

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Downey Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of 3 residents (Residents 2, 3, and 4) received care consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence). The facility failed to ensure: Resident 2 was turned and repositioned every two hours to prevent skin breakdown. Resident 3, who had an unstageable wound (a full-thickness pressure ulcer whose depth and severity cannot be determined because the wound bed is obscured [covered] by dead tissue, slough, or eschar [dead tissues]) at the sacrum (tailbone), had the low air loss mattress pump (LALM, a small electric machine that constantly blows air into a medical air bed to prevent a pressure ulcer/injury from developing or worsening), set according to the resident's weight and was not left on static mode (a setting for a LAL mattress where the bed stays at one steady, firm level rather than circulating air to help prevent pressure injuries) for an extended length of time. Resident 3's unstageable wound at the sacrum was correctly assessed. A care plan was created for Resident 4, who refused to be turned and repositioned, and was at high risk to develop pressure ulcer. These failures had the potential for Resident 3's sacral wound to worsen, leading to infections and hospitalization and placed Residents 2 and 4 at risk for developing pressure ulcers. Findings: a). 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]. Resident 2's diagnoses included other sequelae (after effect, long-term complication) of cerebral infarction (stroke) and multiple myeloma (a type of blood cancer that starts off in plasma cells [white blood cells that help fight infections]) relapse (a return of cancer). Resident 2 was sent to a general acute care hospital (GACH) on 3/25/2026 and was readmitted on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 6/23/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 2 had severe (extreme) cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). Resident 2 was dependent (helper does all of the effort) to perform Activities of Daily Living (ADLs) such as toileting hygiene and showering/bathing self. Resident 2 required partial/moderate assistance (helper does less than half the effort) to perform movements such as rolling left and right. During a review of Resident 2's Braden Scale (a standardized tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers, or bedsores), dated 3/19/2026, the Braden Scale indicated Resident 2 was at high risk for developing pressure ulcer. During a review of Resident 2's care plan titled, Has potential for pressure ulcer development related to (r/t) impaired mobility, bowel incontinence (accidental passing of stool or gas), Type 2 Diabetes Mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing), pancytopenia (low counts (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055519	Facility ID: 055519
		If continuation sheet Page 1 of 8

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of blood cells), anemia (a condition where the body does not have enough health red blood cells), multiple myeloma, hyperlipidemia (having too much fat or cholesterol in the blood), thrombocytopenia (low blood platelet [cells that help blood clot or stop bleeding] count), dated 3/31/2026, the interventions indicated to place call light within reach, encourage to turn and reposition, provide assistance as necessary, LALM with bolsters (a built-in support feature, often a pillow-like structure designed to stabilize the head, neck, or body while the mattress is in use) for wound management setting based on resident's current weight or resident's comfort level. During a review of Resident 2's Documentation Survey Report for the month of 3/2026 and 4/2026, the intervention/ task indicating Turned and Repositioned every 2 hours, had x and did not indicate Resident 2 was turned and repositioned every two hours from 3/31/2026 to 4/7/2026. During an interview on 7/30/2026 at 1:31 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated residents should be repositioned every two hours to prevent skin breakdown and should be documented on resident's ADL turning and repositioning log to indicate it was done according to the resident's care plan. b). During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of sacral (tailbone) region, unstageable (a full-thickness pressure ulcer whose depth and severity cannot be determined because the wound bed is obscured [covered] by dead tissue, slough, or eschar [dead tissues]) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) with late onset. During a review of Resident 3's H&P, dated 6/23/2026, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment. Resident 3 required substantial/maximal assistance (helper does more than half the effort) to