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	07/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post Acute	909 S Lake Street Los Angeles, CA 90006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not maintain privacy for one of five sampled residents (Resident 21) due to broken window blinds that were visible from the main street in Resident 21's room. This failure had the potential to result in Resident 21 being exposed to people outside of the roomFindings: During a review of Resident 21's Face sheet (admission Record) dated 7/21/2025, the Face sheet indicated Resident 21, a [AGE] year old female, was admitted to the facility on [DATE], with diagnosis that included heart failure (a condition where the heart does not pump blood as well as it should making it hard for the body to get the oxygen and nutrients needed) and muscle weakness (a condition where the muscles do not have as much strength as before). During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool used for screening of clinical and functional status), dated 7/12/2025, the MDS indicated Resident 21 had an occasional bowel incontinence episode. During a concurrent observation and interview on 7/21/2025 at 10:19 AM, with Resident 21 in Resident 21's room, there were broken slats (the individual horizontal strips) in the window blinds. There were 22 broken slats out of 39 on one set of blinds and five broken slats out of 33 in the other set of blinds. Resident 21 stated that someone had gone into the room to measure the windows for new blinds but that it had been a few weeks since that occurred and had not seen anyone else since then. Resident 21 stated she does not have privacy due to the broken blinds. During an interview on 7/22/2025 at 11:34 AM, with Resident 21, Resident 21 stated that at night, the staff turn the light on when changing her and stated that anyone can see from the outside into the room. During a concurrent observation and interview on 7/22/2025 at 2:02 PM, with Certified Nursing Assistant 6 (CNA 6) in Resident 21's room, the broken slats in the blinds were observed. CNA 6 stated the blinds were broken and someone from the outside could see into the room. CNA 6 stated it can be a privacy issue to the residents and could affect the residents emotionally and not make them feel good. During an interview on 7/25/2025 at 1:30 PM, with Interim Director of Nursing (IDON), IDON stated most of the residents' rooms face the outside and anyone can look into the room. IDON stated it can affect the privacy and resident's need to feel comfortable while in the facility. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 11/2024, the P&P indicated Each resident shall be care for in a manner that promotes and enhances quality of life, dignity.

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify Resident 61's primary physician (MD 1), for one of three sampled residents (Resident 61), by failing to: 1. Ensure the licensed nurses (in general) informed MD 1 that General Acute Care Hospital 1 (GACH 1) could not accept Resident 61 on [DATE] for dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) and experiencing shortness of breath (SOB) and weakness.2. Ensure licensed nurses (in general) informed MD 1 and initiated a change of condition (COC, internal form) when Resident 61 was not transferred out to GACH 1.These failures resulted Resident 61 did not receive dialysis care and services and did not receive medical interventions for the SOB and weakness. On [DATE] at 4:30 AM, Certified Nursing Assistant 5 (CNA 5) and Licensed Vocational Nurse 3 (LVN 3) found Resident 61 unresponsive (not reacting or moving at all) with no pulse (the number of times the heart beats) inside Resident 61's room. Resident 61 expired at the facility.Findings:During a review of Resident 61's admission Record, the admission Record indicated the facility admitted Resident 61 on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and truck on the same side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain), end stage renal disease (ESRD, irreversible kidney failure), dependence on renal (kidney) dialysis, dysphagia (difficulty swallowing), paroxysmal atrial fibrillation (an irregular heartbeat), and adult failure to thrive (a decline caused by diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 61's admission Cover Sheet, dated [DATE], the admission Cover Sheet indicated Resident 61 received dialysis every Wednesday.During a review of Resident 61's Nursing Progress Note dated [DATE] at 10:51 PM, the Nursing Progress Note indicated Resident 61 missed dialysis. The Nursing Progress Note indicated Resident 61 was rescheduled to go to dialysis later in the day at 4:15 PM. The Nursing Progress Note indicated once Resident 61 got to Dialysis Center 1 (DC 1), DC 1 called and stated they (DC 1) refused to do dialysis on Resident 61 due to Resident 61 feeling weak and had shortness of breath. The Nursing Progress Note indicated DC 1 recommended sending Resident 61 to the hospital. The Nursing Progress Note indicated DC 1 could not reschedule Resident 61 for dialysis the following day because they (DC 1) were booked up. The Nursing Progress Note indicated Resident 61's MD 1 was made aware of the situation. The Nursing Progress Note indicated Resident 61's MD 1 provided physician orders to send Resident 61 to GACH 1 for dialysis. The Nursing Progress Note indicated that the coordinator (unidentified) was contacted about setting up transportation and transfer Resident 61 to GACH 1. The Nursing Progress Note indicated the coordinator (unidentified) stated GACH 1 was saturated (full). The Nursing Progress Note indicated the coordinator (unidentified) would keep the facility updated. The Nursing Progress Note did not indicate Resident 61's MD 1 was notified GACH 1 was saturated. During a review of Resident 61 Care Plan Report dated [DATE], the Care Plan Report indicated Resident 61 had a need for dialysis and was dependent on dialysis. The Care Plan Report indicated Resident 61 was at risk for complications such as SOB, chest pains, elevated blood pressure, edema (swelling caused by excess fluid trapped in the body's tissues), weight fluctuation (instability), and dehydration (occurs when the body loses more fluids than it takes in, leading to a deficiency of water and other essential fluids). During an interview on [DATE] at 11:06 AM, the Interim Director of Nursing (IDON) stated Resident 61's nurse should have called 911 immediately upon Resident 61's return to the facility from the dialysis center. The IDON stated a COC note should have been documented for Resident 61's SOB and weakness and the resident's change of condition should have been monitored for 72 hours after the symptoms were first identified. The IDON stated there was no documentation in Resident 61's progress notes of the resident's monitoring of change in condition and his symptoms on [DATE] from 3 PM to 11 PM, from [DATE] 11 PM to [DATE] 7 AM, [DATE] from 7 AM to 3 PM, and [DATE] from 3 PM to 11 PM. The IDON stated Resident 61 was not transferred out to GACH 1 because GACH 1 was saturated (full) and the earliest time the resident would be able to be transported (to GACH 1) was the following day, [DATE]. The IDON stated Resident 61 remained in the facility and was not transferred out despite having SOB and weakness. The IDON stated that when Resident 61 was not accepted by GACH 1 for transfer, the nurse should have informed MD 1 and should have called 911 to transfer Resident 61 to another hospital. During a concurrent interview and record review, on [DATE] at 11:40 AM, with the IDON, Resident 61's Progress

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to provide mandatory information on Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN: a Skilled Nursing Facility [SNF] must issue this notice to a resident when it believes that Medicare may not cover their care or stay. The SNF must provide the notice to the resident before providing the non-covered care.) appeal process in a timely manner for one of three randomly selected residents (Resident 42). This deficient practice denied Resident 42 the right to accept or decline non-covered specific skilled services or file an appeal. Placing Resident 42 at risk for unexpected financial burden/crisis.Findings:During a review of Resident 42's admission Record, the admission Record indicated the facility re-admitted the resident on 8/20/2023 with diagnoses that included muscle weakness, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should).During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool) dated 7/3/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason).During a review of Resident 42's SNF Beneficiary Notification Review form, SNF Beneficiary Notification Review form indicated the resident's last covered day for Medicare Part A skilled services was on 11/9/2024. The SNF Beneficiary Notification Review form indicated the facility initiated Resident 42's discharge from Medicare part A Services when benefit days were not exhausted. The SNF Beneficiary Notification Review form indicated Resident 42 was not provided with a SNFABN because the resident remained in the facility.During a concurrent interview and record review on 7/23/2025 at 3 PM, with Admissions (AS1), Resident 42's SNF Beneficiary Notification Review form was reviewed. AS1 stated and verified that Resident 42 was still residing in the facility. AS1 stated Resident 42's last covered day of Medicare Part A services was 1/12/2025. AS1 confirmed by stating Resident 42 was not given a SNF ABN. AS1 did not know why Resident 42 did not receive a SNF ABN. AS1 was not familiar with the SNF ABN process or when one should be given. AS1 stated the Business Office Manager (BOM) handles the SNFABN process, but the BOM was not at the facility.During a concurrent interview and record review on 7/24/2025 at 10:52 AM, with the Interim (temporary) Director of Nursing (IDON), Resident 42's SNF Beneficiary Notification Review form was reviewed. The IDON stated the BOM was not available for interview. The IDON stated Resident 42 did not receive a SNFABN. The IDON stated the resident should have received a SNFABN. The IDON stated there was a potential for Resident 42 to not have knowledge that their Medicare Part A benefits were ending and not be able to make an informed decision about her care.During a review of the facility's Policy & Procedure (P&P) titled Medicaid Medicare Coverage Liability Notice dated 1/2025, the P&P indicated The facility informs each resident before, during admission, and periodically the services available and of charges for those services.The facility provides the beneficiary with a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), form CMS 10055, to inform the Medicare A beneficiary of his or her potential liability for payment and related standard claim appeal rights; at the initiation, reduction or termination of services.When the beneficiary is expected to remain in the facility and the facility believes the services may not be covered under Medicare, the SNF shall issue a SNFABN, to inform the beneficiary of potential liability for the non-covered stay. The SNF shall issue a SNFABN to the resident when:a. Initiation: When a SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary.b. Reduction: In the situation in which a SNF proposes to reduce a beneficiary's extended care items or service because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary.c. Termination: In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving care, the SNF must provide a SNFABN to the beneficiary before it terminates such extended care items or services.