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 03/27/2025

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 - Some

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 45009

Based on observation, interview, and record review, the facility failed to develop a care plan (a document that outlines a person's health needs and the care they required) for four out of four sampled residents (Resident 27, 71, 78, and 62) by failing to:

1. Ensure Resident 27 received a magic cup (a nutritious frozen supplement designed to enhance nutritional intake for individuals experiencing involuntary weight loss) on his lunch meal tray as indicated in Resident 27's physician orders and in his nutritional care plan.

2. Ensure a resident centered care plan was developed for Resident 71's vision impairment.

3. Ensure a care plan was developed for Resident 78's vision impairment.

4. Ensure the facility developed a care plan for Resident 62's medication refusal.

This deficient practice had the potential to delay and negatively affect the delivery of care for Resident 71 and 78's vision impairment, Resident 27's nutritional intake, and Resident 62's overall health.

Findings:

1. During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 27's diagnoses included dysphagia (difficulty swallowing), cerebral infarction (stroke, loss of blood flow to a part of the brain), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).

During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 27's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 27 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).

During a review of Resident 27's Nutritional Care Plan Interventions, initiated 3/6/2025, the Care Plan indicated Resident 27 was to receive magic cup with lunch [meals].

(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

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 03/27/2025
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's Physician Orders, dated 3/5/2025, the orders indicated Resident 27 was to receive magic cup one time a day for nourishment with lunch. During a concurrent interview and observation on 3/24/2025 at 12:46 p.m. with Certified Nursing Assistant (CNA) 1, while in Resident 27's room, Resident 27's food tray was observed. There was no magic cup on the tray. CNA 1 stated that she was not sure what a magic cup was. During a concurrent interview and record review on 3/24/2025 at 12:46 p.m. with CNA 1, Resident 27's meal slip, dated 3/24/2025, was reviewed. The meal slip indicated Resident 27 was to receive one magic cup on his meal tray. During a concurrent interview and observation on 3/26/2025 at 1:11 p.m. with the Dietary Supervisor (DS), a photo of Resident 27's lunch meal tray, dated 3/24/2025, timed at 12:44 p.m., was reviewed. The photo indicated Resident 27 received a plate of vegetables, ground meat, potatoes and a bread roll. The photo indicated there was an apple dessert and a glass of milk served on the side. The DS stated there was no magic cup on Resident 27's lunch meal tray on 3/24/2025. During a concurrent interview and record review on 3/26/2025 at 1:11 p.m. with the DS, Resident 27's Physician Orders, dated 3/2025, were reviewed. The Physician Orders indicated Resident 27 was to receive a magic cup once a day with his lunch meal. The DS stated the kitchen staff were to ensure all magic cups were placed on the meal tray. The DS stated that if the tray was missing a magic cup, the CNA staff would ask the kitchen staff to provide one. The DS stated if the magic cup was missing from Resident 27's lunch tray, then there was a possibility that Resident 27 did not get all his recommended nutrients for the meal. During an interview on 3/26/2025 at 2:43 p.m. with CNA 1, CNA 1 stated Resident 27's lunch meal tray did not have a magic cup, and she did not ask the kitchen for a magic cup because she did not know what a magic cup was. 2. During a review of Resident 71's Admission Record, the admission record indicated Resident 71 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and diabetic retinopathy (leading cause of vision loss in diabetic people. Diabetes damages blood vessels in the retina and the light sensitive tissue at the back of the eye). During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71's vision was moderately impaired (limited vision, not able to see newspaper headlines) The MDS indicated Resident 71's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 71 required moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 71 required supervision for oral hygiene. During a review of Resident 71's History and Physical (H&P) dated 7/14/2025, the H&P indicated Resident 71 had fluctuating capacity to understand and make decisions. The H&P indicated Resident 71was legally blind. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 71's Care Plan for impaired vision, dated 7/19/2024, the care pan indicated Resident 71's goals was to attend activities of choice. The care plan interventions included playing cards, cooking and gardening. During an interview on 3/26/2025 at 3:22 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was important to develop a care plan for a resident that is vision impaired. LVN 1 stated a care plan should include interventions such as talking to the resident, playing music, reading to the resident and provide things for the resident to touch. During a concurrent interview on 3/27/2025 at 10:48 a.m. with the Assistant Director of Nursing (ADON), Resident 71's Care Plan, dated 7/19/2024, was reviewed. The ADON stated an intervention of playing cards was not an ideal intervention for a person with a vision impairment because they cannot see the cards. The ADON stated an intervention of gardening was not an appropriate intervention for a resident with a vision impairment because they could not see what they were doing. The ADON stated an intervention of cooking was not an appropriate intervention for a resident with a vision impairment because it placed the resident's safety at risk. The ADON stated these interventions were not resident centered because vision was important to carry out these interventions. The ADON stated it was important to develop a care plan that was resident centered for it to be beneficial to the resident. 3. During a review of Resident 78's Admission Record, the admission record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses of DM and left below the knee amputation (removal of limb). During a review of Resident 78's H&P, dated 12/19/2024, the H&P indicated Resident 78 had the capacity to understand and make decisions. During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78's cognitive skills for daily decision making were intact. The MDS indicated Resident 78 required moderate assistance for toileting hygiene, showering/bathing, and lower body dressing. The MDS indicated Resident 78 required setup assistance for eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 78's Optometry Consultation Notes, dated 3/3/2025, the Optometry Consultation Notes indicated Resident 78 had a diagnosis of cataracts (condition where the lens of the eye became progressively opaque, resulting in blurred vision) on the left and right eyes. The Optometry Consultation Notes indicated Bifocal glasses (eyeglasses with two distinct optical powers correcting vision at both long and short distances) were recommended for Resident 78. During a review of Resident 78's electronic medical record there was no care plan located for Resident 78's vision impairment. During an interview on 3/27/2025 at 10:55 a.m. with the ADON, the ADON stated a care plan is a resident's plan of care that nursing staff must follow. The ADON stated residents' diagnosis are included in the resident's care plan. The ADON stated it was important to develop a care plan to provide goals and interventions for resident's medical condition. The ADON stated if there was no care plan it could affect the resident's quality of life, and their needs could possibly not be met. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included End Stage Renal Disease (ESRD- irreversible kidney failure), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and DM. During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 had intact cognitive skills for daily decision making. The MDS indicated Resident 62 was independent (resident completed the activity by himself without assistance from a helper) with eating; required supervision with oral hygiene, toileting hygiene, and personal hygiene; and required moderate assistance with showering/ bathing self and transferring in-and-out of bed/ chair. The MDS indicated Resident 62 used a walker for mobility devices. During a review of Resident 62's H&P, dated 5/2/2024, the H&P indicated Resident 62 had fluctuating capacity to understand and make decisions. During a review of Resident 62's March Medication Administration Record (MAR), the MAR indicated Resident 62 refused auryxia (medication to treat high phosphorus levels for ESRD adults), clopidogrel (medication to prevent blood clots in PVD), and Rena Vite (a combination of B vitamins used to treat or prevent low vitamin due to poor diet and certain illnesses) at 5 p.m. on 4/12/2025, 4/19/2025, and 4/25/2025. The MAR indicated Resident 62 refused atorvastatin (medication to decrease the amount of fat that might build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body) at 9 p.m. on 4/12/2025, 4/19/2025, and 4/25/2025. During an interview on 3/27/2025 at 1:25 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the assigned licensed nurse for the resident should develop the care plan when made aware of the resident's condition. LVN 2 stated the purpose of a care plan was to address the resident's condition and provide proper care. LVN 2 stated it would delay necessary care for the resident without a care plan. During a concurrent interview and record review on 3/27/2025 at 10:23 a.m. with the ADON, all Resident 62's Care Plans were reviewed. The ADON stated there was no Care Plan for Resident 62's medication refusal, and there should have been a Care Plan for medication refusal. The ADON stated it was the standard of practice for a licensed nurse to develop a care plan for Resident 62's medication refusal upon acknowledgment. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated the facility will implement a comprehensive person-centered care plan for each resident and will include resident's needs identified in the comprehensive assessment, and resident's goals and desired outcomes, and preferences for future discharge and discharge plan. The P&P indicated In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk.