perform ADLs such as upper body dressing and personal hygiene. Resident 3 required substantial/maximal assistance to roll left and right and to change positions from sitting to lying. During a review of Resident 3's Braden Scale, dated 6/16/2026, the Braden Scale indicated Resident 3 had a Braden Scale score of 12 for high risk for developing pressure ulcer. During a review of Resident 3's Order Summary Report, dated 7/8/2026, the Order Summary Report indicated to cleanse sacrococcyx (tailbone) Stage 4 Pressure Injury (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) with normal saline (NS), pat dry, apply medihoney (a special, medical-grade honey used to help heal cuts, burns, and sores), then cover with dry border dressing every dayshift and LAL Mattress with Bolsters for Wound Management setting based on resident's current weight or resident's comfort level every dayshift. During a concurrent observation and interview on 7/23/2026 at 4:12 p.m., with Licensed Vocational Nurse (LVN) 1 at Resident 3's bedside, LVN observed Resident 3's LAL mattress pump was set to 350 lbs. During a concurrent interview and record review on 7/23/2026 at 4:19 p.m., with LVN 1, Resident 3's order dated 6/29/2026, indicating LAL mattress with bolsters for wound management setting based on resident's comfort weight or resident's comfort level every dayshift, and Resident 3's weight was reviewed. Resident 3 weight indicated 130 lbs. LVN 1 stated because Resident 3 weighed 130 lbs., setting of 350 lbs. was not appropriate because it was too firm for Resident 3. During a concurrent observation and interview on 7/23/2026 at 4:58 p.m., at Resident 3's bedside, with the Director of Nursing (DON), the DON stated Resident 3's LAL mattress pump was not set correctly because Resident 3 did not weigh 350 lbs. During a concurrent observation and interview on 7/23/2026 at 4:12 p.m., with LVN 1 at Resident 3's bedside, LVN 1 stated Resident 3's LAL mattress pump's static mode had been on all day. LVN 1 could not provide the potential outcome when a LALM was in a static mode. During an interview on (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/31/2026 - 4/7/2026 and should have had documentation to indicate that he was turned and repositioned every two hours to prevent skin breakdown. The ADON stated she did not know what the x meant in the turning and repositioning log. The ADON stated wound should be assessed including color, size, depth, drainage, odor, and pain upon discovery to ensure proper treatment is obtained from the doctor. The ADON stated Resident 3's COC and progress notes, dated 6/21/2026 had incomplete wound assessment. The ADON stated Resident 4 had no care plan for refusal of turning and repositioning. During a review of the facility's policy and procedure (P&P) titled, Turning and Repositioning Program, dated 9/2025, the P&P indicated, all residents who were at high risk for skin breakdown, requiring repositioning, should be repositioned per turning schedule unless another individualized plan is developed. During a review of the facility's P&P titled, Comprehensive Person-Centered Planning, dated 4/2025, the P&P indicated, the resident has the right to refuse treatment. In the event that resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan should identify care or services declined, the associated risks, Interdisciplinary Team (IDT)'s effort to educate the resident and resident representative and any alternative means to address risk. During a review of facility's P&P titled, Change in Condition, dated 4/2025, the P&P indicated, the nurse should perform and document resident assessment, identify the need for additional interventions, consider implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed ensure belongings of one of four residents (Resident 1) who was discharged from and readmitted to the facility were created and itemized (list per item) in the resident's inventory list (a detailed record of items). This failure had the potential for the resident's belongings to be lost or stolen. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], readmitted on [DATE]. Resident 1's diagnoses included Alzheimer's disease (a disease characterized by progressive decline in mental abilities) with Late Onset (occurring later in a person's life). The census sheet indicated Resident 1 was transferred out of the facility on 6/21/2026 and returned on 6/25/2026. During a review of Resident 1's History and Physical (H&P) dated 6/14/2026, 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) dated 7/2/2026, the MDS indicated Resident 1 had severe (extreme) cognitive impairment. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with Activities of Daily Living (ADLs) such as showering/bathing self and lower body dressing. Resident 1 required substantial/maximal assistance to roll left and right and in changing position from sitting to standing. During a review of Resident 1's discharge belongings list (lists of resident's property) dated 5/26/2026, the belongings list indicated All items kept at facility. The belonging list did not itemize what items were left at the facility. During a review of Resident 1's belongings lists, a belonging list dated 6/12/2026 was created when Resident 1 returned to the facility. There were no belonging lists created when Resident 1 was transferred out of the facility on 6/21/2026 and when Resident 1 returned to the facility on 6/25/2026. During a concurrent interview and record review on 7/29/2026 at 12:48 p.m., with the Social Services Director (SSD), Resident 1's belongings list dated 5/26/2026, was reviewed. The SSD stated Resident 1's belongings should have been itemized in the belongings list when Resident 1 was transferred out of the facility on 5/26/2026. During interview on 7/30/2026 at 3:42 p.m., with the Assistant Director of Nursing (ADON), Resident 1's belongings list and census were reviewed. The ADON stated an inventory list should have been created when Resident 1 was discharged from the facility on 6/21/2026 and during his readmission on [DATE]. During a review of the facility's policy and procedure (P&P) titled, Resident Belongings, dated 1/2026, the P&P indicated, the facility should protect the personal belongings of residents who were transferred or discharged from the facility. During a review of facility's P&P titled, Theft and Loss, dated 2/2023, the P&P indicated, a written resident personal property inventory must be recorded on an appropriate form upon the resident's admission and must be retained during the resident's stay.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four residents' (Resident 1) missing dentures were followed up with the dental consultant timely. This failure resulted in Resident 1 not having dentures while eating for more than a month and placed the resident at risk for poor food intake. 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 diagnoses included Alzheimer's Disease (a disease characterized by progressive decline in mental abilities) with late onset (occurring later in a person's life). During a review of Resident 1's History and Physical (H&P), 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) dated 7/2/2026, the MDS indicated Resident 1 had severe (extreme) cognitive impairment. Resident 1 required substantial/maximal assistance (helper does more than half the effort) to perform Activities of Daily Living (ADLs) such as showering/bathing self and lower body dressing. The MDS indicated Resident 1 required substantial/maximal assistance to roll left and right and change positions from sitting to standing. During an observation on 7/23/2026 at 12:13 p.m., Resident 1 was observed eating without teeth in the dining room. During an interview on 7/29/2026 at 11:42 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated she has not seen Resident 1 with dentures. During a concurrent interview and record review on 7/29/2026 at 12:05 p.m., with the Speech Language Pathologist (SLP), Resident 1's speech therapy evaluation, dated 6/29/2026, was reviewed. SLP stated because Resident 1 did not have teeth, Resident 1 took a longer time to chew their food. During a concurrent interview and record review on 7/29/2026 at 12:48 p.m., with the Social Services Director (SSD), the email communication between SSD and the dental consultant, dated 6/16/2026, 7/14/2026, 7/23/2026, 7/28/2026, and the dental evaluation dated 6/23/2026, were reviewed. The SSD stated on 6/16/2026, she was made aware by Resident 1's family member regarding the missing dentures. The SSD stated Resident 1 had dental evaluation done on 6/23/2026 but did not indicate if Resident 1 was seen for dentures. The SSD stated she did not follow up on Resident 1's dentures until 7/23/2026 which was more than one month after she was initially made aware. The SSD stated leaving Resident 1 without dentures for a month was not acceptable because it could affect the resident's food intake. The SSD stated Resident 1's denture referral was not followed up timely. During a review of the facility's policy and procedure (P&P) titled, Job Description: Social Services Manager, dated 11/2021, the P&P indicated one of the essential duties and responsibilities of the Social Services was to coordinate social services activities with other departments as necessary and delegate authority, responsibility, and accountability to other responsible department personnel.