STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055519	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Post Acute	13007 S. Paramount Blvd. Downey, CA 90242

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an observation, interview, and record review the facility failed to practice pressure related injury preventive practices for three out of seven residents (Resident 1, 2, and Resident 3): 1. Nursing staff did not follow doctor's order for a low air loss mattress ([LALM], a mattress that provides airflow to help keep skin dry, as well as to relieve pressure, treat pressure sores and prevents pressure sores) for Resident 1, 2, and 3. 2. Nursing staff did not follow up on LALM order status. 3. Nursing staff did not ensure Resident 1, 2, and 3 had LALM to prevent pressure injuries (localized area of tissue damage that develops when prolonged pressure or shear forces are applied to the skin and underlying tissues). These deficient practices placed Resident 1, 2, and 3 at risk for further skin damage and it placed residents at risk for developing pressure injuries. Findings: During an observation on 7/24/2025 at 1146 a.m. Resident 1, 2, and 3 did not have a LALM on their bed. 1. A review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included diabetes mellitus ([DM]a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension ([HTN]high blood pressure). During a review of Resident 1's History and Physical (H&P) dated 7/21/2025, the H&P indicated Resident 1 could make his needs known but could not make medical decisions. During a review of Resident 1's electronic record, unable to locate Minimum Data Set ([MDS] a resident assessment tool) due to Resident 1's recent admission to the facility. During a review of Resident 1's Doctor Orders, dated 7/21/2025, the orders indicated Resident 1 had an order for a LALM for skin maintenance. During a review of Resident 1's Interdisciplinary Team (IDT) Skin Review Notes, dated 7/23/2025, the IDT notes indicated Resident 1 would use a LALM as a pressure redistributing device. IDT notes indicated a LALM was recommended for Resident 1 due to wounds and immobility. The IDT notes indicated Resident 1 had a wound on his coccyx (last bone at the bottom (base) of the spine) extending to left buttock (either of the two round fleshy parts that form the lower rear area of a human trunk) and wound was noted with 100% necrosis (death of cells or tissues in the body, occurs when cells are deprived of blood supply (ischemia) or injury). IDT notes indicated Resident 1 was at risk for wound decline or slow healing due to his comorbidities (simultaneous presence of two or more diseases or medical conditions) and limited mobility. 2. A review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 2's diagnosis included pressure ulcer (a localized injury to the skin and underlying tissues that occurs due to prolonged pressure or pressure combined with shear and/or friction) of sacral region (located at the base of the spine), stage 2 (partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red or pink wound bed) and dementia (the loss of cognitive functioning [ability to think and reason], thinking, remembering, and reasoning). During a review of Resident 2's H&P dated 7/22/2025, the H&P indicated Resident 2 had fluctuating ability to make medical decisions.During a review of Resident 2's Doctor Orders, dated 7/22/2025, the orders indicated Resident 2 had an order for LALM for skin maintenance. During a review of Resident 2's IDT Skin Review Notes, dated 7/23/2025, the IDT notes indicated Resident 2 would use a LALM as a pressure redistributing device. IDT notes indicated a LALM was recommended for Resident 2 due to wounds and immobility. The IDT notes indicated Resident 1 had a coccyx pressure injury stage 2. IDT notes indicated Resident 2 was at risk for wound decline or slow healing due to his comorbidities and limited mobility. During a review of Resident 2's electronic record, unable to locate MDS due to Resident 2's recent admission to the facility. 3. A review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnosis included fracture (a break or discontinuity in a bone) of left humerus (bone of the upper arm) and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 3's H&P dated 7/7/2025, the H&P indicated Resident 3 could make needs known but could not make medical decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making was intact. The MDS indicated Resident 3 needed maximal assistance (helper does more than the effort) for toileting hygiene, shower/bathing, and dressing. The MDS indicated Resident 3 needed supervision for eating and oral hygiene. The MDS indicated Residents 3's skin and ulcer/injury treatment was a pressure reducing device for bed. During a review of Resident 3's Skin Evaluation, dated 7/18/2025, skin evaluation indicated Resident 3 had bilateral buttock redness and redness to bilateral heels. During a review of