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to meet professional standards of care for two of two sampled residents (Resident 62 and 142) by failing to: 1. Ensure the nurse documented Resident 62's medications refusal on the Progress Notes. 2. Ensure the nurse did not educate Resident 62 on risk and benefit of refusing medications. 3. Ensure Resident 142's doctor was informed of a change in condition to Resident 142's urine. This deficient practice had the potential to result in delayed necessary medical care for Resident 62 and Resident 142. Findings: 1. During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included end stage renal disease (ESRD- irreversible kidney failure), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 62's History and Physical (H&P), dated 5/2/2024, the H&P indicated Resident 62 had fluctuating capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2025, the MDS indicated Resident 62 had intact cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 62 was independent (resident completed the activity by himself without assistance from a helper) with eating; required supervision with oral hygiene, toileting hygiene, and personal hygiene; and required partial assistance (helper did less than half the effort) with showering/ bathing self and transferring in-and-out of bed/ chair. The MDS indicated Resident 62 used walker for mobility devices. During a review of Resident 62's March Medication Administration Record (MAR), the MAR indicated Resident 62 refused auryxia (medication to treat high phosphorus levels for ESRD adults), clopidogrel (medication to prevent blood clots in PVD), and Rena Vite (a combination of B vitamins used to treat or prevent low vitamin due to poor diet and certain illnesses) at 5 p.m. on 3/12/2025, 3/19/2025, and 3/25/2025. The MAR indicated Resident 62 refused atorvastatin (medication to decrease the amount of fat that might build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body) at 9 p.m. on 3/12/2025, 3/19/2025, and 3/25/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/2025 at 9:20 a.m. with Resident 62, while in Resident 62's room, Resident 62 stated he did not receive his heart disease medications (unable to recall name) at dinner time for couple of days in March (unable to recall dates). Resident 62 stated he refused the 5p.m. medications if the nurse (unidentified) offered the medication too late after dinner around 8 p.m. or 9 p.m. Resident 62 stated he would like to take his medication with dinner, and he already informed nurses (unidentified) that he did not want to take the medication without dinner. Resident 62 stated he did not receive an answer from the nurse (unidentified) when he asked why he did not receive medication at dinner time. Resident 62 stated the nurse (unidentified) did not offer him medication before dinner time around 5 p.m. Resident 62 stated the nurse (unidentified) did not come back and offer the dinner medication after the first refusal. Resident 62 stated he felt staff working in the facility were not experienced and that made him concerned about his care. During an interview on 3/27/2025 at 8:33 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a medication was ordered to give with a meal, the nurse should ensure the resident has food within 30 minutes of the medication administration. LVN 1 stated if the resident refused medications, the nurse should offer the resident the medication a couple of times and explain the risk and benefits of the medication refusal to the resident. LVN 1 stated the nurse should document the resident's medication refusal on the nursing progress note, including that the nurse offered medication couple of times and explained the risk and benefit. LVN 1 stated it was the standard of practice to document on the Progress Notes. LVN 1 stated the purpose of documenting on the Progress Notes was to ensure the right patient care and continuous of care. During a concurrent interview and record review on 3/27/2025 at 10:23 a.m. with the Assistant Director of Nursing (ADON), Resident 62's nursing Progress Notes in March was reviewed. The ADON stated there were no documentation on Resident 62's medication refusal in the March Progress Notes. The ADON stated the medication nurse should document resident's medication refusal on the Progress Notes because it was the standard of practice. The ADON stated the purpose of documenting on the Progress Notes was that staff could monitor for any side effects (unwanted undesirable effects that were possibly related to a medication) of not taking the medication. The ADON stated it was important for Resident 62 to take auryxia, clopidogrel, atorvastatin, and Rena Vite because they were for Resident 62's heart, kidney, and bones. The ADON stated the negative outcome of medication refusal could lead to life threating events such as stroke (cerebrovascular accident - CVA, loss of blood flow to a part of the brain). 2. During a review of Resident 62's Care Plan for ESRD, dated 5/8/2024, the care intervention indicated staff to provide resident the teaching on the importance of compliance with medications. During an interview on 3/27/2025 at 9:26 a.m. with Resident 62, while in Resident 62's room, Resident 62 stated the nurse (unidentified) never provided him the education on the risk and benefit of medication refusal. During a concurrent interview and record review on 3/27/2025 at 10:23 a.m. with the ADON, Resident 62's Progress Notes in March was reviewed. The ADON stated there was no documentation about education for Resident 62's medication refusal in the March Progress Notes. The ADON stated the nurse should educate the resident on the risk and benefits when the resident refused the medication. The ADON stated the nurse should provide education to the resident upon the first medication refusal because it was the standard of practice. The ADON stated documenting on the Progress Notes could show that the resident was aware of the potential side effect because the resident had the right to be informed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated License Vocational Nurse/Licensed Practical Nurse Job Description, the job description indicated the essential duties and responsibilities were to Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident, as well as the resident's response to the care. During a review of the facility's Policy and Procedure (P&P), titled Medication Administration-General Guidelines, dated 10/2019, the P&P indicated if a dose of regularly scheduled medication was refused, an explanatory note should be documented on the record. During a review of the facility's P&P, titled Resident Rights, dated 12/2023, the P&P indicated To assure that our residents, staff, and visitors are continually informed and aware of resident rights. 3. During a review of Resident 142's Admission Record, the admission record indicated Resident 142 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). During a review of Resident 142's H&P dated 3/11/2025, the H&P indicated Resident 142 was alert and oriented to person, place, time and event. The H&P indicated Resident 142 followed simple commands. During a review of Resident 142's MDS, dated [DATE], the MDS indicated Resident 142's cognitive skills for daily decision making were intact. The MDS indicated Resident 142 required maximal assistance (helper does more than half) for toileting hygiene, shower/bathing, and lower body dressing. The MDS indicated Resident 142 required assistance with eating, oral hygiene, and personal hygiene. During a review of Resident 142's Nursing Progress Notes, dated 3/24/2025 at 12:30 p.m., the Nursing Progress Notes indicated Licensed Vocational Nurse (LVN) 3 documented that Resident 142 returned to the facility from dialysis. During a review of Resident 142's Nurse's Dialysis Communication form, dated 3/24/2025, the Nurse's Dialysis Communication form indicated the dialysis nurse documented that Resident 142 had brownish urine. During an interview on 3/25/2025 at 11:07 a.m. with Resident 142, Resident 142 stated he had informed the nursing staff that his urine was brown, and he had pain when he urinated. During an interview on 3/27/2025 at 11:10 a.m. with the Assistant Director of Nursing (ADON), the ADON stated she expected her licensed nurses to review the Nurse's Dialysis Communication form every time a resident returned from dialysis. The ADON stated it was important for the licensed nurses to review the dialysis nurse section to make sure the resident was ok during dialysis, and if there were any new orders or change of conditions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/27/2025 at 11:19 a.m. with the ADON, Resident 142's Nurse's Dialysis Communication form, dated 3/24/2025 was reviewed. The Nurse's Dialysis Communication form indicated the Dialysis Nurse had documented the Resident had brownish urine. The ADON stated the licensed Nurses should have reviewed the dialysis nurse comments. The ADON stated the licensed nurse should have informed Resident 142's doctor of the brownish urine and documented the change in urine. The ADON stated this change in condition could potentially be a urinary tract infection (an infection in any part of the urinary system [body's filtering system, produces urine]) and not reporting the COC could have delayed treatment. During an interview on 3/27/2025 at 12:56 p.m. with LVN 3, LVN 3 stated she did not see Resident 142 when he returned from dialysis because Resident 142 returned to the facility during another shift. LVN 3 stated she did not review the Nurse's Communication Form. During a review of the facility's undated Policy and Procedure (P&P) titled Change of Condition Reporting, the P&P indicated it was the facility's policy that all changes in residents' condition would be communicated to the physician. The P&P indicated the charge nurse was responsible for notification of the physician prior to the end of assigned shift when a significant change in resident's conditions is noted.

