STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055519	A. Building B. Wing	05/07/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food safety and food preparation practices was observed for all 95 residents. The facility failed to:1. Maintain cold food items at safe temperatures when glasses of milk and flan measured 50 to 61 degrees Fahrenheit (F, a scale of temperature).2. Ensure staff did not wear a beaded bracelet during trayline service.3. Ensure one bottle of Martinelli's Sparkling Cider was labeled with the date received.These deficient practices had the potential to allow bacterial growth in potentially hazardous foods (PHFs- foods that require strict time and temperature control to prevent the growth of harmful bacteria or the formation of toxins) and increased the risk for food borne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for residents who consumed food prepared and served from the kitchen.Findings:1. During a concurrent observation and interview on 5/5/2026 at 12:15 p.m., with the Dietary Supervisor (DS) during tray line, one pre-plated glass of milk measured 53.2 F and another glass of pre-plated milk measured 51.8 F was observed. One bowl of flan measured 60.4 F, another bowl of flan (made with milk) measured 60.2 F, 61.8 F, and 60.8 F. The DS stated the glasses of milk, and the bowls of flan were pre-plated approximately five minutes prior to observation. The DS stated the milk and the flan were potentially hazardous foods that required to be maintained at or below 41 F. The DS stated if temperatures of the milk and flan were not maintained below 41 F, there was potential for bacterial growth and food borne illness. During a concurrent interview and record review on 5/7/2026 at 11:47 a.m. with the DS, the facility's Policy and Procedure (P&P) titled, Food Preparation, revised 2023, was reviewed. The P&P indicated cold food were to be held at 41 F or below. The DS stated the kitchen staff did not follow the P&P if temperatures of the milk and bowls of flan measured 50 F to 61 F. The DS confirmed the elevated temperatures were not identified prior to the temperature checks conducted with the state surveyor on 5/5/2026.During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19. Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less.During the facility's Policy and Procedure (P&P) titled, Food Handling, revised 2023, the P&P indicated food would be prepared and served in a safe and sanitary manner. 2. During a concurrent observation and interview on 5/5/2026 at 12:07 p.m. with the DS, DA 1 wore a red beaded bracelet while serving food onto the plates during tray line. The DS stated bracelets worn during tray line had the potential to harbor bacteria and lead to cross contamination. The DS stated wearing jewelry during tray line had the potential to lead to cross contamination and food borne illness. During the facility's Policy and Procedure (P&P) titled, Dress Code, revised 2023, the P&P indicated kitchen staff were not to wear excessive jewelry, just wedding rings on hand, non-dangling earrings on ears, and wristwatch. The P&P indicated the wristwatch and wedding rings need to be covered with gloves when handling food.During the facility's Policy and Procedure (P&P) titled, Food Handling, revised 2023, the P&P indicated food would be prepared and served in a safe and sanitary manner. 3. During a concurrent observation and interview on 5/4/2026 at 8:10 a.m., in the kitchen, with the Dietary Supervisor (DS), one bottle of Martinelli's Sparkling Cider stored in the facility's walk-in refrigerator (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lacked a received date. The DS stated every item stored in the refrigerator should have a received date label to ensure the food item was safe for consumption.During the facility's Policy and Procedure (P&P) titled, Labeling and Dating of Foods, revised 2023, the P&P indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation. The P&P indicated food delivered to the facility needed to be marked with a delivery or received date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control measures for four of eight sampled residents by failing to: 1. Ensure Resident 10's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) collection bag did not touch the floor.2. Ensure Licensed Vocational Nurse (LVN) 1 performed hand hygiene (cleaning hands to remove dirt and bacteria) after preparing Resident 86's medications and before administering Resident 86's medications.3. Ensure LVN 1 sanitized the blood pressure cuff before using on Resident 101 after using on Resident 86.4. Ensure Certified Nursing Assistant (CNA) 1 wore personal protective equipment when changing Resident 82, who was on Enhanced Barrier Precaution (EBP- an infection control measure to protect residents at high risk for multidrug-resistant organisms [MDRO- bacteria resistant to multiple classes of antibacterial medication]).These deficient practices had the potential to result in the avoidable spread of bacteria and disease to Residents 10, 86, 101, and 82. Findings: 1. During a review of Resident 10's Face Sheet, the Face