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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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 0726 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 did not ensure Braden scale assessment (tool used in Skilled Nursing Facilities to assess a patient's risk of developing pressure injuries [localized area of tissue damage that develops when prolonged pressure] or shear forces [horizontal force that causes the bony prominence to move across the tissue as the skin is held in place] are applied to the skin and underlying tissues) was accurately performed for one resident (Resident 1) out of 4 sampled residents. 1. Facility did not ensure Resident 1 was correctly assessed during Braden Scale assessment. 2. Facility did not ensure Nursing staff had the knowledge of scoring resident during the Braden Scale assessment. This deficient practice placed Resident 1 at a low risk of developing pressure injuries and potentially caused Resident 1 not to receive the preventive measures in developing pressure injuries. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnosis included pressure ulcer of sacral region (located at the base of the spine), stage 4 (full-thickness skin and tissue loss) and dementia (a progressive state of decline in mental abilities).During a review of Resident 1's History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), the MDS indicated Resident 1's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for toileting hygiene. The MDS indicated Resident 1 required supervision for oral hygiene. The MDS indicated Resident 1 required set up assistance for eating. During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 11/8/2024, the Braden scale indicated Resident 1 had a score of 15 (Scores: 15 and above - low risk, 13-14 moderate risk, 10-12 high risk, and less than 9 severe risk). The Braden scale indicated Resident 1 had a low risk of developing a pressure injury. During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 10/22/2024, the Braden scale indicated Resident 1 had a score of 15. The Braden scale indicated Resident 1 had a low risk of developing a pressure injury During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 10/15/2024, the Braden scale indicated Resident 1 had a score of 15. The Braden scale indicated Resident 1 had a low risk of developing a pressure injury. During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 9/18/2024, the Braden scale indicated Resident 1 had a score of 15. The Braden scale indicated Resident 1 had a low risk of developing a pressure injury. During a review of Resident 1's Weights and Vitals Summary, dated 10/9/2024 - 11/09/2024, the Summary indicated Resident 1 lost 16 pounds in 1 month. The summary indicated Resident 1 weighed 113 pounds on 10/9/2024 and weighed 97 pounds on 11/9/2024. During a review of Resident 1's Interdisciplinary Team (IDT) Skin Review Notes, dated 10/18/2024, the IDT notes indicated Resident 1 had a sacrococcyx (fused bone formed by the sacrum and coccyx [tailbone]) pressure injury that was unstageable (a type of pressure ulcer where the wound bed is completely obscured by slough [dead tissue] or eschar [dead tissue that forms over healthy skin and over time falls off]. The IDT notes indicated Resident 1 was at risk for slow healing or worsening of wound due to poor oral intake and fragile appearance. The IDT notes indicated Resident 1 was at high risk for skin integrity breakdown. During a review of Resident 1's Interdisciplinary Team (IDT) Skin Review Notes, dated 10/18/2024, the IDT notes indicated Resident 1 had a sacrococcyx pressure injury that was unstageable. IDT notes indicated Resident 1's health conditions were incontinence, compromised nutritional status and decreased sensory perception (ability to understand and interact with the environment using senses of sight, smell, hearing, taste, touch). IDT notes indicated Resident 1 was at risk for slow healing or worsening of wound due to poor oral intake and fragile appearance. The IDT notes indicated Resident 1 was at high risk for skin integrity breakdown. During a review of Resident 1's IDT Skin Review Notes, dated 10/24/2024, the IDT notes indicated Resident 1 had a sacrococcyx pressure injury that was unstageable. The IDT notes indicated Resident 1's health conditions were incontinence, declining condition (a gradual decrease or deterioration in health or physical condition), compromised nutritional status and decreased sensory perception. The IDT notes indicated Resident 1 was at risk for slow healing or worsening of wound due to poor oral intake and fragile appearance. The IDT notes indicated Resident 1 was at high risk for skin integrity breakdown During a review of Resident 1's IDT Skin Review Notes, dated 11/7/2024, the IDT notes indicated Resident 1 had a sacrococcyx pressure injury that was unstageable. The IDT notes indicated Resident 1's