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F 0685

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Assist a resident in gaining access to vision and hearing services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45009

Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 78) was seen by an Ophthalmologist (a doctor trained in diagnosing and treating eye problems, including injury and disease) by failing to:

1. Ensure Resident 78 was referred to an ophthalmologist per the optometrist (healthcare provider that examine, diagnose, and treat diseases and disorders that affect eyes and vision) recommendation.

This deficient practice had the potential to result in a delay in treatment for Resident 78.

Findings:

During a review of Resident 78's Admission Record, the admission record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and a left below the knee amputation (removal of limb).

During a review of Resident 78's History and Physical (H&P) dated 12/19/2024, the H&P indicated Resident 78 had the capacity to understand and make decisions.

During a review of Resident 78's Minimum Data Set ([MDS] a required resident assessment tool), dated 12/23/2024, the MDS indicated Resident 78's cognitive skills for daily decision making was intact. The MDS indicated Resident 71 required moderate assistance for toileting hygiene, shower/bathing, and lower body dressing. The MDS indicated Resident 71 required assistance for eating, oral hygiene, upper body dressing, and personal hygiene.

During a review of Resident 78's Optometry Consultation Notes, dated 3/3/2025, the Optometry Consultation Notes indicated Resident 78 had a diagnosis of cataracts (condition where the lens of the eye becomes progressively opaque, resulting in blurred vision) on left and right eyes. The Optometry Consultation Notes indicated Bifocal glasses (eyeglasses with two distinct optical powers correcting vision at both long and short distances) were recommended for Resident 78. The Optometry Consultation Notes indicated Resident 78 needed an ophthalmology referral due to cataracts.

During an interview on 3/26/2025 at 3:37 p.m. with the Social Services Director (SSD), the SSD stated when the optometrist sees a resident, they must inform her or the nursing staff. The SSD stated the optometrist provides her a list of the residents that were seen by the optometrist. The SSD stated social services must follow up on referrals by making an appointment. The SSD stated she was not aware Resident 78 needed to get referred to see an ophthalmologist. The SSD stated she did not review Resident 78's consultation notes.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/27/2025 at 3:56 p.m. with SSD, Resident 78's Optometry Consultation notes, dated 3/3/2025 was reviewed. The Optometry Consultation Notes indicated Resident 78 needed an ophthalmology referral due to cataracts. The SSD stated Resident 78 had to be referred to see an ophthalmologist due to his cataracts. The SSD stated she should have followed up on this referral. The SSD stated it was important to follow up on referrals for residents to get the medical attention they need. The SSD stated not following up on doctor referrals was delaying resident care. During an interview on 3/27/2025 at 10:58 a.m. with the Assistant Director of Nursing (ADON), the ADON stated optometry consultation notes are given to SSD, and they must follow up on referral. The ADON stated the SSD must inform the nursing staff to get an order for a referral. The ADON stated referrals must be followed up quickly to prevent further vision impairment. The ADON stated SSD should have followed up on referral. The ADON stated not following up on a referral delayed the residents care and meant Resident 78 did not receive the necessary treatment for his cataracts. During a review of the facility's job description for social services Manager, dated 11/2021, the job description indicated the SSD would refer resident/families to appropriate social service agencies when the facility does not provide the services or needs of the resident.

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 03/27/2025
NAME OF PROVIDER OR SUPPLIER Downey Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13007 S. Paramount Blvd. Downey, CA 90242	

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure weekly skin interdisciplinary (IDT) meetings were conducted between the dates of 1/9/2025 through 2/27/2027 after a resident had developed redness on his left hip and left anterior iliac crest (a bony prominence located on the anterior (front) portion of the left iliac bone, which is part of the pelvis) for one of six sampled residents (Resident 27). This had the potential to result in additional pain-inducing, pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for Resident 27. Findings: During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 27's diagnoses included dysphagia (difficulty swallowing), cerebral infarction (stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and pressure induced deep tissue damage of the sacrum (located at the lower end of the spine, in the pelvic area region), left hip, and right ankle. During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 27's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 27 was entirely dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent record review and interview on 3/27/2025 at 11:10 a.m. with the Director of Nursing (DON), all of Resident 27's IDT meetings, dated in 2025, and Resident 27's SBAR, dated 2/10/2025, were reviewed. There were no IDT meetings conducted between the dates of 1/9/2025 through 2/27/2027. The SBAR indicated Resident 27 developed left hip and left anterior iliac crest (a bony prominence located on the anterior (front) portion of the left iliac bone, which is part of the pelvis) skin redness on 2/10/2025. The DON stated the normal practice was to conduct a skin IDT meeting weekly and every time there was a change of condition in the resident's skin. The DON stated there should have been an IDT conducted weekly, and especially after a change of condition was identified on 2/10/2025. The DON stated it was important to conduct the IDT meetings to evaluate the plan of care and ensure the proper interventions were in place. The DON stated if the meetings were not conducted, there would be a potential for Resident 27's new skin impairments could worsen. During a review of the facility's Policy and Procedure (P&P), titled, Skin and Wound Monitoring and Management, revised 12/2023, the P&P indicated the facility would conduct a comprehensive skin review on an as needed basis through the activity of the Interdisciplinary Team. The P&P indicated the facility would monitor the pressure injury or the wound weekly via Skin Weekly Committee. The P&P indicated the Skin Weekly Committee was to prepare and maintain Skin Committee Review Notes and Recommendations in the resident's clinical record. (continued on next page)