Sheet indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included end stage renal disease (irreversible kidney failure), obstructive and reflux uropathy (a blockage in the urinary tract prevents urine from flowing out of the body and will flow backward towards the kidneys), and benign prostatic hyperplasia (BPH- enlargement of the prostate gland in older men). During a review of Resident 10's Physician Order, dated 2/11/2026, the Physician Order indicated for Resident 10 to have an indwelling catheter, 16 French (size of the catheter's diameter) to gravity drainage for BPH and obstructive uropathy. During a review of Resident 10's History and Physical (H&P), dated 2/13/2026, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 3/6/2026, the MDS indicated Resident 10's cognition (process of thinking) was severely impaired. The MDS indicated Resident 10 required maximal assistance (helper does more than half the effort) with bathing, upper/lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 10 had an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine).During an observation on 5/4/2026 at 9:52 a.m., in Resident 10's room, Resident 10 was lying in bed and had an indwelling urinary catheter collection bag hung on the left side of the bed frame. Resident 10's bed was in the lowest-to-the-floor position, and the indwelling urinary catheter collection bag was touching the floor. During an interview on 5/6/2026 at 10:23 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated Resident 10 had an indwelling urinary catheter, which increased his risk for infection. The IPN stated the indwelling urinary catheter collection bag should be hung below the level of Resident 10's bladder and should never touch the floor. The IPN stated the collection bag could get caught on something and rip, which would introduce bacteria through the urinary catheter tubing and into Resident 10's bladder. The IPN stated when Resident 10's bed was in the lowest position; a basin should be kept underneath to hold the collection bag to prevent the collection bag from touching the floor directly. The IPN stated having the urinary catheter collection bag touching the floor increased Resident 10's risk of infection, such as a urinary tract infection (UTI- an infection in the bladder/urinary tract). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2026 at 11:27 a.m., with the Director of Nursing (DON), the DON stated Resident 10 was at an increased risk for infection due to the presence of an indwelling urinary catheter. The DON stated the indwelling urinary catheter was a direct passage to Resident 10's bladder. The DON stated Resident 10's indwelling urinary catheter collection bag should not touch the floor. The DON stated bacteria could enter through the collection bag and enter Resident 10's bladder, which could cause infection. During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care, revised 11/2017, the P&P indicated the facility was to promote hygiene, comfort, and decrease risk of infection for catheterized residents. 2. During a review of Resident 86's Face Sheet, the Face Sheet indicated Resident 86 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 86's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- caused by a blocked blood vessel in the brain) affecting the left side and dementia (a progressive state of decline in mental abilities). During a review of Resident 86's H&P, dated 12/12/2025, the H&P indicated Resident 86 had fluctuating capacity to understand and make decisions. During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86's cognition was intact. The MDS indicated Resident 86 was dependent on staff's assistance with toileting, lower body dressing, putting on and taking off footwear. During an observation on 5/5/2026 at 8 a.m., in Resident 86's room, Licensed Vocational Nurse (LVN) 1 introduced himself to Resident 86 and explained he would be administering her medications. After LVN 1 checked Resident 86's vital signs, LVN 1 excused himself back to the medication cart to prepare Resident 86's medications. During an observation on 5/5/2026 at 8:03 a.m., outside of Resident 86's room, LVN 1 returned to the medication cart and performed hand hygiene (cleaning hands to remove dirt and bacteria). LVN 1 proceeded to prepare a total of nine medications for Resident 86 and placed each medication in a separate medication cup. LVN 1 placed the nine medication cups onto his tray and entered Resident 86's room. During an observation on 5/5/2026 at 8:12 a.m., in Resident 86's room, LVN 1 reentered Resident 86's room and pulled the curtain to provide privacy. LVN 1 did not perform hand hygiene upon entering Resident 86's room. LVN 1 put on a pair of gloves and assisted Resident 86 with her medications. During an interview on 5/5/2026 at 8:18 a.m., with LVN 1, LVN 1 stated he forgot to perform hand hygiene after he prepared Resident 86's medications. LVN 1 stated he should have performed hand hygiene prior to entering Resident 86's room and putting on gloves. LVN 1 stated hand hygiene was essential in preventing cross contamination (the physical transfer of