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	05/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement an effective discharge planning process for one of the three sampled residents (Resident 1) who was bedridden (a person is forced to stay in bed because of severe illness, injury, weakness, or old age) and was dependent on staff for feeding via his G-Tube (Gastrostomy tube - a small, flexible medical device inserted directly through the abdomen into the stomach) by failing to:1. Developing a care plan which focuses on the Resident 1's discharge goals.2. Verify that Resident 1 had 24-hour caregiving services and providing orientation. This deficient practice resulted in Resident 1 being left alone from 4/16/2026 approximately 3 pm to 4/17/2026 at approximately 8 am.A review of Resident 1's admission record indicated that Resident 1 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a temporary change in brain function caused by a chemical imbalance, illness, or organ malfunction elsewhere in the body), ileostomy (a surgical procedure that creates an opening in the belly for waste to leave the body), and dementia (a loss of memory, language, reasoning, and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 1's history and physical (H&P) dated 2/8/2026 indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a assessment tool) dated 2/9/2026, the MDS indicated Resident 1 had severe cognitive impairment (a person has profound difficulties with thinking, remembering, and making decisions). The MDS indicated Resident 1 was dependent on staff for all of his Activities of Daily Living (ADLs such as oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, lying to sitting onside of bed, and chair/bed to chair transfer). During a review of a physician's order dated 4/16/2026 indicated, Resident may discharge on [DATE] to Home. The same order indicated tube feeding, Jevity [fiber-fortified liquid formula primarily used as a medical food for tube-feeding] 1.2 [1.2 calories] 400ml [milliliter - unit of measure] 4 times a day (8am, 12pm, 4pm, 8pm) flush [push] with 60ml water before and after each feeding. start with 1/2 the volume for the first couple feeds if switching right away. During a concurrent interview and record review of Resident 1's chart on 5/20/2026 at 11:57 am with the Director of Nursing (DON), the DON stated that Resident 1 did not verbally communicate but utilized communication boards (a simple, visual tool that helps people with limited or no speech express their thoughts, needs, and choices). The DON stated that Resident 1 previously resided at a senior living facility (independent specialized housing and lifestyle communities designed for older adults) and was constantly asking to return. The DON stated that they postponed the discharge because it was not safe which is why they had arranged for Resident 1 to be discharged with Home Health (HH - skilled medical care provided in your home to treat an illness, injury, or chronic condition by licensed professionals such as nurses) and Resident 1's caregiver (CG). The DON stated that nursing staff had provided caregiver training to CG which included G-Tube feedings and ADL care but was unable to provide documented evidence. The DON stated that the importance of documentation was to show and prove that said teachings were provided. The DON stated that there could be certain things that (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be missed when caregiver training is not provided which could worsen resident's health condition. The DON confirmed that there was no individualized discharge care plan developed which should have included continuation of services such as G-Tube feeding. During an interview with Resident 1's caregiver (CG) on 5/20/2026 at 3:21 pm stated she (CG) had worked with Resident 1 prior to being admitted to the facility. CG stated that she had received a call from the facility staff asking her if she was going to continue working with Resident 1 as his caregiver. CG stated that she had made it clear to the facility staff that she would continue working the hours that she worked previously, which was from 8 am to 3 pm. CG stated that on 4/16/2026, Resident 1 was discharged to his apartment and CG stayed with him until 3 pm and left as per agreement. CG stated that when she returned the following day at 8 am, Resident 1 appeared unwell. CG stated that Resident 1's colostomy bag was full and leaking around the site and that there was brownish-foul smelling discharge from his mouth which CG thought was fecal matter. CG stated that she called Resident 1's case manager who then instructed her to call 911 (lines designated for emergencies such as crime, fire, or request for an ambulance). During a follow up interview with the DON on 5/21/2o26 at 11 am, the DON acknowledged that HH services are not initiated the day of discharge meaning that Resident 1 would not have received the skilled services at least the day after his discharge on [DATE]. The DON confirmed that Resident 1 required 24 and depended on staff for all ADLs. During a review of a policy and procedure (P&P) titled, TRANSFER AND DISCHARGE, with a review date of 1/2025, indicated the facility transfers and discharges in a safe manner which ensures that discharge needs, needed support, and resources required by the residents are met. The same P&P indicated the discharge process addressed each resident's goals and needs which included caregiver support and referrals which must include the resident if applicable, resident representative and the interdisciplinary team in developing a discharge plan. The same P&P indicated under the discharge planning process that the discharge must be consistent with the resident's rights which included:- Consider caregiver/support person availability and the resident's or caregiver's/supportperson(s) capacity and capability to perform required care, as part of the identificationof discharge needs.- Involve the resident and resident representative in the development of the dischargeplan and inform the resident and resident representative of the final plan.The same P&P indicated under discharge summary:i. When the facility anticipates a resident's discharge, the resident shall have a dischargesummary that includes, but is not limited to, the following:- A post-discharge plan of care that is developed with the participation of the resident and,with the resident's consent, the resident representative(s), which will assist the resident toadjust to his or her new living environment.- The post-discharge plan of care must indicate where the individual plans to reside, anyarrangements that have been made for the resident's follow up care and any postdischargemedical and non-medical services.