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

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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	During a review of the facility's P&P, titled, Significant Change of Condition, Response, revised 12/2023, the P&P indicated the IDT shall collaborate to review risk indicators and the plan of care, and the IDT will document this collaboration in the electronic medical record.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to ensure a resident who required dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) had failed) received services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of one resident (Resident 62), when the facility failed to remove Resident 62's pressure dressing (a bandage designed to apply pressure to a dialysis access site, to help control bleeding and promote clotting after a needle was removed) on the arteriovenous shunt (AV shunt, a surgically created connection in the arm to facilitate blood flow for dialysis) site as ordered. This deficient practice had the potential to increase the risk of infection (the invasion and growth of germs in the body), prolonged bleeding, and damage to the AV shunt site for Resident 62. Findings: During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included end stage renal disease (ESRD- irreversible kidney failure), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 62's History and Physical (H&P), dated 5/2/2024, the H&P indicated Resident 62 had fluctuating capacity to understand and make decisions. During a review of Resident 62's Care Plan for ESRD, dated 5/8/2024, the care interventions indicated the nurses are to remove the pressure dressing two hours after dialysis, apply bandage, and remove bandage 24 hours after dialysis. During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2025, the MDS indicated Resident 62 had intact cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 62 was independent (resident completed the activity by himself without assistance from a helper) with eating, required supervision with oral hygiene, toileting hygiene, and personal hygiene, and required partial assistance (helper did less than half the effort) with showering/ bathing self and transferring in-and-out of bed/ chair. The MDS indicated Resident 62 used a walker for mobility devices. During a review of Resident 62's Order Summary Report dated 3/26/2025, the report indicated a physician order dated 11/19/2024, to remove Resident 62's pressure dressing two hours after dialysis on Monday, Wednesday, and Friday. During a review of Resident 62's Progress Note dated 3/24/2025 at 12:18 p.m., the note indicated Resident 62 returned from dialysis at 12:12 p.m. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/25/2025 at 9:20 a.m. with Resident 62, while in Resident 62's room, Resident 62 was observed scratching his left upper arm AV shunt site area. The pressure dressing on Resident 62's left upper arm AV shunt site was undated. Resident 62 stated the AV shunt site was itching. Resident 62 stated he went to dialysis yesterday on 3/24/2025, and no one changed his AV shunt site dressing after returning from dialysis. During a concurrent observation and interview on 3/25/2025 at 3:06 p.m. with Resident 62, while in Resident 62's room, the same undated pressure dressing was still on Resident 62's left upper arm AV shunt site. Resident 62 stated no one changed his AV shunt site dressing. During a concurrent observation and interview on 3/25/2025 at 3:08 p.m. with Licensed Vocational Nurse (LVN) 4, while in Resident 62's room, the undated pressure dressing was on Resident 62's left upper arm AV shunt site. LVN 4 stated the AV shunt dressing should be removed two hours after the resident came back from dialysis. LVN 4 stated the nurse should monitor for bruit (swishing or blowing sound heard over a blood vessel), thrill (a palpable vibration felt over a vessel), and bleeding at the AV shunt site. During a concurrent interview and picture review on 3/27/2025 at 10:23 a.m. with the Assistant Director of Nursing (ADON), the pictures taken of Resident 62's AV shunt site dressing on 3/25/2025 at 9:49 a.m. and 3:05 p.m. were reviewed. The pictures indicated Resident 62's AV shunt dressing was not removed two hours after returning from dialysis. The ADON stated the receiving licensed nurse was responsible to remove the AV shunt pressure dressing two hours after the resident returned from dialysis per the physician's order. The ADON stated it was not acceptable that Resident 62's pressure dressing from dialysis was not removed till the next day. The ADON stated it could clot the shunt causing malfunction and would be unable to be used for dialysis. The ADON stated it could potentially lead to fluid overload (too much fluid volume in body), electrolyte imbalance (occurred when you had too much or not enough of certain minerals in the body), AV shunt revision, and delay in necessary care. During a review of the facility's Policy and Procedure (P&P) titled Dialysis (Renal), Pre- and Post-Care, dated 12/2023, the P&P indicated Post dialysis AV shunt access care as ordered.

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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 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49900

Based on observation, interview and record review, the facility failed to accurately account for and document the administration of one out of three doses of lorazepam (a controlled medication [had a high potential for abuse] to treat anxiety [a feeling of fear, dread, and uneasiness]) for one of one resident (Resident 77) on East Station, Medication Cart East.

This deficient practice increased the risk for unsafe medication administration with the potential for diversion (situation when a medication was taken for use by someone other than whom it was prescribed) and medication errors due to lack of documentation, possibly resulting in serious health complications that could lead to hospitalization or death for Resident 77.

Findings:

During a review of Resident 77's Admission Record, the Admission Record indicated Resident 77 was admitted to the facility on [DATE]. The Admission Record indicated Resident 77 had the following diagnoses which included seizure (a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness), autistic disorder (a neurological and developmental disorder that affected how people interact with others, communicate, learn, and behave), and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest).

During a review of Resident 77's History and Physical (H&P), dated 12/12/2024, the H&P indicated Resident 77 had the capacity to understand and make decisions.

During a review of Resident 77's Minimum Data Set (MDS - a resident assessment tool), dated 12/17/2024, the MDS indicated Resident 77's cognition (the ability to think, remember and reason) was severely impaired. The MDS indicated Resident 77 was dependent (helper does all the effort) in self-care (eating, oral hygiene, toileting hygiene, personal hygiene, and showering/bathing self) and mobility.

