

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  02/06/2026
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 the nursing interventions according to the care plan for two of four sampled residents (Resident 1 and Resident 2). 1.For Resident 1, the facility failed to monitor and record food intake after each meal.2. For Resident 1 and Resident 2, the facility failed to specify in the care plan the frequency of obtaining their weight, what time of day the weight should be taken and specify the scale that would be used to obtain their weights.These deficient practices had the potential for the facility not meet Resident 1's and Resident 2's needs to maintain ideal body weight.1.During a review of the admission Record indicated the facility admitted Resident 1 on 12/22/21 and re-admitted on [DATE] with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) dysphagia (difficulty swallowing) and pneumonitis (inflammation of the lungs [breathing organ]).During a review of the Minimum Data Set (MDS, resident assessment tool) dated 11/21/25 indicated Resident 1 had moderately impaired cognition. Resident 1 was dependent on staff for shower/bathe self, lower body dressing, putting on/taking off footwear; substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, upper body dressing, personal hygiene and partial assistance with eating.During a review of Resident 1's care plan initiated on 12/31/25 indicated Resident 1 had unplanned/unexpected weight loss related to poor oral intake and episodes of refusal of food. The care plan goal indicated Resident 1 will not have further weight loss for three months. The care plan interventions included monitor and record food intake at each meal and weigh at the same time and record (Frequency), weighed at (time) using (specify scale). The frequency, time and scale were not specified. During a review of Resident 1's Meal Intake indicated Resident 1's meal intake was monitored as follows:1/8/26 - 9 a.m. and 1 p.m.1/9/26 - 8:43 a.m. and 6:04 p.m.1/15/26 -2:33 p.m. and 6:15 p.m.1/22/26 -2:09 p.m. and 8:11 p.m.1/24/26 - 9:21 a.m. and 5:29 p.m.1/27/26 - 8:18 a.m. and 6:10 p.m.1/28/26 - 8:08 a.m. and 6:08 p.m.1/31/26 - 2:34 p.m. and 9:57 p.m.2/1/26 1:16 p.m. and 10:04 p.m. 2. During a review of the admission Record indicated the facility admitted Resident 2 on 8/14/23 and re-admitted on [DATE] with diagnoses including DM, protein calorie malnutrition and reduced mobilityDuring a review of the MDS dated [DATE], indicated Resident 2 had moderately impaired cognition. Resident 2 was dependent on staff for toileting hygiene, shower/bathe self, upper/lower body dressing and taking off footwear. Resident 2 needed substantial assistance with oral hygiene and partial assistance with eating.During a review of Resident 2's care plan initiated on 12/10/25 indicated Resident 2 had unplanned/unexpected wight loss of seven pounds in one week related to disease process. The care plan goal indicated Resident 2 will not have further weight loss for three months. The nursing interventions included weighing at same time of day and record (frequency) weighed at (time) using (specify scale). The frequency, time and scale were not specified.During a concurrent interview and record review on 2/6/26 at 12:57 p.m., Resident 1's meal intake and Resident 1's</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and Resident 2's care plan was reviewed with the director of nursing (DON). The DON stated monitoring of Resident 1's meal intake was inconsistent. The DON stated the purpose of monitoring Resident 1's meal intake is to know the pattern of Resident 1's meal intake and to prevent further weight loss. The DON stated mealtimes are at 7 a.m., 12 p.m. and 5 p.m. The DON stated Resident 1's meal intake should be recorded after each meal. During a review of the care plan for Resident 1 and Resident 2, the DON stated the frequency of taking Resident 1 and Resident 2's weight should be specified including what time and what scale was used to obtain the weights. The DON stated the care plan should be specific and thorough. During a review of the facility's policy and procedures titled Develop-Implement Comprehensive Care Plans reviewed on 1/25, the P&amp;P indicated each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. The facility establishes, documents and implements the care and services to each resident to assist in attaining or maintaining his or her highest practicable quality of life. During a review of the facility's policy and procedures titled Weight Management revised on 12/24, the P&amp;P indicated the weight management committee will review and update the resident's care plan as indicated.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to revise the care plan for one of four sampled residents (Resident 2). The facility failed to:1.Ensure the care plan reflected that Resident 2 was on enhanced barrier precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs, germ that is resistant to many antibiotics) due to the presence of indwelling catheter (medical devices that remain in the bladder (body organ that stores urine) to continuously drain urine in patients who are unable to void spontaneously).2.Obtain physician order to place Resident 2 on EBP.These deficient practices had the potential to spread infection to other residents, staff and visitors.During a review of the admission Record indicated the facility admitted Resident 2 on 8/14/23 and re-admitted on [DATE] with diagnoses including DM, protein calorie malnutrition and reduced mobilityDuring a review of the MDS dated [DATE], indicated Resident 2 had moderately impaired cognition. Resident 2 was dependent on staff for toileting hygiene, shower/bathe self, upper/lower body dressing and taking off footwear. Resident 2 needed substantial assistance with oral hygiene and partial assistance with eating. The same MDS indicated Resident 2 had an indwelling catheter.During a review of the care plan initiated on 7/3/24 indicated Resident 2 was on EBP due to wound but failed to reflect that Resident 2 had indwelling catheter. During observation on 2/6/26 at 9:26 a.m., Resident 2 was observed lying in his bed with an indwelling catheter hanging on the right side of his bed.During a concurrent interview and record review on 2/6/26 at 1 p.m., Resident 2's care plan was reviewed with the director of nursing (DON). The DON stated Resident 2 should be placed on EBP because Resident 2 had wounds and indwelling catheter. The DON further added there was no physician order to place Resident 2 on EBP. DON stated Resident 2's care plan should be revised, and a physician order is needed to place Resident 2 on EBP. The DON stated it is important to have care plans up to date because all staff need to know what kind of care Resident 2 needs. During a review of the facility's policy and procedures (P&amp;P) titled Documentation Policy revised on 1/25 indicated care plans shall be reviewed and revised at a minimum of quarterly or more often as the resident's condition warrants and be in accordance with state and federal regulations.During a review of the facility's P&amp;P titled Enhanced Barrier Precautions implemented on 4/24, indicated EBP are indicated for residents with wounds and/or indwelling medical devices even if the resident is now known to be infected or colonized with MDRO.</p>		