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure the drug regimen of two of five sampled Residents (Resident 7 and Resident 11) were free of unnecessary psychotropic medications (types of medication that affects brain activity and is used to treat mental health disorders) medication by: Failing to ensure the gradual dose reduction (GDR, a method used to slowly and carefully decrease the dosage of a medication over time) for risperidone (Risperdal, a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought]) was performed in February 2025 for Resident 7.Failing to ensure an informed consent form (a formal conversation and a signed document that acknowledges the resident's understanding and agreement to the medication treatment plan) for alprazolam (Xanax, a medication used to treat anxiety [a feeling of fear, dread, and uneasiness]) was signed by the Responsible Party (RP, an individual who is responsible for handling a resident's finances and medical care) for Resident 11. This failure had the potential to Resident 7 to experience adverse affects (undesired, harmful effects resulting from a medical treatment or intervention, ranging from mild to severe, and potentially life-threatening) from taking Risperdal; and Resident 7 to experience inappropriate or excessive treatment. This failure had the potential to Resident 11 to experience adverse effects from taking Xanax; and affect the ability of Resident 11's RP to make an informed decision about the medication Resident 11 was receiving. Findings: 1.During a review of Resident 7’s admission Record, the admission Record indicated the facility re-admitted the resident on 1/5/2025, with a diagnosis that included schizophrenia, cognitive communication deficit (a communication impairment resulting from difficulties with cognitive processes like attention, memory, and problem-solving), and depression (a serious mood disorder that goes beyond feeling sad or having a bad day). During a review of Resident 7’s Minimum Data Set (MDS, a resident assessment tool) dated 6/21/2025, the MDS indicated the resident did not experience hallucinations, delusions, or behavioral symptoms. The MDS indicated Resident 11 was taking anti-psychotic medication (used primarily to treat symptoms of psychosis [a mental state characterized by a disconnect from reality, often involving hallucinations, delusions, and disorganized thinking]). During a review of Resident 7’s Order Audit Report dated 7/25/2025, the Order Audit Report indicated the resident had a Physician’s Order (PO) for 1.5 milligrams (mg, a unit of measurement) of Risperdal by mouth two times a day for schizophrenia manifested by auditory hallucinations starting on 1/5/2025 at 6:12 PM. During a review of Resident 7’s Medication Administration Record (MAR, a document that details the medications administered to a resident by healthcare professionals) dated 7/25/2025, the MAR did not indicate Resident 7 experienced behavior of schizophrenia manifested by auditory hallucinations from 4/1/2025 to 7/25/2025. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/26/2025 at 1:40 PM, with Registered Nurse (RN) 3, Resident 7’s Medication Regimen Review (MRR, a process where a pharmacist thoroughly examines a resident's medications to identify potential problems or opportunities for improvement) dated 2/10/2025 was reviewed. The MRR indicated a GDR for Risperdal was due and the Resident 7 should be evaluated to determine if a dose reduction was warranted. RN 3 stated there was no documented evidence to indicate the facility completed a GDR for Risperdal 1.5 mg by mouth two times a day for schizophrenia manifested by auditory hallucinations in February 2025 for Resident 7. RN 3 stated GDR ensures residents receive appropriate medication and dosage while reducing unnecessary administration and potential adverse effects. RN 3 stated Resident 7 was at increased risk of experiencing hypotension (the pressure of blood circulating around the body is lower than normal), lethargy (a state of extreme tiredness, sluggishness, and lack of energy), falls (a situation where a patient unexpectedly drops to the floor or another lower level), extrapyramidal symptoms (side effects of certain medications, particularly antipsychotics, that affect movement and coordination), and isolation (a state of being alone, detached, or separated from a group, whether physically or socially). During an interview on 7/25/2025 at 3:22 PM, the Interim (temporary) Director of Nursing (IDON) stated GDR is performed to ensure safe medication use by minimizing unnecessary medications, using the lowest effective dose, and reducing the risk of adverse effects. During a review of the facility’s Policy and Procedure (P&P) titled “Dignity and Respect Psychoactive Medications” dated 1/2025, the P&P indicated, “Psychotropic drug: any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic. [.] Adequate indications for use: the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident’s condition and therapeutic goals, and after any other treatments have been deemed clinically contraindicated. [.] Gradual Dose Reduction (GDR): stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued. [.] Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. [.] The facility shall document evidence that a GDR has been attempted unless clinically contraindicated in the medical record” b. During a review of Resident 11’s admission Record, the admission Record indicated the facility re-admitted the resident on 5/10/2025, with a diagnosis that included dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety. The admission Record indicated Family Member 1 (FM 1) was Resident 11’s RP. During a review of Resident 11’s Physician Progress Note dated 5/11/2025 at 7:26 AM, the Physician Progress Note indicated the resident could make her needs known but could not make medical decisions. During a review of Resident 11’s Minimum Data Set (MDS, a resident assessment tool) dated 6/20/2025, the MDS indicated the resident had severely impaired cognition (impairment in the ability to think, understand, and reason). The MDS indicated Resident 11 was taking anti-anxiety medication (medication used to treat anxiety). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11’s Order Summary Report dated 7/18/2025, the Order Summary Report indicated the resident had a Physician’s Order (PO) for 2 milligrams (mg, a unit of measurement) of Xanax by mouth every six hours as needed for increased anxiety and restlessness for 14 days. During a review of Resident 11’s Informed Consents: Risks and Benefits of Anti-Anxiety Medications form dated 7/18/2025, the Informed Consents: Risks and Benefits of Anti-Anxiety form indicated the resident was taking 2 mg of Xanax by mouth every 6 hours as needed for a diagnosis of anxiety disorder and a behavior of restlessness (feeling uneasy, agitated, or unable to relax or stay still). The Informed Consents: Risks and Benefits of Anti-Anxiety Medications form indicated it was signed by Resident 11. The Informed Consents: Risks and Benefits of Anti-Anxiety Medication form did not indicate a signature of a resident representative. During a concurrent interview and record review on 7/23/2025 at 10:51 AM, with Licensed Vocational Nurse 6 (LVN 6), Resident 11’s Informed Consents: Risks and Benefits of Anti-Anxiety Medications form dated 7/18/2025 was reviewed. LVN 6 stated FM 1 was Resident 11’s RP. LVN 6 stated FM 1 made medical decisions for Resident 11. LVN 6 stated Resident 11’s physician indicated the resident could make needs known, but the resident could not make medical decisions. LVN 6 stated the Informed Consents: Risks and Benefits of Anti-Anxiety Medications form dated 7/18/2025 was signed by Resident 11 and not Resident 11’s RP. LVN 6 stated Resident 11’s RP should have provided consent for the resident to take Xanax. LVN 6 stated there was a potential for Resident 11 and Resident 11’s RP to not be aware of the type of medication the resident was receiving. During a concurrent interview and record review on 7/24/2025 at 10:54 AM, with the Interim (temporary) Director of Nursing (IDON), Resident 11’s Informed Consents: Risks and Benefits of Anti-Anxiety Medications form dated 7/18/2025 was reviewed. The IDON stated Resident 11 could verbalize her needs but could not make medical decisions. The IDON stated FM 1 was Resident 11’s RP. The IDON stated FM 1 made medical decisions for Resident 11. The IDON stated the signature on the Informed Consents: Risks and Benefits of Anti-Anxiety Medications form dated 7/18/2025 was Resident 11’s. The IDON stated there was no signature from FM 1 on Resident 11’s Informed Consents: Risks and Benefits of Anti-Anxiety Medications form dated 7/18/2025. The IDON stated nursing staff (in general) needed to ensure that the RP and the resident were aware of the risk and benefits of each medication the resident would take, especially the antianxiety medications because the medications have adverse side effects. The IDON stated there was a potential for Resident 11 and FM 1 to not be able to make an informed decision about the medication the resident was taking. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s Policy and Procedure (P&P) titled “Dignity and Respect Psychoactive Medications” dated 1/2025, indicated “Psychotropic Drug: Any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic…Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative shall be informed of the benefits, risks and alternatives for the medication, including any black box warning for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The resident’s medical record shall include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives that he or she preferred. The facility has a written consent form which may serve as evidence of a resident’s consent to psychotropic medication; and may have other documented evidence of the resident’s consent or decline to treatment.”