During a review of Resident 77's Order Summary Report, dated 3/27/2025, the order summary report indicated Resident 77 had an active order started on 3/24/2025 to administer lorazepam tablet 0.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) one tablet by mouth every six hours as needed for crying for no apparent reason.

During a review on Resident 77's Medication Administration Record (MAR) for 3/2025, the MAR indicated Resident 77 was documented to receive three doses of lorazepam between 3/25/2025 to 3/26/2025 as indicated by nurses' initials documented on the MAR, for the dates and times of 3/25/2025 at 7:10 a.m., 3/25/2025 at 2 p.m., and 3/26/2025 at 11:30 a.m.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/26/2025 at 2:39 p.m. with LVN 3, Resident 77's Narcotic Count Sheet (NCS) for lorazepam and the bubble pack (a card that packaged doses of medication within small, clear, or light-resistant-amber-colored plastic bubbles) of Resident 77's lorazepam was reviewed. Resident 77's NCS for lorazepam indicated there were 27 tablets remaining in the bubble pack. The bubble pack was observed containing 26 tablets of Resident 77's lorazepam. LVN 3 stated there is one missing nurse's signature on Resident 77's lorazepam NCS, and she forgot to sign Resident 77's NCS in the morning after administrating the lorazepam to Resident 77. LVN 3 stated she should sign the NCS immediately after administration because she needed to prove the medication was given. LVN 3 stated it was a medication error and dangerous. LVN 3 stated the nurses needed to be delicate for controlled medication administration. LVN 3 stated the resident might state the medication was not given. During an interview on 3/27/2025 at 10:23 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the nurse should sign the MAR and the NCS immediately after medication administration. The ADON stated the purpose was to ensure the narcotic count was correct and to avoid any medication error. The ADON stated the nurses might forget they gave the medication already. The ADON stated the resident might possibly receive an extra dose of the medication and potentially overdose which was life threatening. During a review of the facility's policy and procedure (P&P) titled Controlled Substances, dated 10/2019, the P&P indicated When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and/or the medication administration record (MAR): 1. Date and time of administration. (MAR, Accountability Record) 2. Amount administered. (Accountability Record) 3. Remaining quantity. (Accountability Record) 4. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from supply.

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49900

Based on observation, interview, and record review, the facility failed to ensure one of one resident (Resident 25) was free from a significant medication error (one which caused the resident discomfort or jeopardizes his health and safety) when Licensed Vocational Nurse (LVN) 3 administered a chewable aspirin tablet to Resident 25 without a physician's order on 3/26/2025 at 9:01 a.m.

This deficient practice had the potential to result in an adverse drug reaction (unwanted undesirable effects that were possibly related to a drug) which could lead to ulceration and/or bleeding to the gastrointestinal ([GI] organ system in the human body that included mouth, throat, esophagus, stomach, small intestine, large intestine, rectum, and anus) tract, hospitalization , or death for Resident 25.

Findings:

During a medication pass observation on 3/26/2025 at 9:01 a.m. with LVN 3, LVN 3 crushed one chewable tablet with the intent to administer as a mixture with applesauce for Resident 25. LVN 3 was stopped by the surveyor at the bedside from her intent to administer the crushed mixture of aspirin chewable tablet and applesauce to Resident 25.

During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 25 had the following diagnoses which included cerebral infarction (stroke, loss of blood flow to a part of the brain), gastritis with bleeding (inflammation of the stomach lining that led to bleeding), and gastroesophageal reflux disease (GERD- a condition in which stomach acid repeatedly flew back up into the tube connecting the mouth and stomach).

During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 25's cognition (the ability to think, remember and reason) was moderately impaired. The MDS indicated Resident 25 was dependent (helper does all the effort) for self-care (eating, oral hygiene, toileting hygiene, personal hygiene, and showering/bathing self) and mobility.

During a review of Resident 25's History and Physical (H&P), dated 3/22/2025, the H&P indicated Resident 25 was alert and oriented to person, place, time, and event.

During a review of Resident 25's Care Plan titled At risk for bleeding/ bruising r/t (related to) anticoagulant (medications that prevented blood from clotting) therapy ASA (aspirin), dated 3/26/2025, the Care Plan indicated Resident 25's goal was to be free from discomfort or adverse reaction from aspirin use. The care interventions indicated to administer aspirin 81 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) delayed release (DR, a formulation designed to delay the release of the active ingredient in the body, typically until it reached the small intestine, bypassing the stomach).