harmful bacteria from one person, object, or surface to another) and infection. LVN 1 stated he delivered oral medications to Resident 86, which was a portal for infection to enter her body. During an interview on 5/6/2026 at 10:27 a.m., with the IPN, the IPN stated hand hygiene was essential to prevent the spread of bacteria from residents and staff. The IPN stated during medication (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration, the licensed nurse was responsible for performing hand hygiene throughout the process. The IPN stated bacteria could be present on the medication cart, the laptop, and the medication containers. The IPN stated hand hygiene was especially important after preparing the medications to ensure the licensed nurse's hands were clean prior to administering the medications. The IPN stated the lack of hand hygiene increased the risk of spreading bacteria and infection to Resident 86. During a review of the facility's P&P titled, Hand Hygiene, revised 4/2025, the P&P indicated hand hygiene was performed before and after direct contact with residents. 3. During a review of Resident 101's Face Sheet, the Face Sheet indicated Resident 101 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 101's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right side, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and low back pain. During a review of Resident 101's H&P dated 4/16/2026, the H&P indicated Resident 101 had the capacity to understand and make decisions. During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101's cognition was intact. The MDS indicated Resident 101 required maximal assistance with toileting, lower body dressing, and putting on/taking off footwear. During an observation on 5/5/2026 at 8:03 a.m., outside of Resident 86 and 101's room, LVN 1 returned to the medication cart after taking Resident 86's blood pressure. LVN 1 placed the blood pressure cuff on top of the medication cart and proceeded to prepare and administer Resident 86's medications. During an observation on 5/5/2026 at 8:19 a.m., outside of Resident 101's room, LVN 1 picked up the blood pressure cuff, which was not sanitized, and entered Resident 101's room. LVN 1 prepared to place the blood pressure cuff onto Resident 101's arm until he was stopped by the observer and was excused out of the room. During an interview on 5/5/2026 at 8:21 a.m., with LVN 1, LVN 1 stated he did not sanitize the blood pressure cuff after checking Resident 86's blood pressure. LVN 1 stated after using the blood pressure cuff on Resident 86, he should have immediately sanitized the blood pressure cuff to ensure it was clean and ready to use on Resident 101. LVN 1 stated sanitizing equipment between residents was important to prevent cross contamination. LVN 1 stated sanitizing the blood pressure cuff ensured any bacteria transferred from Resident 86 skin to the blood pressure cuff was removed prior to using it on Resident 101. During an interview on 5/6/2026 at 10:30 a.m., with the IPN, the IPN stated the licensed nurse was responsible for disinfecting any equipment used on a resident to ensure the equipment was clean to use on the following resident. The IPN stated the blood pressure cuff should have been sanitized after its use on Resident 86. The IPN stated any kind of bacteria could have been present on Resident 86's skin and transferred to the blood pressure cuff. The IPN stated the bacteria would have been transferred to Resident 101. The IPN stated although bacteria could be harmless, if there was an open wound on Resident 101's skin, the bacteria could enter Resident 101's bloodstream and make her sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2026 at 11:24 a.m., with the DON, the DON stated hand hygiene and equipment sanitation were necessary to stop the spread of bacteria from one individual to another. The DON stated by not abiding by the facility's infection control practices, LVN 1 increased Resident 86 and 101's risk for infection. During a review of the facility's P&P titled, Infection Control Program, revised 5/2010, the P&P indicated the facility's infection control goal was to decrease the risk of infection to residents and staff. 4. During a review of Resident 82's Face Sheet (admission Record), the Face Sheet indicated the facility initially admitted Resident 82 on 3/13/2026 and was re-admitted on [DATE] with diagnosis including displaced comminuted fracture (a severe injury where a bone breaks into three or more pieces and shifts out of alignment) of shaft of right femur, subsequent encounter for closed fracture with routine healing (a broken bone that does not puncture the skin, progressing through normal repair stages). During a review of Resident 82's Minimum Data Set (MDS – a resident assessment tool), dated 4/16/2026, the MDS indicated Resident 1's cognition (ability to think) was moderately impaired. The MDS indicated Resident 82 needed substantial assistance (helper does more than half effort) with toileting hygiene, showering, upper body dressing, and lower body dressing. During a review of Physician orders dated 4/10/2026, indicated Enhanced