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	11/26/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident-centered care plan, for one of three residents (Resident 1), who was incontinent (no control) of bowel and bladder functions and who developed a Moisture-Associated Skin Damage (moisture associated skin damage caused from prolonged exposure to moisture) on 11/3/2025, was created, with interventions, to keep the resident's skin clean and dry. This failure resulted in delayed interventions and had resulted in the development of further MASDs, placing the resident at risk for wound complications and further skin breakdown.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and discharged on 11/24/2025. The admission Record indicated Resident 1 had a history of muscle weakness, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and subarachnoid hemorrhage (bleeding in the brain) with loss of consciousness. Resident 1 was discharged from the facility on 11/24/2025. During a review of Resident 1's Progress Note, dated 10/11/2025, the Progress Notes indicated Resident 1's skin was warm and dry with normal skin color. The progress notes did not indicate Resident 1 had MASD. During a review of Resident 1's Braden Scale (a standardized tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers, or bedsores) for Predicting Pressure Ulcer Risk Evaluation, dated 10/11/2025, the evaluation indicated Resident 1 had very limited sensory perception, was constantly moist, and completely immobile. The evaluation indicated Resident 1 was at high risk of skin breakdown. During a review of Resident 1's History and Physical (H&P), dated 10/14/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make medical decisions. During a review of Resident 1's Bowel and Bladder Evaluation, dated 10/14/2025, the evaluation indicated Resident 1 was not continent (no control) of bowel and bladder for an unknown length of time. The evaluation indicated Resident 1's incontinence was related to an old cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), other debilitating disease over 2 years. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/17/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was dependent (helper does all of the effort) for toileting hygiene (the ability to maintain perineal hygiene) and rolling left and right (ability to roll from lying on back to left and right side). During a review of Resident 1's care plan titled, Has potential for impairment to skin integrity related to (r/t) a Braden scale score of 12, high risk for pressure ulcer, dated 10/18/2025, the interventions indicated to administer treatments as ordered, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, identify/document potential causative factors and eliminate/resolve where possible, reposition at least every 2 hours or as needed, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. During a review of Resident 1's Plan of Care (POC) Response History for Bowel movement/Bowel incontinence, dated 10/28/2025-11/24/2025, the response history indicated Resident 1 had 2-7 bowel movements per day. During a review of Resident 1's Surgical Consult, dated 11/3/2025, the consult indicated Resident 1 had MASD on the (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peri wound (the surrounding area of the wound) of his coccyx (tailbone) wound and right ischium (curve bone at the pelvis) wounds with mild and serous (bloody) exudate (drainage). During a review of Resident 1's Physical Therapy (PT) Progress Report, dated 11/19/2025, the PT Progress Report indicated Resident 1 required moderate assistance and required consistent cuing for safety to roll left and right while in bed with weight shifting. During a review of Resident 1's Surgical Consult, the consultation indicated the following:1). On 11/3/2025, Resident 1's coccyx peri wound area had MASD.2). On 11/10/2025, Resident 1's right ischium wound was classified as MASD. 2). On 11/10/2025, Resident 1's coccyx peri wound area had MASD.3). On 11/17/2025, Resident 1 developed MASD on the peri wound of his coccyx. During a review of Resident 1's care plan titled Has MASD to right ischium., dated 11/11/2025, the interventions indicated nursing staff to administer treatment as ordered, identify/document potential causative factors and eliminate/resolve where possible. During a concurrent interview and record review on 11/25/2025 at 9:40 a.m. with Licensed Vocational Nurse 2 (LVN 2), Resident 1's Nursing Notes dated 10/11/2025, POC Response History for Bowel movement/Bowel incontinence dated 10/28/2025-11/24/2025, and Resident 1's Braden Skin assessment dated [DATE], were reviewed. LVN 2 stated the Nursing Notes indicated Resident 1 did not have MASD upon admission to the facility. LVN 2 stated the Braden Scale indicated Resident 1 was at high risk of skin breakdown due to high levels of moisture, limited mobility, and limited perception. LVN 2 stated the POC Response History indicated Resident 1 required frequent monitoring and cleaning to keep him clean and dry of his frequent bowel movements. During an interview on 11/25/2025 at 2:35 p.m., with Resident 1, Resident 1 stated he developed a red, painful, stinging rash while at the facility. Resident 1 stated he poops 3-10 times per day, due to a gunshot wound and surgical procedure over 30 years ago. Resident 1 stated staff would not respond to his call light for 2-3 hours every night, forcing him to urinate and have bowel movements in his bed, and sit in his urine and feces for up to three hours. Resident 1 stated he felt dreaded (fearful), dehumanized (deprived), and frustrated because of his rash. During a concurrent interview and record review on 11/25/2025 at 10:30 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1's Surgical Consult, dated 11/3/2025, and Care Plan titled Resident has MASD . dated 11/11/2025, were reviewed. LVN 1 stated Resident 1 was constantly soiled, contributing to MASD on his skin of his perineum, buttocks, and coccyx. LVN 1 stated the nursing notes indicated Resident 1 did not have MASD when he was admitted . LVN 1 stated the MASD was first identified on 11/3/2025, but the care plan to address the MASD was not started until 11/11/2025. LVN 1 stated the care plan should have been created and implemented to address Resident 1's MASD for healing and to prevent it from worsening. LVN 1 stated the care plan indicated that Resident 1 should have been kept clean of urine and stool. LVN 1 stated Resident 1 was constantly soiled and the care plan for Resident 1's incontinence was not enough to prevent skin breakdown and MASD. During a concurrent interview and record review on 11/26/2025 at 10:05 a.m. with Medical Doctor 1 (MD 1), Resident 1's Surgical Consults, dated 11/3/2025, 11/10/2025, 11/17/2025, and 11/24/2025, were reviewed. MD 1 stated Resident 1 had MASD on his buttocks and perineum since 11/3/2025. MD 1 stated Resident 1's MASD on the right ischium and peri wound was definitely caused by Resident 1's incontinence. MD 1 stated Resident 1's wound edges, perineum, and buttock area was reddened due to MASD during his consultation on 11/24/2025. MD 1 stated MASD was due to Resident 1's incontinence of bowel and bladder and placed Resident 1 at high risk of skin breakdown and wound infection. During a concurrent interview and record review on 11/26/2025 at 4:26 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P), titled Comprehensive Person-Centered Care Planning, dated 4/2025, was reviewed. The DON stated the care planning P&P indicated care plans should have been created to address Resident 1's needs after the MASD developed on 11/3/2025, especially that Resident 1 was constantly soiled. The DON stated the P&P indicated staff should have provided the treatments and services to maintain and improve Resident 1's skin. During a review of the facility's P&P, titled Comprehensive Person-Centered Care Planning, dated 4/2025, the P&P indicated the Interdisciplinary (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) should develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs. The P&P indicated care plans must include interventions, planned services and treatment, and resident's goals.