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the safe discharge planning of one of four sampled residents (Resident 3), who had an unstageable (a full-thickness pressure ulcer whose depth and severity cannot be determined because the wound bed is obscured [covered] by dead tissue, slough, or eschar [dead tissues]) sacral (tailbone) wound, and had home health services (are skilled, physician-directed medical care and related support provided in a patient's home to help them recover from illness, injury, or surgery, manage chronic conditions, or maintain their current health status) ordered prior to the discharge on [DATE]. These failures had the potential that Resident 3's needs will not be met at the receiving facility and had the potential for recurrent hospitalization. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 3's diagnoses included Pressure Ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of Sacral Region, Unstageable and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) with late onset (occurring later in life). During a review of Resident 3's H&P, dated 6/23/2026, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment. Resident 3 required substantial/maximal assistance (helper does more than half the effort) to perform ADLs such as upper body dressing and personal hygiene. Resident 3 required substantial/maximal assistance to roll left and right and to change positions from sitting to lying. During a review of Resident 3's Order Summary Report, active orders as of 6/22/2026, the Order Summary Report indicated an order placed on 6/19/2026 to Discharge [Resident 3] back to ALF on 6/22/2026 per patient request. No Durable Medical Equipment ([DME], reuseable, doctor-prescribed devices used in a home or long-term care setting), Home Health Physical Therapy (PT)/ Occupational Therapy (OT)/ Registered Nurse (RN) as continuation of care. The Order Summary Report indicated Resident 3 had a low air loss mattress pump (LALM, a small electric machine that constantly blows air into a medical air bed to prevent a pressure ulcer/injury from developing or worsening) and a treatment order to the unstageable sacrum (tailbone) wound (a full-thickness pressure ulcer whose depth and severity cannot be determined because the wound bed is obscured [covered] by dead tissue, slough, or eschar [dead tissues]), to cleanse with normal saline (NS), pat dry, apply Thera-honey (a sterile, medical-grade honey used to treat cuts, burns, and wounds), cover with foam dressing every day shift for 30 days and to apply Ammonium Lactate External Cream 12%, 2-4 grams ([gm], a unit of measurement), topically (on the skin) to the bilateral lower extremity, every day shift for xerosis cutis (a term for abnormally dry skin)/skin management. During an interview on 7/30/2026 at 12:55 p.m., with the Social Services Director (SSD), the SSD stated she was not made aware of Resident 3's unstageable wound at the sacrum on 6/21/2026. The SSD stated that because of Resident 3's unstageable sacral wound, an ALF was not an appropriate setting for Resident 3 to be discharged to. The SSD stated they were not aware if ALF staff had re-evaluated Resident 3 prior to his return to the ALF on 6/22/2026 to determine if he was safe to be discharged back to the ALF. During an interview on 7/30/2026 at 12:55 p.m., with the SSD, SSD stated that they did not coordinate with a home health agency prior to Resident 3's discharge on [DATE] and stated ALF was to coordinate with home health instead. During an interview on 7/30/2026 at 1:47 p.m., with ALF Staff, the ALF staff stated there were no on-staff nurses at the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ALF Resident 3 was discharged to. During a concurrent interview and record review on 7/30/2026 at 3:42 p.m., with the Assistant Director of Nursing (ADON), Resident 3's Discharge Order, dated 6/19/2026 and Resident 3's Discharge summary, dated [DATE], were reviewed. The ADON stated that the SSD and Case Manager were not made aware of Resident 3's wounds prior to the discharge to ensure that Resident 3 was discharged appropriately to the right living arrangement and ensure the resident's needs could be met at the receiving facility. The ADON stated, coordinating and confirming home health PT/OT/RN to follow Resident 3 after discharge should have been done prior to the resident's discharge for continuity of care. During a review of the facility's policy and procedure (P&P) titled, Discharge Planning Process, dated 12/2023, the P&P indicated, it was the facility's policy that the discharge planning should focuses on the resident's discharge goals, and effectively transition them to post-discharge care. The P&P indicated the facility's discharge process should include regular re-evaluation of residents (e.g. on a change of condition) to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes and to Consider caregiver/super person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.		