Barrier Precautions (EBP): personal protective equipment (PPE) required for high resident contact care activities. The indication for EBP was Resident 82's surgical site. During a review of Resident 82's Care Plan dated 4/23/2026, indicated The resident is on enhanced barrier precautions (EBP) related to surgical site. The care plan interventions include direct care staff to utilize gowns and gloves for all personal care. During an observation on 5/4/2026 at 9:30 a.m. in Resident 82's room, outside of the room an enhanced barrier precautions (EBP) sign was observed outside the door. Certified nurse assistant (CNA) 1 was observed not wearing personal protective equipment (PPE) while cleaning and changing Resident 82 with Resident 82's surgical site exposed. During an interview on 5/6/2026 at 9:30 a.m. with the Infectious Preventionist Nurse (IPN), the IPN stated personal protective equipment (PPE) was worn with enhanced barrier precautions (PPE) when performing direct care such as Activities of Daily Living (ADLs)and cleaning residents. The IPN stated the importance of wearing PPE was to protect the residents. The IPN stated if PPE was not worn, resident can get an infection or go septic (a life-threatening blood infection). During an interview on 5/6/2026 at 2:30 p.m. with the Director of Nursing (DON), the DON stated personal protective equipment (PPE) was worn by direct care staff to protect the resident. The DON stated PPE should be worn for enhanced barrier precautions (EBP) with incontinent brief changes, showers, or any direct contact with residents were being performed. The DON stated due to the fact direct care staff go from resident to resident, direct care staff must protect the resident to prevent infection. The DON stated EBP was placed to protect the resident. During a review of facility's policy and procedure (P&P) titled IPCP (Infection Prevention and Control Program) Standard and Transmission-Based Precautions, dated 6/2021, last revised 4/2025, the P&P (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Enhanced Barrier Precautions (EBP) used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (multi drug resistant organism – bacteria or other microorganisms that have developed resistance to multiple common antibiotics, making infections difficult to treat). Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide timely notification to the responsible party (RP) and physician for one of six sampled residents (Resident 58) by failing to:Ensure the licensed nursing staff notified the Responsible Party (RP) that Resident 58 exhibited increased confusion and had partially slid off the bed on 4/20/2026.Ensure the licensed nursing staff notified the physician that Resident 58:Exhibited increased confusion during the early morning hours of 4/20/2026.Partially slid off the bed between approximately 2:30 am to 3:00 a.m. on 4/20/2026.Developed bruising to the left arm on 4/22/2026.These deficient practices had the potential to place Resident 58 at risk for delayed diagnosis, delayed treatment, worsening injury, unmanaged pain, and further decline. Resident 58 was later hospitalized and diagnosed with a left elbow fracture (broken bone).Cross Reference F689 and F842.Findings: During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included a displaced comminuted supracondylar fracture (a severe elbow injury where the humerus bone breaks into multiple pieces, with the bones separating), osteoarthrosis (a progressive disorder of the joints, caused by a gradual loss of cartilage), muscle weakness, and repeated falls. During a review of Resident 58's Minimum Data Set ([MDS], a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 58 required maximal assistance (helper does more than half the effort) for bed mobility, showering, toileting, and upper body dressing. During a review of Resident 58's History and Physical (H&P), dated 3/11/2026, the H&P indicated Resident 58 could make needs known but could not make medical decisions. During a review of Resident 58's care plan, titled, At risk for Bleeding or Bruising Related to Anticoagulant Therapy, initiated 3/13/2026, the care plan interventions indicated to monitor, document, and report to the physician as needed for signs of bruising. During a review of Resident 58's care plan, titled, Fluid Deficit, initiated 3/24/2026, the care plan interventions indicated to monitor, document, and report to the physician as needed when signs and symptoms of dehydration like new onset confusion was present. During a review of Resident 58's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 4/20/2026, timed at 7:00 a.m., and authored by the Director of Nursing (DON), the note indicated Resident 58 was caught in the process of sliding from the bed on 4/20/2026 at 7:00 a.m. The SBAR did not indicate physician notification related to Resident 58's acute confusion. During a review of Resident 58's SBAR Note, dated 4/20/2026, timed at 9:55 a.m., the SBAR note indicated Resident 58 complained of two out of ten acute pain to the left arm and Physician 1 ordered an in-house x-ray (a medical imaging test). During a review of