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/26/2025 at 9:03 a.m. with LVN 3, Resident 25's active aspirin order was reviewed. The order indicated to administer aspirin 81 mg DR one tablet by mouth one time a day for stroke prevention. The order indicated not to crush. LVN 3 stated she was not able to crush the aspirin DR tablet and that was why she changed the medication to aspirin chewable tablet. LVN 3 stated they were the same medications and did not know the difference between aspirin DR and aspirin chewable. LVN 3 further stated she needed to clarify the aspirin order with the physician because it was not the right medication. LVN 3 stated she had to follow the physician's order for the resident's safety. LVN 3 stated the LVN was responsible to ensure the right medication and had to read and compare the orders before administration. LVN 3 stated they were the rights of medication administration. During an interview on 3/27/2025 at 10:23 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the nurse needed to call the physician to clarify the aspirin DR order, if the medication need to be changed to a chewable form. The ADON stated maybe the physician ordered the aspirin DR for a reason because the DR tablet did not dissolve. The ADON stated administering the aspirin chewable instead of aspirin DR would cause higher risk of GI bleeding. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administering - General Guidelines, revised on 10/2019, the P&P indicated, Medications are administered in accordance with written orders of the attending physician.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to implement infection (the invasion and multiplication of microorganisms [like bacteria, viruses, etc.] in body tissues, potentially causing illness or harm) control practices for two of two residents (Resident 33 and 62) by failing to: 1. Ensure Resident 33's opened nebulizer mask (a plastic cup that fit over the mouth and nose to deliver liquid medication as a mist into the lungs) was placed directly on the surface of the nightstand at bedside on 3/25/2025. 2. Resident 66's dirty clothes and linen were observed on Resident 66's bed unattended on 3/26/2025 This deficient practice had the potential to place Resident 33 and Resident 62 at risk for infection which could increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death) among residents. Findings: 1. During a review of Resident 33's Admission Record, the record indicated Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and heart failure (HF-a heart disorder which caused the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/2025, the MDS indicated Resident 33's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 33 required supervision for eating; partial assistance (helper did less than half the effort) with transferring in-and-out of bed/ chair; maximal assistance (helper does more than half the effort) with oral hygiene and personal hygiene; and was dependent (helper did all the effort) for toileting hygiene and showering/ bathing self. During a review of Resident 33's History and Physical (H&P), dated 3/8/2025, the H&P indicated Resident 33 had the capacity to understand and make decisions. During a review of Resident 33's Oder Summary Report dated 3/26/2025, the order summary report indicated Resident 33 had an active order started on 3/7/2025 to inhale ipratropium-albuterol solution (medication used to help control the symptoms of lung diseases) 3 milliliters (ml, a measure of volume) orally via nebulizer every six hours for shortness of breath (SOB). During a review of Resident 33's Care Plan, dated 3/11/2025, the Care Plan indicated Resident 33 was at risk of infection. The Care Plan Indicated Resident 33's goal was to decrease the risk of transmission of a pathogen (any organism that caused disease). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/5/2025 at 8:40 a.m. with Resident 33, while in Resident 33's room, an opened nebulizer mask was placed directly on the surface of the nightstand at bedside. Resident 33 stated the nurse (unidentified) just threw the nebulizer mask there and did not put the mask into a plastic storage bag. Resident 33 stated she had not seen the plastic storage bag recently. During a concurrent observation and interview on 3/5/2025 at 2:42 p.m., with Resident 33, while in Resident 33's room, an opened nebulizer mask was placed directly on the surface of the nightstand at the bedside. Resident 33 stated she used the nebulizer for her breathing to get rid of the phlegm (mucus, thicker than normal due to illness). Resident 33 stated she did not want to get an infection. Resident 33 stated it made her feel neglected when the nurse (unidentified) left the nebulizer mask directly on the surface of the nightstand. During a concurrent observation and interview on 3/5/2025 at 2:58 p.m. with Licensed Vocational Nurse (LVN) 4, while in Resident 33's room, an opened nebulizer mask was placed directly on the surface of the nightstand at bedside. LVN 4 stated the nebulizer mask needed to be stored inside a bag for infection control because the resident could be infected. LVN 4 stated the signs and symptoms of respiratory infection were difficulty breathing and coughing. LVN 4 stated the charge nurse and infection control nurse were responsible to ensure the nebulizer mask was stored in the bag. LVN 4 stated the nebulizer mask was dirty and needed to change to a new one. During a concurrent interview and picture review on 3/25/2025 at 3:49 p.m. with the Infection Preventionist Nurse (IPN), the pictures taken on 3/25/2025 at 8:48 a.m. and 2:41 p.m. were reviewed. The pictures indicated the opened nebulizer mask was placed directly on the surface of the nightstand at the bedside. The IPN stated it was not acceptable to have the nebulizer mask touching the surface of the nightstand. The IPN stated the nurse should keep the nebulizer mask in a storage bag for infection control. The IPN stated if the nebulizer mask was dirty, the resident would inhale the dirtiness. The IPN stated the resident would have bacteria that potentially led to respiratory infection. The IPN stated after the resident finished using the nebulizer mask, the assigned LVN needed to place the nebulizer mask back into the storage bag till the next use. During a review of the facility's Policy and Procedure (P&P) titled Infection Control Policy/Procedure, dated 3/2019, the P&P indicated Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. 2. During an observation on 3/26/2025 at 9:42 a.m. while in Resident 62's room, the dirty clothes and linen were left on the bed unattended. During an observation on 3/26/2025 at 11:05 a.m. while in Resident 62's room, the dirty clothes and linen were left on the bed unattended. During an observation on 3/26/2025 at 12:04 p.m. while in Resident 62's room, the dirty clothes and linen were left on the bed unattended. (continued on next page)