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was created and transmitted to the Centers for Medicare and Medicaid Services (CMS, a federal agency that administers the Medicare program, among other health-related programs like Medicaid and the Children's Health Insurance Program) for one of 10 sampled residents (Resident 24), when Resident 24 was discharged from the facility on 6/17/2025.This failure had the potential to result in delayed discharge care for Resident 24.Findings:During a review of Resident 24's admission Record, the admission Record indicated the facility admitted the resident on 1/16/2025 with diagnoses that included urinary tract infection (UTI, an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), muscle weakness and transient cerebral ischemic attack (TIA, a temporary blockage of blood flow to the brain).During a review of Resident 24's quarterly MDS assessment dated [DATE], the quarterly MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason).During a review of Resident 24's Social Service Note dated 6/16/2025 at 2:35 PM, the Social Service Note indicated the resident would be discharged home with her family on 6/17/2025.During a review of Resident 24's Discharge Summary Progress Note dated 6/17/2025 at 7:39 AM, the Discharge Summary Progress Note indicated the resident may be discharged on 6/17/2025 at 7 AM. The Discharge Summary Progress Note indicated the resident left the facility at approximately 7 AM. The Discharge Summary Progress Note indicated Resident 24 was discharged with her family and her medications. The Discharge Summary Progress Note indicated Resident 24 left the facility with her Responsible Party (RP) in stable condition.During a concurrent interview and record review on 7/25/2025 at 10:13 AM, with MDS Coordinator (MDSC 1), Resident 24's quarterly MDS assessment dated [DATE] was reviewed. MDSC 1 stated that Resident 24 was discharged home from the facility on 6/17/2025. MDSC 1 stated a discharge MDS assessment for Resident 24 was not created or transmitted to the CMS system when Resident 24 was discharged from the facility. MDSC 1 stated the discharge MDS should have been created the same day Resident 24 was discharged from the facility. MDSC 1 stated the facility had 14 days to complete the discharge MDS assessment, and 14 days from completing the discharge MDS assessment to transmit the MDS information to CMS. MDSC 1 stated the last MDS assessment in the system was Resident 24's quarterly MDS assessment dated [DATE].During an interview on 7/26/2025 at 3:30 PM with the Interim (temporary) Director of Nursing (IDON), the IDON stated an MDS assessment should be completed when a resident is discharged from the facility. The IDON stated that there was a potential for a delay in discharge care for the resident if the MDS discharge assessment was not completed or transmitted to the CMS system.During a review of the facility's Policy & Procedure (P&P) titled Automated Data Processing dated 1/2025, the P&P indicated The facility provides resident specific information for payment and quality measure purposes.Within 14 days after a facility completes a resident's assessment, the facility shall electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:.g. A subset of items upon a resident's transfer, reentry, discharge, and death.The facility shall transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

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	055461	A. Building B. Wing	07/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post Acute	909 S Lake Street Los Angeles, CA 90006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident's needs for three of 14 sampled residents (Resident 3, Resident 10, and Resident 11) as evidenced by: Failing to specify Resident 3's significant personal interests and activities to support coping with auditory hallucinations (when someone hears sounds or voices that are not there).Failing to reduce environmental noise while cleaning Resident 10. Failing to develop a comprehensive person-centered care plan for Resident 11's diagnosis of dementia (a progressive state of decline in mental abilities). These failures had the potential for Resident 3, Resident 10, and Resident 11 to receive inadequate care and services needed. Findings:During a review of Resident 3's Face sheet (admission Record) dated 7/22/2025, the Face sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included hemiplegia (a condition where there is paralysis or severe weakness on one side of the body) and paranoid schizophrenia (a condition that involves delusions [false beliefs] and hallucinations [seeing or hearing things that are not real]). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 6/20/2025, the MDS indicated the resident had anxiety disorder (a condition where someone has excessive and persistent feelings of worry or fear) and schizophrenia (a mental health condition that affects someone's thoughts, behavior and feelings). The MDS indicated it was very important for Resident 3 to listen to music he likes, keep up with the news and do his favorite activities. During a review of Resident 3's care plans, the care plans did not indicate there was a specific care plan with interventions for Resident 3 auditory hallucinations. During an interview on 7/23/2025 at 9:39 AM, with Resident 3, Resident 3 stated he enjoyed watching the news on the television and he enjoyed listening to music on the radio. During an interview on 7/23/2025 at 9:43 AM, with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated specific activities and preferences should be included in their care plan. LVN 6 stated that not having a resident specific care plan can affect the resident and the resident may perceive that the care provided is inadequate of that the facility is incapable of meeting their needs, which may lead to feelings of isolation. During an interview on 7/23/2025 at 10:00 AM, with Interim (temporary) Director of Nursing (IDON), the IDON stated care plans should be personalized, incorporating activities the resident enjoys, whether that includes watching television or playing games like dominoes, and the care plan should not be general. IDON stated when personal preferences are not reflected in the care plan, the resident may experience feelings of isolation. 2. During a review of Resident 10's Face Sheet (admission record) indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a change in how the brain works due to an underlying condition that can cause confusion and memory loss), chronic kidney disease, and Alzheimer's disease (a progressive disease that destroys memory and other brain functions). During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), the MDS indicated Resident 10 had difficulty communicating some words or finishing thoughts but is able if prompted or given time. During a review of Resident 10's Care Plan titled Communication, dated 1/3/2023, the Care Plan listed interventions including: Allow adequate time to respond. Request clarification from the resident to ensure understanding. Turn off television (TV)/radio to reduce environmental noise. Use alternative communication tools as needed. During a concurrent observation and interview on 7/22/2025 at 2:20 PM in Resident 10's room, Resident 10's roommates were watching TV and listening to music at loud volumes. CNA 4 spoke to Resident 10 at a normal volume and stated she was going to clean her. CNA 4 stated she was going to lay Resident 10 flat in bed and began adjusting the bed before waiting for Resident 10 to respond. CNA 4 began wiping Resident 10's perineal area without telling Resident 10. CNA 4 gently pushed Resident 10 to help her turn to her left and stated at a normal volume to turn, then repeated the same to tell the resident turn to the right side. When CNA 4 finished cleaning Resident 10, CNA 4 stated she should have been communicating with the resident more thoroughly throughout the process because Resident 10 has difficulty speaking due to her Alzheimer's. During an interview on 7/23/2025 at 12:35 PM with the IDON, the IDON stated the importance of following care plans for residents because the care plans outline individualized interventions for each resident. The IDON stated that when communicating to residents with Alzheimer's disease, staff must provide cues, use pictures, allow enough time for the resident to respond yes or no, and explain each

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident 40 maintained clean and intact skin in the perineal area (area between the anus and the external genitalia) when Resident 40 developed Moisture-Associated Skin Damage (MASD, a type of skin damage that occurs when prolonged exposure to moisture, such as urine, weakens the skin's protective barrier, leading to inflammation, breakdown, and potential infection).This failure resulted in Resident 40 developing MASD in the perineal area and experiencing discomfort and pain in the affected area due to skin breakdown and exposure to urine and feces.Findings:During a review of Resident 40's admission Record (a document that collects essential information about a resident when they enter a healthcare facility), dated 7/25/2025, the record indicated Resident 40, a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis that included left above the knee amputation (the surgical removal of a leg above the knee joint), stage 2 (characterized by a partial thickness loss of skin involving the outer layer and second layer) pressure ulcer (an injury to the skin and underlying tissue caused by continuous pressure on the skin) of the right buttock, type 2 diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool) dated 7/22/2025, the MDS indicated Resident 40 was always incontinent of bladder and bowel (difficulty or inability to control the release of urine and stool) and was at risk of developing skin injuries. The MDS indicated Resident 40 required substantial/ maximal assistance for activities of daily living such as toileting hygiene, oral hygiene, personal hygiene (including combing hair, shaving, applying makeup, washing/drying face and hands) and dressing. The MDS indicated Resident 40 had functional and range of motion limitations in both legs and required the use of a wheelchair for mobility. During a review of Resident 40's Care Plan, last reviewed on 5/28/2025, the care plan indicated Resident 40 had potential/actual risk for impaired skin integrity in the perineal area due to MASD and fragile skin. The care plan indicated interventions to minimize skin injury included keeping the skin clean and dry, frequent visual checks, and resident repositioning.During an interview on 7/23/2025 at 10:01 AM, Certified Nursing Assistant (CNA) 6 stated Resident 40 relied on staff to perform perineal care (the cleaning or washing of the genitals and anal area). CNA 6 stated Resident 40 was provided with perineal care twice in an 8-hour shift. CNA 6 stated Resident 40 had developed skin redness in the right and left inguinal folds (crease between the thigh and groin).During a perineal care observation on 7/23/2025 at 10:34 AM in Resident 40's room, Resident 40 had erythematous (exhibiting abnormal redness), weeping (oozing fluid), and excoriated (superficial skin loss or open areas) skin in the perineal area. Resident 40 stated it hurts down there while staff provided perineal care.During an interview on 7/23/2025 at 3:30 PM Treatment Nurse (TN) stated that Resident 40 had developed MASD and dermatitis (inflammation of the skin) in the perineal area. TN stated Resident 40 had developed a denuded line (a wound where the outermost layer of skin has been removed) with watery exudate (clear or pale-yellow fluid that leaks from a wound) below the coccyx (the last bone at the bottom of the spine). TN stated Resident 40's skin injuries were caused by moisture from urinary and fecal incontinence. Stated Resident 40 should be monitored for incontinence every two hours to ensure her skin remains as dry as possible.During a review of the facility's policy and procedure (P&P) titled, Treatment Services to Prevent/Heal Pressure Ulcers, last reviewed January 2025, the P&P indicated, both urine and feces contain substances that may irritate the epidermis [the outermost layer of the skin] and may make the skin more susceptible to breakdown and moisture-related skin damage. Fecal incontinence may pose a greater threat to skin integrity, due to bile acids [substance produced in the liver that help digest and absorb fats] and enzymes [proteins that help speed up chemical reactions in the body] in the feces. Irritation or maceration [the softening and breakdown of skin tissue due to prolonged exposure to moisture] resulting from prolonged exposure to urine and faces may hasten skin breakdown, and moisture may make skin more susceptible to damage from friction during repositioning. The P&P stated that risk factors include exposure of skin to urine and feces, the presence of previously healed PU/PI, impaired/decreased mobility and decrease functional ability, co-morbid conditions, and cognitive impairment. The P&P indicated the facility shall: Evaluate resident specific risk factors and changes in the resident's condition that may impact the development and/or healing of a PU/PI. Implement, monitor, and modify interventions to attempt to stabilize, reduce or remove underlying risk factors.