Resident 58's SBAR Note, dated 4/23/2026, the note indicated Resident 58 was ordered to be transferred to the General Acute Care Hospital (GACH) for further evaluation and treatment for abnormal labs. There was no documentation to indicate Physician 1 was made aware of Resident 58'S bruising (injury where blood vessels under the skin are damaged and leak blood without breaking the skin surface) of the left arm or reminded of Resident 58's previous incident of partially sliding off the bed. During a review of Resident 58's GACH Physician Progress Notes, dated 4/24/2026, the notes indicated Resident 58 recently suffered a fall and had left arm swelling, bruising, mild redness, pain with elbow range of motion. During a record review of Resident 58's GACH X-Ray (medical imaging technique) Results, dated 4/24/2026, the results indicated Resident 58's clinical history included a fall and the final impression indicated an impacted transverse comminuted left distal humeral supracondylar fracture with approximately 1.2 centimeters (a unit of measurement) of medial displacement (a significant shift of the bone fragments). During an observation and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 5/5/2026 at 8:10 a.m. with Resident 58, in Resident 58's room, Resident 58 was in her bed with a left arm sling (suspension device to immobilize the elbow) and demonstrated limited movement of the left arm secondary to pain. Resident 58 stated she believed she fell but she could not recall and stated that her granddaughter, Responsible Party (RP) 2, would be able to provide more details. 1. During an interview on 5/5/2026 at 8:29 a.m. with RP 2, RP 2 stated Resident 58 sustained a left elbow fracture. RP 2 stated the DON contacted her on 4/20/2026 during the daytime hours but did not clearly explain what had occurred. RP 2 stated facility staff were unable to clearly explain what had occurred and informed her x-rays would be obtained. RP 2 stated she visited Resident 58 on 4/22/2026 and observed swelling and bruising to Resident 58's left arm. RP 2 stated, on 4/22/2026, she later learned Resident 58 had been found hanging off her bed during the early morning hours of 4/20/2026. RP 2 stated Resident 58 was not normally confused, did not typically attempt to get out of bed independently, and required assistance for mobility. During an interview on 5/5/2026 at 1:08 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 confirmed she was Resident 58's nurse on 4/20/2026 during the 11:00 p.m. to 7:00 a.m. shift. LVN 3 stated at approximately 2:00 a.m., Resident 58 exhibited acute confusion, repeatedly threatened to get up from bed, and stated she needed to go to an appointment. LVN 3 stated Certified Nursing Assistant (CNA) 4 initiated one-to-one supervision and sat outside of Resident 58's room to maintain safety. LVN 3 stated, at some point, CNA 4 went to lunch. LVN 3 stated, during her rounds at approximately 3:00 a.m., she heard Resident 58 moan and caught Resident 58 in the act of sliding off the bed and landed in an inverted ?L' position with legs dangling off the left side of the bed. LVN 3 stated she did not notify RP 2 immediately after the changes of condition because she believed the DON would do so. LVN 3 stated RP 2 should have been notified immediately because RP 2 had the right to be informed of any changes of condition for Resident 58. During a concurrent interview and record review on 5/6/2026 at 10:55 a.m. with DON, Resident 58's Nursing Progress Notes, dated 4/22/2026, and SBAR Notes, dated 4/2026, were reviewed. The SBAR note, dated 4/20/2026, indicated Resident 58 experienced an episode of partially sliding off the bed at 7:00 a.m. and that RP 2 and Physician 1 were notified at 8:00 a.m. The DON stated LVN 3 notified her at approximately 2:30 a.m. to 3:00 a.m. on 4/20/2026 that Resident 58 partially slid off the bed. The DON stated RP 2 should have been promptly notified because RP 2 was actively involved in Resident 58's care and had the right to be informed of significant changes. The DON stated that she attempted to notify RP 2 regarding the incident at approximately 8:00 a.m. on 4/20/2026 but did not verify whether RP 2 understood the circumstances of the incident. 2. During a concurrent interview and record review on 5/5/2026 at 12:49 p.m. with Licensed Vocational Nurse (LVN) 2, two of Resident 58's SBAR Notes, dated 4/20/2026 and timed at 7:00 a.m. and 9:55 a.m., were reviewed. LVN 2 stated timely physician notification was important during any change in condition to ensure prompt assessment, monitoring and treatment. LVN 2 stated a delay in physician notification delayed treatment opportunities for Resident 58. LVN 2 further stated he was unaware Resident 58 experienced an earlier incident involving partial sliding from the bed and increased confusion when he later notified Physician 1 regarding Resident 58's left arm pain. LVN 2 stated knowledge of the earlier incident would have allowed more complete clinical information to be communicated to Physician 1 for treatment decisions. During an interview on 5/5/2026 at 1:08 p.m. with LVN 3, LVN 3 confirmed she was