

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 01/21/2026
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident's belongings were stored safely to prevent loss for one of three sampled residents (Resident 1). For Resident 1, the facility failed to:1.Update Resident 1's Clothing and Possessions List by including Resident 1's wheelchair after the wheelchair was delivered on 12/28/21.2.Ensure Resident 1's wheelchair was stored securely to prevent loss. 3.Ensure Resident 1's wheelchair was returned to Resident 1 after Resident 1 was discharged from the facility on 3/17/25.These deficient practices resulted in Resident 1's wheelchair being lost and Resident 1 does not have a wheelchair to use for mobility.During a review of the admission Record indicated the facility admitted Resident 1 on 12/10/20 and re-admitted on [DATE] with diagnoses including morbid obesity, muscle weakness and chronic pain syndrome. During a review of the Social Services Note dated 10/28/21 at 5 p.m., indicated Resident 1 was evaluated for .a special wheelchair. by the wheelchair company. During a review of the Social Service Note dated 12/29/21 at 5:05 p.m., indicated the new wheelchair was delivered to Resident 1 on 12/28/21. During a review of the Delivery Ticket dated 11/19/21 at 10:01 a.m., indicated Resident 1's health insurance paid for Resident 1's wheelchair. Resident 1's wheelchair was delivered to the facility on [DATE] and the facility social service designee (SSD) signed the Delivery Ticket. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 2/28/25 indicated Resident 1 was cognitively intact. Resident 1 had impairment of range of motion (ROM, the extent or limit to which a part of the body can be moved around a joint or a fixed point) to both sides of the lower extremities (hip, knee, ankle, foot). Resident 1 used a manual wheelchair for mobility. During a review of the Nursing Progress Notes dated 3/17/25 at 10:30 a.m., indicated Resident 1 was transferred to the general acute hospital (GACH) on 3/17/25. During a review of the admission Record indicated Resident 1 was admitted to another facility on 8/1/25. During a concurrent interview and record review on 1/21/26 at 10:46 a.m., the SSD notes dated 10/28/21 and 12/29/21 for Resident 1 were reviewed with the director of rehabilitation (DOR). The DOR stated Resident 1 was wheelchair bound. The DOR stated on 10/28/21, the wheelchair company evaluated Resident 1 and was .fitted for a special wheelchair for her own use. DOR further added Resident 1 owns the wheelchair and when Resident 1 was discharged from the facility, Resident 1 can take the wheelchair with her. During an interview on 1/21/26 at 1:29 p.m. the administrator (ADM) stated he does not know what happened to Resident 1's wheelchair. ADM stated there was no invoice and he does not know who paid for Resident 1's wheelchair. ADM confirmed that Resident 1's wheelchair was not added to Resident 1's belonging's list. During a telephone interview on 1/21/26 at 3:56 p.m., the customer service representative (CSR) for the wheelchair company stated Resident 1's health insurance paid for Resident 1's wheelchair. CSR stated the wheelchair was delivered to the facility on [DATE]. The CSR stated Resident 1 owns the wheelchair and the facility is responsible for replacing the lost wheelchair. During a review of the</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility's policy and procedures titled Respect and Dignity Right to Have Personal Property revised on 1/25 indicated the resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. A resident's personal property inventory is established upon admission and retained during the resident's stay in the facility and a copy of the written inventory shall be provided to the resident or the authorized resident representative. The same Policy indicated subsequent items brought into or removed from the facility shall be added to or deleted from personal property inventory by the facility at the written request of the resident or an authorized resident representative.</p>		