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of three sampled resident (Resident 61) for closed record review was immediately provided with cardiopulmonary resuscitation (CPR, a lifesaving emergency procedure for a victim who has signs of cardiac [heart] arrest [a situation when a victim becomes unresponsive, no normal breathing, and no pulse], consisting of a combination of chest compressions, mouth-to-mouth, or mechanical breathing [a device used to help someone breathe]) in accordance with the facility's policy and procedure titled, Cardiopulmonary Resuscitation (CPR) by failing to: 1. Verify Resident 1's code status (a set of instructions for medical staff about what to do or not do in a medical emergency) from the hospital record, dated 5/21/2025. The hospital record, dated 5/21/2025, indicated Resident 1 was full code (indicates a resident wishes to be revived when breathing and/or heart stops). 2. Ensure Certified Nursing Assistant 5 (CNA 5) and Licensed Vocational Nurse 3 (LVN 3) initiated and performed CPR to Resident 61, after the resident was found unresponsive on 6/20/2025 at 4:30 AM on his bed. 3. Ensure Resident 61 had a physician order specifying the resident's code status. 4. Implement the facility's policy and procedure (P&P), titled, Cardiopulmonary Resuscitation (CPR) by not providing Resident 61 CPR when he was found unresponsive on 6/20/2025 at 4:30 AM on his bed. These deficient practices resulted in delayed treatment and not providing lifesaving emergency procedures to Resident 61. Resident 61 died at the facility. Resident 61's Record of Death, dated 6/20/2025 record did not indicate the resident's time of death. On 7/25/2025 at 5:27 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the failure to ensure CPR was immediately performed on Resident 61, after the resident was found unresponsive on 6/20/2025 at 4:30 AM. The survey team notified the Interim Director of Nursing (IDON) and the Administrator (ADM) of the IJ situation. On 7/26/2025 at 5:29 AM, the facility submitted an IJ removal plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation), but the IJ removal plan was not accepted. On 7/26/2025 at 4:45 PM, the survey team completed the recertification survey tasks and conducted an exit conference while onsite in the presence of the IDON with the IJ situation not removed. On 7/28/2025 at 4:02 PM, the IJ was removed in the presence of the ADM and the IDON after the facility submitted an acceptable IJ Removal Plan and the surveyor verified and confirmed onsite the facility's implementation of the IJ Removal Plan and that the IJ situation was no longer present. The IJ Removal Plan dated 7/27/2025 at 4:30 PM, included the following: 1. Resident 61 expired on June 20, 2025 (time not indicated) and LVN 3 notified the physician of the resident's death. 2. On 7/26/2025, the facility's IDON and Director of Staff Development (DSD) attended an in-service provided by an outside RN Consultant at the facility on F678 Personnel Provide Basic Life Support including CPR - Verification of Code Status and Performing CPR, Code Blue (an emergency code indicating a patient is experiencing cardiac or respiratory [breathing] arrest [sudden stop] and required immediate resuscitation [the process of restoring life, typically by restarting the heartbeat and breathing]) and Pronouncement of Death. The following process will be implemented as follows: a. The Licensed nurses will verify the code status by checking the written physician order in Point Click Care (PCC, a healthcare management software) and the completed and signed POLST (Physician Orders for Life Sustaining Treatment, a record signed by the resident or representative and a physician that indicates the types of medical treatment they want to receive during serious illness) by resident/responsible party (RP) and physician. b. Licensed nurses will call code blue and initiate CPR after confirming the resident is nonresponsive, with no pulse or rise and fall of chest and will remain with the resident. c. If CPR is unsuccessful, a Registered Nurse (RN) or 911 (an emergency telephone number) will validate the resident's death and inform a physician for the pronouncement of death and will be documented in the nursing progress notes. 3. On 7/26/2025, the IDON provided on- on-one in-service on F678 Personnel Provide Basic Life Support including CPR - Verification of Code Status and Performing CPR, Code Blue and Pronouncement of Death to LVN 3. 4. On 7/26/2025, the facility's DSD checked 52 nursing staff (RN, LVN, CNA) CPR certification records and verified them to be current. 5. On 7/26/2025, the IDON performed skills competency to facility's licensed nurses (RN and LVN) with focus on Performing CPR and Performing Code Blue. 6. On 7/26/2025, the IDON performed skills competency with focus on Performing CPR and Performing Code Blude to LVN 3. 7. On 7/26/2025, CNA 5 was identified and per employee's record review, was discharged on 7/7/2025. 8. On 7/26/2025, the facility's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 6) reviewed for pressure ulcer (an injury to the skin and underlying tissue caused by continuous pressure on the skin) care area did not develop a pressure ulcer by failing to: 1. Ensure that the Certified Nurse Assistant (CNA) monitored and documented the repositioning of Resident 6, who was assessed for a high risk of developing a pressure ulcer. 2. Include the Registered Dietitian (RD, a healthcare professional who has a special training in diet and nutrition) in the interdisciplinary team (IDT, a group of professionals from different fields who collaborate for a common goal) to discuss and implement interventions for promoting the healing of Resident 6's unstageable (when the full extent of the skin damage cannot be determined because there is dead tissue present) at the sacrococcyx (an area of the body where the lower end of the spine meets the tailbone). 3. Ensure Licensed Nursing Staff followed up with RD on the referral as requested on the Weekly Pressure Ulcer Record, dated 6/18/2025. 4. Communicate to Resident 6's physician the resident's lab results, dated 7/18/2025, which showed an albumin (reflects the nutritional status of a patient. Low albumin level can impair the body's ability to heal wounds, including pressure ulcers. Normal albumin levels range from 3.5 to 5.5 grams per deciliter) level of 2.6 grams per deciliter (g/dl, a unit of measurement) and hemoglobin (a protein in the red blood cells that carries oxygen to the body, which is vital for tissue repair and healing. Normal levels range from 12 to 15.5 g/dl) level of 8.6 g/dl. These failures resulted in Resident 6 developing an unstageable pressure ulcer on the sacrococcyx extending to the left and right buttock measuring 10.1 centimeters (cm, a unit of measurement) in length and 14.0 cm in width.Findings: During a review of Resident 6's Face sheet (admission Record) dated 7/24/2025, the Face sheet indicated the facility admitted Resident 6 on 8/14/2023 with diagnosis that included hemiplegia and hemiparesis (a condition where there is paralysis or severe weakness on one side of the body) and anemia (a condition where the blood does not have enough red blood cells to carry oxygen throughout the body). During a review of Resident 6's admission Assessment, dated 7/3/2024, the admission Assessment did not indicate Resident 6 was assessed for skin breakdown. During a review of Resident 6's Braden Scale (a tool used to assess a person's risk of developing pressure ulcers), dated 4/30/2025, the Braden Scale indicated Resident 6 was at a moderate risk to develop a pressure ulcer. During a review of Resident 6's Braden Scale reassessment, dated 6/18/2025, the [NAME] Scale reassessment indicated Resident 6 was at a high risk to develop a pressure ulcer. During a review of Resident 6's Wound Care Specialist note, dated 6/27/2025, the Wound Care Specialist note indicated Resident 6 had an unstageable pressure induced tissue damage on the sacrococcyx, extending to left and right buttock, measuring 10.1 cm in length and 14.0 cm in width. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool used for screening of clinical and functional status), dated 7/25/2025, the MDS indicated Resident 6 had impaired function on one upper extremity, impaired function on both lower extremities, and required staff assistance to roll from lying on their back to the left and right side and return to back-lying position in bed. The MDS did not indicate Resident 6 had a pressure ulcer/injury. During an observation on 7/23/2025 at 12:03 p.m. in Resident 6's room, Resident 6 was positioned onto his back after wound care treatment. During an observation on 7/23/2025 at 2:10 p.m. in Resident 6's room, Resident 6 was observed to be lying on his back. During an interview on 7/23/2025 at 1:23 p.m. with Certified Nursing Assistant 11 (CNA 11), CNA 11 stated that CNAs were unable to chart whether a resident is repositioned to the left or right side. CNA 11 mentioned that there is no set schedule for offloading or repositioning residents, but CNAs clicks on the yes/no at the daily task list if they perform it. During an interview on 7/23/2025 at 12 p.m. with Treatment Nurse (TN), TN stated Resident 6 had a reopened pressure ulcer (a pressure ulcer that was once healed and now has opened again). TN stated Resident 6 had been free from skin breakdown for one year since Resident 6 was readmitted on [DATE] and the reopened pressure ulcer was obtained in the facility. TN stated that during the readmission [DATE]) of Resident 6 in the facility there are no skin issues identified. During a concurrent interview and record review on 7/24/2025 at 9:19 a.m. with TN, the Documentation Survey Report for turn and reposition, dated 6/2025, was reviewed. The Documentation Survey Report did not indicate the staff repositioned Resident 6. TN stated there should be documentation indicating the staff repositioned the resident and the blank spaces on the report indicate that it was not done. TN stated pressure ulcers are avoidable when interventions are implemented. TN stated that the care plan was generalized and not specific to the needs of Resident 6 like

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to apply resting hand splints to both hands for one of 14 sampled residents (Resident 56). This deficient practice has the potential to led for worsening contracture (a condition where muscles, tendons, and skin tighten, leading to a reduced range of motion) and a decrease in right hand mobility for Resident 56. Findings: During a review of Resident 56's Face Sheet (admission record) indicated Resident 56 was admitted to the facility on [DATE] with diagnoses that included fracture of the right femur (a break in the thigh bone), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), the MDS indicated Resident 56 requires supervision and maximal assistance to complete activities of daily living. During a review of Resident 56's Order Summary Report, the Order Summary Report indicated Resident 56 had an order for Restorative Nurse Assistant (RNA, a healthcare worker who focuses on helping patients regain and maintain their mobility) 1 to don (to put on) and doff (to take off) a resting hand splint (a device that supports the hand, wrist, and fingers in a slightly extended position to prevent or manage hand contractures) to Resident 56'sright and left upper extremities once daily for two hours, five times a week. During an observation on 7/22/2025 at 10:12 AM in the Activity Room, Resident 56 was sitting in a wheelchair with both hands in a contracted position with no resting hand splints on. During an interview on 7/22/2025 at 11:40 AM with RNA 1, RNA 1 stated Resident 56's hand splints were missing so she was unable to apply them. During a concurrent observation and interview on 7/23/2025 at 9:55 AM with RNA 1 in Resident 56's room, RNA 1 was performing passive range of motion (PROM, joint movement caused by another person) exercises with Resident 56. Resident 56 grimaced and stated she was in pain when RNA 1 tried opening Resident 56's right hand from its contracted position. During a concurrent interview and record review on 7/23/2025 at 12:15 PM with Physical Therapist (PT, a healthcare worker who helps patients improve or restore movement and function), Resident 56's Occupational Therapy Evaluation and Plan of Treatment, dated 7/1/2025 was reviewed. The evaluation report indicated Resident 56 had impairments of both hands. PT stated the Occupational Therapist (OT, a healthcare worker who helps patients improve their ability to perform activities of daily living) made recommendations for Resident 56 to wear resting hand splints on both hands two hours on and two hours off to reduce pain caused by muscle tightening. PT stated RNA would be responsible for applying the resting hand splints each day. During a phone interview on 7/24/2025 at 11:26 AM with OT, OT stated she assessed Resident 56 yesterday (7/23/2025) and determined Resident 56's right hand contracture has worsened and is also developing left hand contracture. During a review of the facility's policy and procedure (P&P) titled Specialized Rehabilitation Services, revised January 2025, the P&P indicated, The interdisciplinary team provides or arranges for the provision of specialized rehabilitative services to all residents that require these services for the appropriate length of time as assessed in their comprehensive plan of care.

