the maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds and equipment are maintained in a safe and operable manner. During a review of the facility P&amp;P titled Inform of Visitation Rights-Equal Visitation Privileges revised on 1/25 indicated, Reasonable restrictions are imposed by the facility that protects the security of all the facility's residents that included keeping the facility locked at night.</p>		