Resident 58's nurse on 4/20/2026 during the 11:00 p.m. to 7:00 a.m. shift. LVN 3 stated at approximately 2:00 a.m., Resident 58 exhibited acute confusion, repeatedly threatened to get up from bed, and stated she needed to go to an appointment. LVN 3 stated CNA 4 initiated one-to-one supervision and sat outside of Resident 58's room to maintain safety. LVN 3 stated, at some point, CNA 4 went to lunch. LVN 3 stated, during her rounds at approximately 3:00 a.m., she heard Resident 58 moan and caught Resident 58 in the act of sliding off the bed and landed in an inverted ?L' position with legs dangling off the left side of the bed. LVN 3 confirmed Resident 58's acute confusion and partial slide from the bed represented changes in condition that warranted physician notification. LVN 3 stated that she alerted the DON of the incident but did not notify (continued on next page)

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	055519	A. Building B. Wing	05/07/2026

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician 1. LVN 3 stated that she should have made Physician 1 of the acute confusion to ensure orders for safety and supervision were obtained. LVN 3 further stated that she should have notified the physician immediately after Resident 58 was found partially off the bed because the position had the potential to cause injury. LVN 3 stated the lack of timely physician notification placed Resident 58 at risk for missed assessments, delayed treatment, and delayed hospital evaluation. During an interview on 5/6/2026 at 9:04 a.m. with Physician 1, Physician 1 stated that she was not made aware of Resident 58's partial slide off the bed until 4:00 p.m. on 4/20/2026 (approximately 13 hours post incident). Physician 1 further stated that she was never notified of Resident 58's episode of acute confusion before her incident on the bed. Physician 1 stated that she expected to be notified right aware of both changes of condition to allow for further evaluation at the GACH and ensure consideration of additional interventions following an acute change in condition and possible injury event. Physician 1 stated she would have wanted to know about Resident 58's acute onset of confusion because it could have been signs and symptoms of an infection or early signs of dementia (a progressive state of decline in mental abilities). Physician 1 stated that it was important to be made aware of every clinical detail pertinent to Resident 58 so that she could rule out any potential issues and provide accurate orders and the best plan of care. 2c. During an interview and concurrent record review on 5/5/2026 at 3:03 p.m. with LVN 4, Resident 58's Nursing Progress Notes, SBAR Notes, and Changes in Condition Notes, dated 4/22/2026, were reviewed. LVN 4 stated it was important to notify the physician of all changes of condition and ensure appropriate monitoring and treatment. LVN 4 stated Resident 58 developed left arm bruising on 4/22/2026 but the physician was not notified regarding the bruising. LVN 4 further stated bruising should have been documented and reported to ensure complete clinical information was communicated to the physician for ongoing treatment decisions. During a concurrent interview and record review on 5/6/2026 at 10:55 a.m. with the DON, Resident 58's Nursing Progress Notes, dated 4/22/2026, and SBAR Notes, dated 4/2026, were reviewed. The records did not indicate Physician 1 was made aware of Resident 58's development of bruising to the left arm. The SBAR note, dated 4/20/2026, indicated Resident 58 experienced an episode of partially sliding off the bed at 7:00 a.m. and that RP 2 and Physician 1 were notified at 8:00 a.m. The DON stated LVN 3 notified her at approximately 2:30 a.m. to 3:00 a.m. on 4/20/2026 that Resident 58 partially slid off the bed, did not report Resident 58 exhibited acute confusion prior to the incident. The DON stated acute confusion and the incident involving partially sliding off the bed both represented significant changes in condition that should have been immediately reported to Physician1 and RP 2.The DON stated timely physician notification was important to ensure appropriate assessment, treatment, monitoring, and physician orders were implemented following Resident 58's acute change of condition and possible injury event. The DON stated it was important to inform Physician 1 of any development of bruising to ensure all clinical information was provided to ensure proper orders were obtained. The DON stated the lack of timely physician notification for Resident 58's acute onset of confusion, and partial slide from the bed, and the subsequent development of a bruise had the potential to lead to inappropriate orders and delay in Resident 58's improvement in medical condition. During a review of the facility's policy and procedure (P&P) titled, Change in Condition, revised 4/2025, the P&P indicated the facility would ensure each resident received quality of care and services to attain and maintain the highest practicable physician mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The P&P indicated licensed nursing staff would ensure the