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California Post Acute	909 S Lake Street Los Angeles, CA 90006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the fall risk care plan for one of 14 sampled residents (Resident 5) when Resident 5 was not frequently visually monitored to prevent a fall. This failure had the potential to result in Resident 5 experiencing excessive bleeding and serious injury from a fall. Findings: During a review of Resident 5's Face Sheet (admission record) indicated Resident 5 was admitted to the facility on [DATE], with diagnoses that included necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin), generalized muscle weakness, lower leg osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and chronic ulcers (open sores or wounds on the skin) of the right and left feet. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), the MDS indicated Resident 5 has impairments to both feet and requires supervision and assistance to complete activities of daily living. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated Resident 5 had physician orders for aspirin (a medication that thins the blood) tablet 81 milligrams (mg) tablet by mouth one time a day, Eliquis (a medication that thins the blood) tablet 5 mg by mouth two times a day, carvedilol (a medication that lowers blood pressure) tablet 3.125 mg by mouth two times a day, clonidine (a medication that lowers blood pressure) tablet 0.1 mg by mouth every six hours as needed, and diltiazem (a medication that lowers blood pressure) tablet 60 mg by mouth four times a day. During a review of Resident 5's Care Plan Report, dated 5/20/2024, the Care Plan Report listed Frequent visual checks on resident to prevent falls. During a concurrent observation and interview on 7/21/2025 at 8:23 AM in Resident 5's room, Resident 5 had curtains drawn throughout her bed which made her difficult to see. Resident 5 also had both feet wrapped in wound dressings and was not wearing non-slip socks. Resident 5 stated she always has the curtains drawn around her bed. During a review of Resident 5's Change in Condition Evaluation, dated 7/22/2025, the Change in Condition Evaluation indicated Resident 5 stated she fell on 7/22/2025 at 3 AM and got back up. Resident 5 did not sustain an injury from the fall. The Change in Condition Evaluation also indicated Resident 5 is unable to self-transfer. During an interview on 7/22/2025 at 11:35 AM with Licensed Vocational Nurse (LVN) 8, LVN 8 stated Resident 5 is not frequently visually monitored for falls. During a concurrent interview and record review with the Interim Director of Nursing (IDON) on 7/23/2025 at 12:40 PM with the IDON, Resident 5's Fall Risk assessment dated [DATE]was reviewed. The Fall Risk Assessment indicated Resident 5 was ambulatory, only took narcotics (medications used to treat moderate to severe pain), and did not have predisposing conditions. The IDON stated the Fall Risk Assessment was not accurate. The IDON stated Resident 5 has decreased mobility to stand and walk, also takes anticoagulant and antihypertensive medications, and has the predisposing condition of arthritis. The IDON stated the importance of following Resident 5's care plan to frequently visually monitor the resident because she is at a high risk of falling. The IDON stated it is every staff member's responsibility to visually monitor Resident 5 to ensure she does not fall. During a review of the facility's policy and procedure (P&P) titled Fall Management Program, revised January 2025, the P&P indicated, Facilities are obligated to provide adequate supervision to prevent accidents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of two sampled residents (Resident 55) received the appropriate treatment and services needed to maintain and prevent gastrostomy tube (a surgical procedure to insert a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube) complications. By failing to label the resident's tube feeding container and syringe with an open date. This failure placed Resident 55 at risk for gastrointestinal (the digestive system) complications such as infection, diarrhea (frequent loose bowel movements), nausea (sensation of feeling the urge to vomit), and vomiting (forceful expulsion of stomach contents though the mouth). Findings:During a review of Resident 55's admission Record, the admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy. During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 55 had severely impaired cognition (impairment in the ability to think, understand, and reason). The MDS indicated Resident 55 had a feeding tube on admission and while at the facility. During a review of Resident 55's Order Summary Report dated [DATE], the Order Summary Report indicated the resident had a Physician's Order (PO) for enteral feeding (also known as TF) four times a day for dysphagia. The PO indicated Resident 55 was to receive 360 milliliters (ml, a unit of measurement for volume) Jevity 1.2 (a type of TF that contains complete balanced nutrition with fiber) four times a day. During a concurrent observation and interview on [DATE] at 9:34 AM, with Licensed Vocational Nurse 8 (LVN 8) in Resident 55's room, an unlabeled and undated 30 ml syringe and container of approximately 650 ml of Jevity 1.2 TF was observed on the resident's bedside dresser. LVN 8 confirmed by stating Resident 55's TF and syringe needed to be dated and labeled. LVN 8 was then observed disposing of Resident 55's TF and syringe. During an interview on [DATE] at 10:57 AM, with the Interim (temporary) Director of Nursing (IDON), the IDON stated TF containers had to be dated and labeled. The IDON stated if TF was not dated and labeled, facility staff would not know how long the TF had been out and it could be expired. The IDON stated if the undated and unlabeled TF was provided to the resident it could potentially cause GI complications for Resident 61. During a review of the facility Policy & Procedure (P&P) titled Enteral Feeding - Safety Precautions Revised 3/2024, the P&P indicated To ensure the safe administration of enteral nutrition. Preventing Contamination: Personnel responsible for preparing, storing, and administering enteral nutrition formulas will be trained, qualified, and competent in his or her responsibilities. The facility follows accepted standards of practice in enteral nutrition. Sterile formulas poured an open system will be discarded within eight hours hang time.Open system enteral feeding administration sets will be replaced every 24 hours.The nurse shall verify the enteral nutrition label against the order before administration. To ensure: Resident name, ID, and room number. Type of formula. Date and time formula were prepared. Route of delivery. Access site. Method (pump, gravity, syringe); and Rate of administration (mL/hour). The formula label contains the initials, date, and time the formula was hung/administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 61) who required hemodialysis (HD, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) received HD care and services in accordance with Resident 61's Medical Director 1 (MD1) orders, care plan, and the facility's policies and procedures by failing to: -Ensure the licensed nurses (in general) and the Social Services Director (SSD) had ongoing communication and collaboration with Dialysis Center 1 (DC1) to coordinate Resident 61's HD care and services when the transportation did not pick up Resident 61 as scheduled on [DATE] at 11 AM. -Ensure Licensed Vocational Nurse 5 (LVN5) and other licensed nurses (in general) assessed Resident 61 prior to Resident 61 being transported to DC1 on [DATE] at 4:45 PM. -Ensure LVN5 and other licensed nurses (in general) assessed and monitored Resident 61's signs and symptoms of weakness and shortness of breath upon Resident 61's return to the facility on [DATE] (time unknown) from DC1 (missed HD). -Ensure LVN5 and other licensed nurses (in general) transferred Resident 61 to a General Acute Care Hospital (GACH) for a missed HD on [DATE] as ordered by MD1 upon Resident 61's return to the facility from DC1 (DC1 closed at 5PM on [DATE] and did not perform HD to Resident 1). -Ensure the licensed nurses (in general) informed MD1 that GACH 1 could not accept Resident 61 on [DATE] for HD. As a result of these failures, Resident 61 did not receive HD care and services and did not receive medical interventions for the shortness of breath and weakness. On [DATE] at 4:30 a.m., Certified Nursing Assistant 5 (CNA 5) and Licensed Vocational Nurse 3 (LVN 3) found Resident 61 unresponsive (not reacting or moving at all) with no pulse (the number of times the heart beats) inside Resident 61's room. Resident 61 expired at the facility. On [DATE] at 5:27 PM, the Department called an Immediate Jeopardy Situation (IJ, a situation in which the provider's non-compliance with one or more requirements of participation has caused, or likely to cause, serious injury, harm impairment, or death to a patient) in the presence of the facility's Administrator (ADM) and the Interim (temporary) Director of Nursing (IDON) related to the failures to ensure Resident 61 received HD care and services in accordance with Resident 61's MD1's orders, care plan, and the facility's policies and procedures. The above failures resulted in Resident 61 not receiving HD care and services, and/or medical interventions to treat Resident 61's shortness of breath and weakness. These failures also placed four residents who received dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) (Resident 8, Resident 33, Resident 37, Resident 53) at risk for harm and potential death. On [DATE] at 4:45PM, the facility was unable to submit an acceptable IJ removal plan (IJRP, includes all actions the facility has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment, or death likely). On [DATE] at 4:45PM, the Department completed the survey tasks and conducted an exit conference while onsite in the presence of the IDON, the Director of Staff Development (DSD), and the Activity Director (AD). On [DATE] at 4:19 PM, the Department removed the IJ situation while onsite after the surveyors verified the facility's implementation of the IJ removal plan through observation, interview, and record review, which included: -On [DATE] Resident 61 expired. -On [DATE] the SSD, IDON, and the Medical Record Director reviewed the dialysis communication records for four residents who resided at the facility and who received dialysis. The four residents did not miss dialysis and did not have a change of condition (COC, a sudden clinically important deviation from a patient's baseline in physical, cognitive [ability to think and process information], behavioral, or functional domains [categories or areas of focus that describe different aspects of human behavior and mental processes]) from [DATE] to [DATE]. -On [DATE] an outside consultant (a person who provides expert advice professionally) provided in-services to the IDON, DSD regarding dialysis resident management/change of condition. -On [DATE] the IDON in-serviced LVN5 regarding dialysis/resident management/COC. -On [DATE] the IDON performed skills competency assessments to LVN5 regarding dialysis management. -On [DATE] the IDON initiated the in-services to the licensed nursing staff regarding dialysis resident management/COC. Findings: During a review of Resident 61's admission Record, the admission Record indicated the facility admitted Resident 61 on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and truck on the same side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain), end stage renal disease (ESRD, irreversible kidney failure), dependence on renal (kidney) dialysis, dysphagia (difficulty swallowing)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that three of five sampled employees' (Licensed Vocational Nurse 8 [LVN8], Treatment Nurse [TN], and for Interim Director of Nursing [IDON]) files were complete with a performance evaluation, skills competency checklist, and Basic Life Support (BLS, life saving techniques for someone experiencing breathing of heart emergencies) certification.This failure had the potential to result in the staff underperforming, which could affect the residents' care. Findings: During a concurrent interview and record review on [DATE] at 11:21 AM with the Director of Staff Development (DSD), LVN 8's employee file was reviewed. The employee file did not have a BLS certification, skills competency checklist (a list used to assess someone's proficiency in specific skills) and performance evaluation (a process used to give employees feedback on their job performance) for 2024. DSD stated LVN 8 was hired on [DATE]. DSD stated the BLS and skills competency checklist are completed upon hire and the performance evaluation was completed annually but that it was not in LVN 8's employee file. DSD stated it was important to have the BLS certification for the nurse to be able to perform resuscitative efforts on a resident. During a concurrent interview and record review on [DATE] at 11:27AM with DSD, the IDON's employee file was reviewed. The employe filed indicated IDON's hire date was [DATE] and it did not include a skills competency checklist. DSD stated a skills competency checklist was not in the employee file. During a concurrent interview and record review on [DATE] at 11:31 AM with DSD, Treatment Nurse (TN)'s employee file was reviewed. The employee file indicated TN's hire date was [DATE] and it did not have a skills competency checklist and current performance evaluation. DSD stated the skills competency checklist and current performance evaluation were not in the file. DSD stated it was important to have the competency checklist and performance evaluation because it will indicate that staff are proficient in the skills needed to care for the residents. During an interview on [DATE] at 1:28 PM with IDON, IDON stated a skills competency checklist and BLS are to be available in employee files and upon request and it was the Director of Nursing's (DON) responsibility to complete the LVN skills competency checklist and performance evaluation annually. IDON stated it was important to have the BLS in the employee files because without it, it places the residents at risk and the staff would not be able to perform cardiopulmonary resuscitation. During a review of the facility's policy and procedure (P&P) titled, Employee Performance Evaluation, dated 1/2025, the P&P indicated employee job performance was reviewed and evaluated.During a review of the facility's policy and procedure (P&P) titled, Cardiopulmonary Resuscitation, dated 1/2025, the P&P indicated The facility ensures an adequate number of licensed and/or certified staff are present and properly trained in CPR.