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	11/18/2025

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 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. (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 0689 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 provide supervision during toilet use to one of six sampled Residents (Resident 1), who was assessed as high risk for falls. This failure resulted in Resident 1 falling from the toilet and sustaining a forehead laceration (a deep cut in the skin), which required five sutures (used to close wounds and hold tissues together) at a general acute care hospital (GACH). Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Face Sheet indicated Resident 1 had diagnoses that included right femur fracture (a broken thighbone, a serious injury often requiring surgery and extensive rehabilitation, typically caused by high-impact trauma like falls), Alzheimer's (a disease characterized by a progressive decline in mental abilities), and osteoporosis (weak and brittle bones due to a lack of calcium and Vitamin D).During a review of Resident 1's Minimum Data Set (MDS, a Resident assessment tool), dated 9/18/2025, the MDS indicated Resident 1 had severely impaired cognition (the process of thinking). The MDS indicated Resident 1 required moderate assistance (the helper did less than half the effort) with eating and oral hygiene. The MDS indicated Resident 1 required maximal assistance (the helper did more than half the effort) with toileting hygiene. The MDS indicated Resident 1 was dependent (the helper did all the effort) on staff with toilet transferring.During a review of Resident 1's History and Physical (H&P), dated 9/13/2025, Resident 1's H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Fall Risk Evaluation, dated 9/12/2025, the evaluation indicated Resident 1 was at high risk for falls.During a review of Resident 1's Post-Event Interdisciplinary Team (IDT, a group of healthcare professionals from different fields who worked together to plan and provide coordinated care for a Resident) Review, dated 10/7/2025, the IDT record indicated on 10/6/2025 Resident 1 had an unwitnessed fall in the room. The IDT record indicated Resident 1 was sitting on the toilet when Certified Nursing Assistant (CNA) 1 turned to inform another resident that she (CNA 1) was helping Resident 1. The IDT record indicated Resident 1 stood up from the toilet, fell on the floor, and sustained a cut on the forehead. The IDT record indicated Resident 1 had a history of a fall on 9/8/2025 which resulted in a right femur fracture.During a review of Resident 1's General Acute Care Hospital (GACH) records, dated 10/6/2025, the GACH records indicated Resident 1 was brought in by ambulance for an unwitnessed fall resulting in a head laceration and bruising on right side of the face. The GACH records indicated Resident 1 was awake, alert and oriented, and expressed experiencing pain to her right leg and head. The GACH records indicated Resident 1 stated she had fallen from the toilet and hit her head. The GACH records indicated Resident 1 was administered lidocaine (pain medication) and the resident's forehead laceration was repaired with five sutures (used to close wounds and hold tissues together).During a telephone interview on 10/16/2025 at 10:42 a.m. with CNA 1, CNA 1 stated that on 10/16/2025 around 10 a. m., Resident 1 was sitting on the toilet in the restroom. CNA 1 stated she left the restroom and informed another resident that she was assisting Resident 1. CNA 1 stated as soon as she reached the other resident, she heard Resident 1 screaming I fell in Spanish. CNA 1 stated Resident 1 was on the floor in the restroom with blood to the forehead. CNA 1 stated Resident 1 did not provide details on the fall. CNA 1 stated Resident 1 was confused and unaware of her surroundings. CNA 1 stated it was not safe to leave Resident 1 alone in the restroom because of fall risks. CNA 1 stated she should have asked another staff to stay with Resident 1 in the restroom to prevent falls.During an interview on 10/17/2025 at 10:44 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated for safety purposes staff should provide more supervision to high fall risk residents. LVN 1 stated supervision meant the staff should have residents within their visual field. LVN 1 stated it was standard nursing care to provide supervision and monitoring to residents as needed. LVN 1 stated he determined the level and type of supervision residents needed by collecting information from previous shifts, admission assessments, MDS assessments, and the plan of care. LVN 1 stated that he was not aware if the facility had any nursing manual or guidelines regarding resident supervision.During a concurrent interview and record review on 10/17/2025 at 10:44 a.m. with LVN 1, Resident 1's Care Plan titled Activities of Daily Living (ADL) self-care performance deficit related to right femur fracture and a history of falls, revised on 9/22/2025, was reviewed. The Care Plan indicated staff were to safely perform transfers and toilet use. The Care Plan interventions indicated staff were to participate with toilet use and transferring. LVN 1 stated the care plan interventions did not specify the types of assistance Resident 1 needed. LVN 1