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 03/27/2025
NAME OF PROVIDER OR SUPPLIER Downey Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13007 S. Paramount Blvd. Downey, CA 90242	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 62's diagnoses included end stage renal disease (ESRD- irreversible kidney failure), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and diabetes mellitus (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 62's H&P, dated 5/2/2024, the H&P indicated Resident 62 had fluctuating capacity to understand and make decisions. During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 had intact cognitive skills for daily decision making. The MDS indicated Resident 62 was independent (resident completed the activity by himself without assistance from a helper) with eating; required supervision with oral hygiene, toileting hygiene, and personal hygiene; and required partial assistance with showering/ bathing self and transferring in-and-out of bed/ chair. The MDS indicated Resident 62 used a walker for mobility devices. During an interview with Resident 62 on 3/25/2025 at 9:20 a.m. with Resident 62, while in Resident 62's room, Resident 62 stated he had a dirty pile of clothes on his bed earlier in the morning. Resident 62 stated staff just removed his dirty clothes for the past week today, and staff did not provide him any bags for dirty clothes. During a concurrent of interview and picture review on 3/27/2025 at 8:33 a.m. with Certified Nursing Assistant (CNA) 2, the picture taken on 3/26/2025 at 9:42 a.m., 11:05 a.m., and 12:04 p.m. were reviewed. The pictures indicated the dirty clothes and linen were left on the bed unattended on 3/26/2025 at 9:42 a.m., 11:05 a.m., and 12:04 p.m. CNA 2 stated it was not acceptable to leave dirty clothes and linen on the bed unattended. CNA 2 stated the CNA was responsible to remove the dirty clothes and change the linen even if the resident was not in the room. CNA 2 stated it was because of infection control and CNA 2 did not want residents to get an infection. During a concurrent interview and picture review on 3/27/2025 at 9:33 a.m. with the IPN, the pictures taken on 3/26/2025 at 9:42 a.m., 11:05 a.m., and 12:04 p.m. were reviewed. The pictures indicated the dirty clothes and linen were left on the bed unattended on 3/26/2025 at 9:42 a.m., 11:05 a.m., and 12:04 p.m. The IPN stated it was dirty in the pictures, and the nurse should clean out the dirty linen because of infection control. The IPN stated the dirty clothes, and linen should be stored in a proper place like a humper, and the facility would send the dirty clothes to laundry. The IPN stated Resident 62 preferred staff to clean his bed when he was present. The IPN stated the dirty linen germs would not get to the roommates because of the privacy curtain. During an interview on 3/27/2025 at 10:01 a.m. with Resident 62, while in Resident 62's room, Resident 62 stated he did not ask the staff not to remove his dirty clothes and linen on 3/26/2025. Resident 62 stated he wanted to have the dirty clothes removed on his bed, and no staff checked with him about the dirty clothes and linen before he went to dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) had failed) in the morning of 3/26/2025. Resident 62 stated it was dirty, and he did not like dirty. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and picture review on 3/27/2025 at 10:23 a.m. with the Assistant Director of Nursing (ADON), the pictures taken on 3/26/2025 at 9:42 a.m., 11:05 a.m., and 12:04 p.m. were reviewed. The pictures indicated the dirty clothes and linen were left on the bed unattended on 3/26/2025 at 9:42 a.m., 11:05 a.m., and 12:04 p.m. The ADON stated it was it was a mess in the pictures, and the nurse should put the dirty clothes away and tidy up resident's bed a bit. The ADON stated the nurses should be rounding throughout their shift. The ADON stated it was not acceptable to see dirty clothes on the bed because of infection control and resident's dignity. The ADON stated it affected the resident's dignity, and resident would be upset. The ADON stated everyone in the building should maintain each resident's dignity and infection control. During a review of the facility's P&P titled Infection Control Policy/ Procedure with subject Laundry Services, dated on 1/2017, the P&P indicated All soiled linen should be bagged or put into carts at the location where used; it should not be sorted or pre-rinsed in resident-care areas.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to meet the required room size measurement of 80 square feet ([sq. ft.]- a unit of measurement) of room space per resident in rooms with multiple residents. This deficient practice had the potential to result in not providing residents privacy and could potentially affect residents' health and safety. Findings: During a review of the facility's Client Accommodations Analysis form, dated 3/24/2025, the form indicated four rooms in the facility did not meet the room size requirement. The client accommodation form indicated the following: room [ROOM NUMBER] measured 217 sq. ft. room [ROOM NUMBER] measured 232 sq. ft. room [ROOM NUMBER] measured 238 sq. ft. room [ROOM NUMBER] measured 234 sq. ft. During an observation on 3/27/2025 at 12:37 p.m. while in room [ROOM NUMBER], the room had three beds with a wheelchair at the bedside. There was enough room space available to allow wheelchairs to be maneuvered in the room. The Room provided privacy to the three residents along with privacy curtains. All residents were observed to have enough room space for a bedside table and a dresser. During an observation on 3/27/2025 at 12:40 p.m. while in room [ROOM NUMBER], there were three beds in the room and a resident was observed sitting in a wheelchair. The resident was able to propel to his bed. The room provided privacy to the residents with privacy curtains. The residents had sufficient room space for a bedside table and a dresser. During an observation on 3/27/2024 at 12:44 p.m. while in room [ROOM NUMBER], the room was observed to have three beds. There were also visitors observed in the room. The Room provided privacy to the residents with privacy curtains. All residents had sufficient room space for a bedside table and a dresser. During an observation on 3/27/2024 at 12:48 p.m. while in room [ROOM NUMBER], there were three beds. The room provided privacy to the residents with privacy curtains. All residents had room space for a bedside table and a dresser. There was enough room space for resident wheelchairs. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 3/27/2024 at 2:31 p.m. with the administrator, the administrator stated the facility had four rooms (room [ROOM NUMBER], 20, 34, 35) that did not meet the room size requirement. The administrator stated residents in those rooms were comfortable and had enough space for property, nursing care, and treatments. The administrator indicated the room space allowed residents to move freely in the room, whether ambulatory or in a wheelchair. The administrator stated resident rooms offered residents privacy, dignity, and safety. The California Department of Public Health recommends a room waiver.