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: Ensure adequate medication supply for Resident 40 when alogliptin benzoate (a medication used to treat type 2 diabetes [a condition where the body either does not produce enough insulin or does not properly use the insulin] 12.5 milligrams (mg, unit of measurement) oral tablets were not available for administration. Maintain a narcotic count (refers to the systematic process of counting and documenting the amount of controlled substances at specific times to ensure accurate inventory and prevent misuse or diversion) without discrepancy for Resident 65 when the narcotic count sheet for buprenorphine-naloxone (a medication that treats opioid use disorder) 8-2 mg sublingual (situated or applied under the tongue) film indicated 18 films available and the medication count revealed 17. These failures had the potential to result in Resident 40 developing elevated blood glucose (too much sugar in the blood) levels and disruption in her established medication treatment plan, potentially worsening Resident 40's medical condition. And a potential for Resident 65 receiving the wrong medication dose, missing a medication dose, or medication overdose. Findings: 1. During a review of Resident 40's Face Sheet (a document that collects essential information about a resident when they enter a healthcare facility), dated 7/25/2025, the record indicated Resident 40, a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes mellitus with foot ulcer (a sore on the foot that does not heal, often due to underlying health conditions like diabetes), type 2 diabetes mellitus neuropathy (nerve damage caused by high blood sugar levels), and long term current use of insulin (a medication that helps control blood sugar levels, primarily used in the treatment of diabetes). During a review of Resident 40s Minimum Data Set (MDS, a resident assessment tool) dated 7/22/2025, the MDS indicated the resident had physician orders to receive hypoglycemic medications (drugs used to lower blood glucose levels in people with diabetes). During a review of Resident 40's Order Summary Report (a document that collects essential information about medication, lab, diagnostic, and treatment orders for a resident), dated 7/26/2025, the record indicated to give one oral tablet of alogliptin benzoate12.5 mg by mouth one time a day related to type 2 diabetes mellitus with foot ulcer starting on 1/17/2025. During a concurrent observation and interview on 7/22/2025 at 8:57 AM with Licensed Vocational nurse (LVN) 7 outside Resident 40's room, Resident 40 did not receive the scheduled dose of alogliptin benzoate 12.5 mg oral tablet. LVN 7 stated she could not administer the medication because it had not been refilled by the pharmacy and was not available for morning administration. During an interview on 7/22/2025 at 11:47 AM, LVN 7 stated the pharmacy was contacted about the unavailable medication supply after the scheduled administration time. During an interview on 7/22/2025 at 11:47 AM, LVN 7 stated Resident 40 could experience elevated blood sugar levels due to missing a scheduled dose of alogliptin benzoate 12.5 mg oral tablet and might experience confusion, clamminess, and fainting. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed March 2023, the P&P indicated, medications must be administered in accordance with the orders. 2. During an observation on 7/23/2025 at 1:49 PM at Medication Cart 1, LVN 8 conducted a medication count of buprenorphine-naloxone 8-2 mg film for Resident 65 and verified 17 counts were available. During a concurrent interview and record review on 7/23/2025 at 1:49 PM with LVN 8, Resident 65's Controlled Drug Inventory, (undated) was reviewed. The record indicated there was a total of 20 counts of buprenorphine-naloxone 8-2 mg film to begin with. One count was administered on 7/22/2025 at 7:26 PM and one count was administered on 7/23/2025 at 9:00 AM. The record indicated 18 counts of buprenorphine-naloxone film 8-2 mg were available for administration. LVN 8 stated he counted 17 available counts, and one count might have been administered to Resident 65 without documentation on the Controlled Drug Inventory. During an interview on 7/23/2025 at 1:49 PM, LVN 8 stated there was a potential risk of Resident 65 receiving the incorrect dose and experiencing symptoms such as headache, nausea, vomiting, increased heart rate, or increased respiratory rate. During an interview on 7/25/2025 at 1:08 PM, the Pharmacist (RPh) stated buprenorphine-naloxone sublingual film assists in gradually reducing opioid dependence by preventing withdrawal symptoms and preventing opioid overdose. The RPh stated that receiving a lower dose or missing a dose could cause irritability, agitation, increased respiratory rate, increased blood pressure, and opioid cravings. The RPh stated that receiving a higher dose could cause increased sedation. During a review of the facility's P&P titled, Administering Medications, last reviewed March 2023, the P&P indicated that the licensed nurse records the administration after the medication is

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: Administer medication according to the physician order when: Resident 4 received MiraLax (a medication used to facilitate bowel movements) oral powder 17 grams (gm, unit of measurement) per scoop in 7 ounces of water. Resident 4 received acetaminophen (a medication used to relieve pain and reduce fever [elevated body temperature above the normal range]) two 325 milligrams (mg, unit of measurement) tablets for pain. Resident 40 did not receive alogliptin benzoate (a medication used to treat type 2 diabetes (a condition where the body either does not produce enough insulin [define] or does not properly use the insulin) 12.5 mg oral tablets. Preform blood sugar level monitoring prior to insulin administration when Resident 40 received 50 units of insulin glargine subcutaneous solution. These failures had the potential to result in Resident 4 experiencing constipation (a condition characterized by infrequent, hard, or difficult bowel movements), uncontrolled pain, and disruption in his established medication treatment plan, potentially worsening his medical condition and increased safety risks, including medication administration errors. Resident 40 developing fluctuating blood glucose level (sugar in the blood varying between high and low levels) and disruption in her established medication treatment plan, potentially worsening Resident 40's medical condition and causing severe complications. Findings: 1a. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 7/5/2025, the MDS indicated Resident 4 admitted to the facility on [DATE] with a diagnosis that included hypertension (a condition where the force of blood against the artery walls is consistently too high), heart failure (a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs), and peripheral vascular disease (a condition where the blood vessels in the limbs, typically the legs, become narrowed or blocked). During an observation on 7/22/2025 at 9:58 AM in Resident 4's room, Resident 4 received MiraLax oral powder 17 gm per scoop in 7 ounces of water. During a concurrent interview and record review on 7/22/2025 at 11:31 AM with Licensed Vocational Nurse (LVN) 7, Resident 4's Electronic Medication Administration Record (EMAR), dated 7/22/2025 was reviewed. The EMAR indicated, Give 1 scoop by mouth one time a day for bowel management take 1 scoop in at least 8 oz [ounces, unit of measurement] of water daily. LVN 7 stated she administered the medication mixed in 7 ounces of water and not according to physician order. LVN stated Resident 4 could experience constipation, indigestion, bloating, distended abdomen, nausea, vomiting, and discomfort. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed March 2023, the P&P indicated, medications must be administered in accordance with the orders. 1b. During an observation on 7/22/2025 at 10:09 AM in Resident 4's room, Resident 4 received two acetaminophen 325 mg tablets for pain. During a concurrent interview and record review on 7/22/2025 at 11:33 AM with LVN 7, Resident 4's EMAR, dated 7/22/2025 was reviewed. The EMAR indicated, Acetaminophen tablet 325 mg give 2 tablet by mouth every 6 hours as needed for temp >100.4 F [Fahrenheit]. LVN 7 stated the medication was not administered according to physician order for intended use and administering the medication without proper indication was a medication administration error. LVN 7 stated Resident 4 was at increased risk of ineffective pain management and continued discomfort. During a review of the facility's P&P titled, Administering Medications, last reviewed March 2023, the P&P indicated, medications must be administered in accordance with the orders. 1c. During a review of Resident 40's Face Sheet (a document that collects essential information about a resident when they enter a healthcare facility), dated 7/25/2025, the record indicated Resident 40 admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes mellitus with foot ulcer (a sore on the foot that does not heal, often due to underlying health conditions like diabetes), type 2 diabetes mellitus neuropathy (nerve damage caused by high blood sugar levels), and long term current use of insulin (a medication that helps control blood sugar levels, primarily used in the treatment of diabetes). During a review of Resident 40's Order Summary Report (a document that collects essential information about medication, lab, diagnostic, and treatment orders for a resident), dated 7/26/2025, the record indicated to give one oral tablet of alogliptin benzoate 12.5 mg by mouth one time a day related to type 2 diabetes mellitus with foot ulcer starting on 1/17/2025. During a concurrent observation and interview on 7/22/2025 at 8:57 AM with LVN 7 outside Resident 40's room, Resident 40 did not receive the scheduled dose of alogliptin benzoate 12.5 mg oral tablet. LVN 7 stated the medication was not available for administration. During an interview on 7/22/2025 at 11:47 AM, LVN 7 stated Resident 40 could experience elevated blood sugar levels due to missing a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: Maintain the temperature in the medication refrigerator between 36 degrees Fahrenheit (F, a temperature scale) to 46 degrees F when the thermometer indicated 21 degrees F. Dispose Resident 66's medication within 90 days of discharge when a lidocaine (a medication used to numb a specific area of the body) 5% patch was in the medication storage room. Discard medications inside the medication waste bin when tablets were on the bin rim and accessible. Implement accurate medication labeling when insulin lispro (a medication used to control blood sugar in people with diabetes [a condition where the body does not produce or use insulin properly]) 3 milliliter (mL, unit of measurement) injection for Resident 20 did not include a pharmacy medication label. Maintain one of two medication carts free from expired medications when glucagon (used for emergency treatment of very low blood sugar) 1 milligram (mg, unit of measurement) injection for Resident 63 was in the medication cart. These failures had the potential to result in: Residents receive medications with improper stability, potency and safety due to improper storage of medications. Medication administration errors and misuse, potentially resulting in residents receiving