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	03/13/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of quality, for one of three residents (Resident 2), by failing to:1). Ensure timely documentation was performed when Resident 2 was assessed and administered pain medication on 3/11/2026. 2). Ensure Resident 2, who had a foley catheter (catheter that drains urine from bladder into a bag outside the body), was provided a securing device (to keep the catheter from being pulled away), as indicated in the resident's care plan titled Resident with an episode of blood in the urine.These failures had the potential for poor quality care and placed Resident 2 at risk for unintentional drug overdose (taking more than what is safely prescribed) and further catheter-associated trauma (like bleeding), pain and discomforts, leading to complications and hospitalization.Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included metabolic encephalopathy (a change in the how the brain works due to an underlying condition), muscle weakness, and end stage renal disease ([ESRD], irreversible kidney failure). During a review of Resident 2's History and Physical (H&P) dated 2/15/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 3/6/2026, the MDS indicated Resident 2 had severe (extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 2 was dependent (helper does less than half the effort) with Activities of Daily Living (ADLs) such as toileting hygiene and required substantial/maximal assistance (helper does more than half the effort) to perform movements such as rolling left and right. 1). During an observation on 3/11/2026 at 1:25 p.m., at Resident 2's bedside, Licensed Vocational Nurse (LVN) 1 was observed telling Resident 2 that he had just received his pain medication (unspecified). During a concurrent interview and record review on 3/11/2026 at 2:13 p.m., with LVN 1, Resident 2's Medication Administration Record (MAR), for the month of 3/2026, was reviewed. LVN 1 stated on 3/11/2026 at 12:30 p.m., Resident 2 was given Tylenol 325 milligrams ([mg], metric unit of measurement, used for medication dosage and/or amount) for the resident's 2/10 pain ([site not specified] a numerical pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible). LVN 1 stated the Tylenol administered was not documented right away in the MAR because she had to attend to another resident. LVN 1 stated that the Tylenol administered, the assessments and reassessments performed, should have been documented right away to ensure Resident 2 was given the correct dose and documented an accurate record. During an interview on 3/13/2026 at 11:38 a.m., with LVN 3, LVN 3 stated late documentation of the medication administered had the potential for licensed nurses to administer another dose when the resident needs it and placed Resident 3 at risk to receive too much medication. 2). During a concurrent observation on 3/11/2026 at 3:58 p.m., with LVN 2, LVN 2 stated Resident 2 has a foley catheter, and did not have a statlock (a device to secure the foley catheter in place on the skin to prevent from moving or being pulled) in place. During a concurrent interview and record review on 3/13/2026 at 11:38 a.m., with LVN 3, Resident 2's care plan titled, Resident with an (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episode of blood in the urine, dated 2/27/2026, and the picture taken during the observation on 3/11/2026 at 3:58 p.m., were reviewed LVN 3 stated the facility did not follow Resident 2's care plan to address residents' problem and the standard of care when Resident 2 did not have a statlock securing the foley catheter. During a review of Resident 2's care plan titled, Resident with an episode of blood in the urine, dated 2/27/2026, one of the interventions indicated to secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. During an interview on 3/13/2026 at 12:38 p.m., with the Director of Nursing (DON), the DON stated staff should always document assessments performed and medications administered in real time to prevent staff from forgetting the care given. The DON stated Resident 2 was at risk for penile trauma for having the foley catheter for a long period of time and needed the statlock to prevent trauma and irritation to the skin. During a review of facility's policy and procedure (P&P) titled, Medication Administration, dated 10/2019, the P&P indicated, the individual who administers the medication dose records the administration on the resident's MAR after the medication pass is completed. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. During a review of facility's P&P titled, Indwelling Urinary Catheter, dated 4/2025, the P& indicated, it is the policy for this facility that each resident with an indwelling urinary catheter will receive catheter care daily and as needed (PRN) to promote comfort and decrease risk of infection. The P&P indicated that staff, may secure the tubing with a securement device, PRN to prevent migration, friction, or tension of the catheter. During a review of facility's P&P titled, Comprehensive Care Planning, dated 4/2025, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop and implement a comprehensive person-centered care plan for each resident.