medications not prescribed by the physician. Resident safety concerns, potentially resulting in accidental ingestion or administration. Safety risks and medication administration errors for Resident 20, potentially receiving the wrong medication, dose, route, time or expired medications. Resident 63 receiving medication with reduced effectiveness, potentially resulting in inadequate treatment or harm. Findings: 1. During a concurrent medication storage observation and interview on 7/23/2025 at 7:50 AM with Registered Nurse (RN) 3 in the medication storage room, the thermometer inside of the medication refrigerator displayed a temperature of 21 degrees F. RN 3 stated the acceptable temperature range should be between 36 degrees F to 46 degrees F. RN 3 stated that inappropriate temperature maintenance could result in reduced potency and effectiveness of medications and tests. During a concurrent medication storage observation and interview on 7/23/2025 at 8:09 AM with RN 3 in the medication storage room, the following medications were stored inside the medication refrigerator: acetylcysteine (a medication used to help thin and loosen mucus in the airways due to certain lung diseases) 20% inhalation solution vial opened on 6/27/2025 and tuberculin purified protein derivative (PPD, a substance used in a skin test to help diagnose tuberculosis (TB) infection). The acetylcysteine 20% inhalation solution vial medication label indicated the recommended storage temperature range was between 36 degrees F to 46 degrees F after opening. The PPD medication label indicated the recommended storage temperature range was between 35 degrees F to 46 degrees F. RN 3 stated the medications were not stored at the acceptable temperature range. During an interview on 7/23/2025 at 8:09 AM, RN 3 stated failure to store acetylcysteine 20% inhalation solution vial at the recommended temperature range could potentially result in ineffective treatment and exacerbation of shortness of breath or respiratory distress in residents. During an interview on 7/23/2025 at 8:15 AM, RN 3 stated failure to store PPD at the recommended temperature range could potentially result in inaccurate TB skin test results and the spread of TB among residents. During an interview on 7/25/2025 at 1:08 PM, the Pharmacist (RPh) stated storing acetylcysteine 20% inhalation solution vial outside of the recommended temperature range could affect the medication stability making it less effective or ineffective. RPh stated PPD should be discarded if stored outside of the recommended temperature range. During a review of the facility's policy and procedure (P&P) titled, 72357 Pharmaceutical Services- Labeling and Storage, last reviewed January 2025, the P&P indicated, drugs requiring refrigeration shall be stored in a refrigerator between 2 degrees C [Celsius, a temperature scale] (36 degrees F) and 8 degrees C (46 degrees F). The P&P indicated no deteriorated drugs shall be available for use. During a review of the facility's P&P titled, Labeling of Biologicals and Storage of Biologicals, last reviewed January 2025, the P&P indicated, the facility's safe medication storage includes the provision of appropriate environmental controls, including exposure to improper temperature, and as possible, light or humidity. 2. During a concurrent medication storage observation and interview on 7/23/2025 at 8:44 AM with RN 3 in the medication storage room, nine lidocaine 5% patches for discharged Resident 66 were stored on the counter. RN 3 stated medications for discharged residents are held for a maximum of seven days before being discarded. RN 3 stated failure to discard the medications could result in residents receiving medications not prescribed by their physician. During a review of the facility's discharged resident list, (undated), the record indicated Resident 66 was discharged on 3/31/2025. During a review of the facility's P&P titled, Medication

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 7/21/2025 by failing to ensure pureed diets (foods that do not require chewing and are easily swallowed. All food should be smooth and pureed to the consistency of pudding.) were prepared in accordance with the international Dysphagia Diet Initiative (IDDSI - a framework made up of levels and describes food textures and drink thickness) Level Four (pureed foods and extremely thick drinks). This failure had the potential to result in meal dissatisfaction and increased choking risk for residents on pureed diet.During an observation of the tray line (tray line-a system of food preparation, in which tray move along an assembly line) service for lunch on 7/21/2025 at 11:30AM, the pureed meat, pureed corn and potato looked thin and loose consistency. During the serving of the pureed food, the pureed food spread out flat on the plate and didn't hold its shape.During a concurrent interview and taste test of the pureed food with Dietary Supervisor (DS) and [NAME] (Cook1) on 7/21/2025 at 12:45PM, the pureed meat, corn and potato appeared to be loose and did not hold its shape on the plate. Upon tasting the pureed food, the texture was thin in the mouth. When lifted with a fork, the pureed food dripped through the fork prongs. The DS confirmed by stating the pureed food was loose and was on the liquid side. Cook1 stated pureed food had to hold its shape and have the consistency of a pudding. Cook1 stated that cook1 used more liquids than the recipe asked to make sure the food was smooth. Cook1 stated cook1 should have used less water when blending the pureed food. Cook1 stated when the pureed food was thin and not in right consistency it could cause choking in some residents. During a review of the facility's recipe titled Recipe: Pureed (IDDSI Level 4) Meats (dated 2024) the recipe indicated, complete regular recipe.2) puree on low speed to a paste consistency before adding any liquid 3) gradually add warm broth 4) add thickener if needed.5) The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm and should not weep (liquid must not separate from solid). The finish pureed item must pass IDDSI level 4 testing requirements (the fork drip, fork pressure and spoon tilt tests).During a review of the facility's recipe titled Recipe: Pureed (IDDSI Level 4) Vegetables (dated 2024) the recipe indicated, complete regular recipe.2) puree on low speed to a paste consistency before adding any liquid. The finish pureed item must pass IDDSI level 4 testing requirements (the fork drip, fork pressure and spoon tilt tests).During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure dietary preferences were honored for one of five sampled residents (Resident 21) when the resident received food that was listed on the meal ticket as a disliked food. This failure had the potential to result in Resident 21 experiencing a loss of autonomy in choosing meals. Findings: During a review of Resident 21's Face sheet (admission Record) dated 7/21/2025, the Face sheet indicated Resident 21 was admitted to the facility on [DATE], with diagnosis that included heart failure (a condition where the heart does not pump blood as well as it should making it hard for the body to get the oxygen and nutrients needed) and muscle weakness (a condition where the muscles do not have as much strength as before). During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool used for screening of clinical and functional status), dated 7/12/2025, the MDS indicated Resident 21 required assistance with food setup. During an interview on 7/21/2025 at 10:16 AM, with Resident 21, Resident 21 stated sometimes a chef's salad is ordered but the facility does not have all the toppings for the salad. Resident 21 stated that scrambled eggs would be ordered but would receive an omelet instead. During an observation on 7/21/2025 at 12:36 PM, in Resident 21's room, the lunch meal tray was observed. On the plate, the meal consisted of corn, mashed potatoes and meat with gravy on top. During a review of Resident 21's lunch meal tray ticket, dated 7/21/2025, the meal tray ticket indicated the dislikes were the following: Milk Gravy Mashed Potatoes During an interview on 7/22/2025 at 1:17 p.m., with Dietary Supervisor (DS), the DS stated the resident's like and dislikes are available to the kitchen through their diet system. The DS stated that if the resident receives food they do not like, the resident will be upset and not eat. During a review of the facility's policy and procedure (P&P) titled, Food and Drink-Allergies and Preferences, dated 1/2025, the P&P indicated Each resident shall receive food that accommodates resident allergies, intolerances, and preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation in the kitchen when:1.One medium size tray of previously prepared tuna salad was stored in the walk-in refrigerator over three days, exceeding storage period for prepared salad. Six bunches of bananas that were very soft, brown in color and peeled open were stored in the dry storage area with no date. A peeled banana was touching the wall, there were stains on the wall and on the floor under the shelves. One can opener blade was dirty with dried brown residue and when the blade was worn and dented with the potential to harbor harmful bacteria.2.One Dietary Aide (DA1) working in the dishwashing area did not wash hands when removing clean and sanitized dishes from the dish machine.3.Food brought to residents from outside of the facility, were stored in the resident's food refrigerator with no date and not monitored for the expiration date. There was one container of potato salad that was expired and stored in the resident's food refrigerator. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 50 out of 54 residents who received food from the facility and including residents who had food stored in the resident refrigerator.1. During an observation in the kitchen on 7/21/2025 at 8:30 AM, there was one medium-sized tray with previously prepared tuna salad with dates of 7/17/2025-7/20/2025 stored in the walk-in refrigerator.During a concurrent observation and interview with Dietary Supervisor (DS) on 7/21/2025 at 8:30AM, the DS stated previously prepared tuna salad is stored for 3 days. The DS stated the tuna salad ws expired and should have been discarded. The DS stated expired food could make residents sick.During a review of facility policy titled Refrigerated Storage Guide (dated 2019) indicted, Tuna Salad-Maximum refrigerator time is 3 daysA review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#3-501.17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. During an observation in the dry storage area on 8/21/2025 at 8:55AM, there were six bunches of bananas (each bunch had 6-9 bananas) that were very soft and brown in color stored on a large tray with no date. Two bananas peeled open, and contents were touching the wall. There were banana stains on the adjacent wall and on the floor.During a concurrent observation and interview with the DS, the DS stated the bananas should have been discarded because they were very soft to touch, brown and old. The DS stated the bananas had spilled on the floor and that could attract flies and other pests to the dry storage area.During a review of facility's policy and procedure (P&P) titled Food Receiving and Storage (Revised 1/2025) the P&P indicated, Dry storage.designated for the storage of dry goods, such as single service items, canned goods, and packaged or containerized bulk food that is not potentially hazardous foods. The focus of protection for dry storage is to keep non-refrigerated foods.in a clean, dry area, which is free from contaminants. Dry foods and goods should be handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. It is recommended that foods stored in bins .During a review of facility's policy and procedures titled Dietetic Service-Basic Kitchen Sanitation (revised 1/2025) the P&P indicated storage: Label and date all food itemsDuring a review of facility's policy titled Produce Storage Guidelines (dated 2018) the policy indicated, Bananas*- store in the refrigerator for 3-5 days.Bananas can be stored at room temperature until they are ripe, after that that they should be stored in the refrigerator per the chart.During a concurrent observation and interview with the DS in the kitchen food preparation area on 7/21/2025 at 8:50AM, one can opener blade was noted to be worn out, indented and dirty. The blade was not smooth to touch and was nicked and covered with brown residue sticky to touch. The DS verified that the can opener blade was dirty, dented and there were metal shavings around the blade. The DS stated the can opener blade needed to be replaced to prevent cross contamination of canned food.During a review of facility's policy and procedure (P&P) titled Dietetic Service-Basic Kitchen Sanitation (revised 1/2025) the P&P indicated, All utensils. equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion.During a review of the 2022 U.S. Food and Drug Administration Food Code titled Good Repair and proper Adjustment Code # 4-501.11(C), indicated, Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened.A review of 2022 Food Code titled, Can Openers Code# 4-202.15 indicated, Once can openers become pitted or the surface in any

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster areas was maintained in a sanitary manner. By failing to ensure one large trash bin was covered and two recyclable trash bins were not overfilled with boxes and left uncovered.This deficient practice had the potential for harborage and feeding of pests.During a concurrent observation of the facility's trash area and interview with the dietary supervisor (DS) on 7/21/2025 at 9:00AM, one large trash bin that was observed not covered and two recyclable trash bins were observed overfilled with boxes and uncovered. A cat was observed around the trash area in the parking lot. The DS stated trash bins had to be covered to prevent the feeding of animals and attracting flies. The DS proceeded to cover the lid of the large trash bin. During an interview with Maintenance Supervisor (MS) on 7/21/2025 at 9:10AM, the MS stated trash was picked up twice a week. The MS stated cardboard boxes had to be broken down to allow more space in the bins and to cover the lids. The MS stated trash bins had to be covered because there were cats in the alley that would go in the trash. The MS stated closing the lids had to be closed to prevent animal feeding and to prevent attracting pests to the facility.During a review of the facility's policy and procedures (P&P) titled, Dispose of Garbage and refuse (Revised 1/2025) the P&P indicated, Garbage and refuse containers are maintained in good condition and waster is properly contained in dumpsters or compactors with lids covered. During a review of Food and Drug Administration (FDA) Food Code 2022, code number 5-501.113 titled Covering receptacles, indicated: receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Quality Assessment and Assurance committee (QAA, a group of facility staff who identifies, evaluates, and implements measures to improve the quality care and life for the residents in the facility) and Quality Assurance Performance Improvement (QAPI, a group of facility staff who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to identify concerns related to cardio-pulmonary resuscitation (CPR, an emergency procedure that combines chest compressions and rescue breathing to help someone who has stopped breathing or whose heart has stopped beating) and dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) in the facility. This deficient practice had the potential for facility residents who receive dialysis to miss dialysis and improper assessment skills when initiating CPR for residents who are full code (a situation where a resident's heart stops, and the medical team is authorized to use all available life-saving measures including CPR). (Cross reference: F678 and F698)Findings:During a concurrent interview and record review on [DATE] at 4:10 PM with the Interim (temporary) Director of Nursing (IDON), the QAPI meeting minutes titled CQI Meeting Minutes dated [DATE] were reviewed. The IDON stated the last QAPI meeting was conducted on [DATE]. The IDON stated that CPR and dialysis were not part of the CQI Meeting Minutes dated [DATE]. The IDON stated if CPR and dialysis were not listed on the CQI Meeting Minutes dated [DATE], then CPR and dialysis were not discussed or part of the QAPI meeting on [DATE].During a review of the facility's policy and procedure (P&P) titled, Quality Assurance Performance Improvement Plan & Committee (QAPI) dated 9/2017, indicated It is the policy of this facility to provide a process to evaluate and monitor the ongoing quality of services and care provided to residents through the facility's quality assessment and assurance committee, which will be referred by to the facility as the Quality Assurance performance Improvement (QAPI) committee.The QAPI committee identifies and addresses specific care and quality issues and implements an action plan to resolve these issues. The goal of the QAPI committee is to promote excellence in quality of care, quality of life, resident choice, person directed care and resident transitions. All systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for residents and employees will be addressed. The QAPI plan will identify and use data to monitor its performance; establish goals and thresholds for performance measurement; utilize resident and staff input; identify and prioritize problems and opportunities for improvement; systematically analyze underlying causes of systemic problems and adverse events; and develop corrective action plans or performance improvement activities.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when: Resident 5 did not have an order for enhanced barrier precautions (EBP- are an infection control strategy used in healthcare settings, particularly skilled nursing facilities, to reduce the spread of multidrug-resistant organisms (MDROs). Resident 1 did not have proper signage before entering the isolation room. These failures had the potential to result in the spread of infection and placed the residents, staff and visitor at risk to become infected and seriously ill, leading to hospitalization or death. Findings: 1. During a review of Resident 5's Face Sheet (admission record) indicated Resident 5 was admitted to the facility on [DATE], with diagnoses that included necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin), generalized muscle weakness, lower leg osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and chronic ulcers (open sores or wounds on the skin) of the right and left feet. During an interview on 7/23/2025 at 2 PM with Infection Prevention Nurse (IP), IP stated enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs]) are put in place for residents with wounds, indwelling medical devices, receive dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), or have a history of MDROs. During a concurrent interview and record review on 7/23/2025 at 2:46 PM with IP, Resident 5's Order Summary was reviewed. The Order Summary did not indicate an order for EBP. IP stated Resident 5 should have an order for EBP because she has wounds on both of her feet. IP stated all residents on EBP must have a physician order for EBP so staff know how to protect themselves and other residents when they provide care. 2. A review of Resident 1's Face Sheet indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE], with diagnoses that included cerebral infarction (a medical condition where a part of the brain is damaged or dies due to a lack of blood supply), pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) of the sacral (triangular shaped bone at the base of the back) region, muscle weakness, and sepsis (a life-threatening blood infection). During a concurrent observation and interview on 7/23/2025 at 2:35 PM with IP outside of Resident 1's room, Resident 1 had a sign for both contact precautions and EBP. IP stated Resident 1 had an MDRO. IP stated only the contact precautions sign should be posted in front of Resident 1's room because it could cause confusion for the staff for what personal protective equipment (PPE, equipment used to prevent or minimize exposure to hazards) to wear when they enter the room. IP stated using the correct PPE is important to prevent the spread of infection in the facility. During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, implemented April 2024, the P&P indicated, EBP.employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices. and wounds or presence of unhealed pressure ulcers. During a review of the facility's policy and procedure (P&P) titled Standard and Transmission Based Precautions, revised December 2024, the P&P indicated, Contact precautions will be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.

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	07/26/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. (continued on next page)

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	07/26/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 17 of 66 sampled resident rooms (Rooms 3, 5, 6, 7, 8, 9, 11, 14, 15, 16, 18, 19, 21, 22, 23, 24, and 25) met the minimum space requirements of 80 square feet for each resident in multiple resident bedrooms.This failure had the potential to result in inadequate space to provide safe nursing care and privacy for the residents in Rooms 3, 5, 6, 7, 8, 9, 11, 14, 15, 16, 18, 19, 21, 22, 23, 24, and 25).Findings:During an initial tour observation of the facility on 7/21/2025 from 9 AM to 10:30 AM, nursing staff (in general) were observed with enough space to provide care for the residents in each facility room.During a review of a facility letter dated 7/22/2025, submitted by the Administrator (ADM), the facility letter indicated the facility was requesting a wavier for the room size of the following rooms:RoomSq FtApprox Dimensions3224.3520' x 11'35220.9120' x 11'16221.8320' x 11' 17230. 2320' x 11' 68236.9520' x 11' 109231.9120' x 11' 711235.2720' x 11' 914230.920' x 11' 71523720' x 11' 1018230.1220' x 11' 619219.1420' x 10' 1121236.1120' x 11' 1022221.8320' x 11' 123231.0720' x 11' 724233.5920' x 11' 825230.2320' x 11' 6 The facility letter indicated all the identified locations above were noted to be free of projections or obstructions that could interfere with the safe and unrestricted movement of wheelchairs or other mobility devices. The facility letter indicated there was adequate space in each room to ensure residents received care with dignity and privacy, and to support their individual needs. The facility letter indicated the room configurations did not pose a risk to the health or safety of residents and did not hinder the residents' ability to achieve their highest practicable level of physical, mental, and psychosocial well-being. The facility letter indicated all reasonable measures would be taken to ensure the comfort of every resident.During a review of the facility's Client Accommodations Analysis form dated 7/23/2025, the Client Accommodations Analysis form indicated the following room with their corresponding measurements:RoomSq FtApprox Dimensions3224.3520' x 11'35220.9120' x 11'16221.8320' x 11' 17230. 2320' x 11' 68236.9520' x 11' 109231.9120' x 11' 711235.2720' x 11' 914230.920' x 11' 71523720' x 11' 1018230.1220' x 11' 619219.1420' x 10' 1121236.1120' x 11' 1022221.8320' x 11' 123231.0720' x 11' 724233.5920' x 11' 825230.2320' x 11' 6 During a concurrent observation and interview on 7/24/2025 at 10 AM, with Resident 65, in room [ROOM NUMBER], Resident 65 stated he (Resident 65) felt there was adequate space for all his belongings in the room. Resident 65 stated the staff (in general) could easily move around the room and were able to bring in equipment like wheelchairs easily. room [ROOM NUMBER] was observed with two beds, a dresser, a bedside table, a privacy curtain and a Television (TV) for each resident. There were no projections or obstructions observed in room [ROOM NUMBER] that could interfere with the movement of wheelchairs or other mobility devices.During a concurrent observation and interview on 7/24/2025 at 10:06 AM, with Resident 17, in room [ROOM NUMBER], Resident 17 was observed sitting in a wheelchair at the foot of her bed. room [ROOM NUMBER] was observed with three beds, a privacy curtain, a bedside table, a dresser, and a TV for each resident. Resident 17 stated she (Resident 17) had enough space for her wheelchair. Resident 17 stated she (Resident 17) could go around in her wheelchair to go inside and outside the room easily. Resident 17 stated she (Resident 17) did not feel like her room was too tight. There were no projections or obstructions observed in room [ROOM NUMBER] that could interfere with the movement of wheelchairs or other mobility devices.During a concurrent observation and interview on 7/24/2025 at 10:10 AM, in room [ROOM NUMBER], Certified Nursing Assistant 9 (CNA 9) was observed transferring a resident from a shower chair to the resident's bed. CNA 9 was observed to be able to maneuver the resident's bed and the shower chair without difficulty. CNA 9 stated there was enough space in room [ROOM NUMBER] to move the resident from the shower chair to the bed. room [ROOM NUMBER] was observed with three beds, a privacy curtain, a bedside dresser, a bedside table, and a TV for each resident. There were no projections or obstructions observed in room [ROOM NUMBER] that could interfere with the movement of wheelchairs or other mobility devices.During an interview on 7/24/2025 at 10:15 AM, with CNA 10, CNA 10 stated she was taking care of the residents in room [ROOM NUMBER] and room [ROOM NUMBER]. CNA 10 stated Interview with she had no issues with the amount of space in room [ROOM NUMBER] and room [ROOM NUMBER]. CNA 10 stated she could bring Hoyer lifts (a mechanical device designed to safely lift and transfer individuals with limited mobility from one place to another) and shower chairs in the room without issue. CNA 10 stated there was adequate space for her to get her work done in room [ROOM NUMBER] and room [ROOM NUMBER]. During a concurrent observation and