physician would be notified based on the urgency of the situation and the resident representative would be notified of the change of condition and any changes in the resident's medical or nursing care. The P&P indicated the nurse would perform and document an assessment of the resident and identify need for additional interventions, through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. During a review of the facility's LVN Job Description (undated), the job description indicated the LVN was to chart nurses' notes in a professional and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate manner that timely, accurately and thoroughly reflected the care provided to the residents, as well as the resident's response to the care. The Job Description indicated to chart the following:1) all reports of accidents/incidents involving residents.2) all changes in resident condition and the response to those changes.3) all communications with the residents attending physician regarding the resident, the residents treatment, or the response to that treatment.The Job Description indicated to perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan was initiated for a resident's development of a bruise for one out of six sampled residents (Resident 58). These deficient practice had the potential to place Resident 58 at risk for delayed treatment, delayed assessment, and further injury. Resident 58 was later hospitalized and diagnosed with a left elbow fracture (broken bone). Cross Reference F580, F689, and F842. During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included a displaced comminuted supracondylar fracture (a severe elbow injury where the humerus bone breaks into multiple pieces, with the bones separating), osteoarthrosis (a progressive disorder of the joints, caused by a gradual loss of cartilage), muscle weakness, and repeated falls. During a review of Resident 58's Minimum Data Set ([MDS], a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 58 required maximal assistance (helper does more than half the effort) for bed mobility, showering, toileting, and upper body dressing. During a review of Resident 58's History and Physical (H&P), dated 3/11/2026, the H&P indicated Resident 58 could make needs known but could not make medical decisions. During a review of Resident 58's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 4/20/2026, timed at 7:00 a.m., and authored by the DON, the note indicated Resident 58 was caught in the process of sliding from the bed on 4/20/2026 at 7:00 a.m. During a review of Resident 58's General Acute Care Hospital (GACH) Physician Progress Notes, dated 4/24/2026, the notes indicated Resident 58 had left arm swelling, bruising, mild redness, pain with elbow range of motion and had recently suffered a fall. During a record review of Resident 58's GACH X-Ray (a type of medical imaging) Results, dated 4/24/2026, the results indicated Resident 58's clinical history included a fall and the final impression indicated an impacted transverse comminuted left distal humeral supracondylar fracture with approximately 1.2 centimeters (a unit of measurement) of medial displacement (a significant shift of the bone fragments). During an observation and interview on 5/5/2026 at 8:10 a.m. with Resident 58, in Resident 58's room, Resident 58 was in her bed with a left arm sling and demonstrated limited movement of the left arm secondary to pain. Resident 58 stated she believed she fell but she could not recall and stated that her granddaughter, Responsible Party (RP) 2, would be able to provide more details. During an interview on 5/5/2026 at 8:29a.m. with RP 2, RP 2 stated she observed bruising to Resident 58's left arm when she visited Resident 58 on 4/22/2026. During an interview and concurrent record review on 5/5/2026 at 3:03 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 58's Nursing Progress Notes, SBAR Notes, and Changes in Condition Notes, dated 4/22/2026, were reviewed. LVN 4 stated changes in condition should be assessed, monitored and care planned. LVN 4 stated Resident 58 developed left arm bruising on 4/22/2026 but LVN 4 did not document her assessment nor initiate a care plan. During an interview and record review on 5/6/2026 at 10:55 a.m. with the Director of Nursing (DON), Resident 58's Care Plans, dated 4/2026, were reviewed. There was no care plan for Resident 58's development of a bruise to the left arm on 4/22/2026. The DON stated Resident 58's bruising should have been care planned to ensure proper monitoring and interventions were implemented. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Resident Centered Care Plan, revised 1/2021, the P&P indicated the facility would ensure the interdisciplinary team (IDT) would develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise two of two sampled residents' (Residents 52 and 10) care plans to reflect their need for the Hoyer Lift (a mechanical device used to lift and/or transfer a person) during transfers.This deficient practice had the potential to result in the miscommunication of the transfer needs for Residents 52 and 10, which could lead to unsafe transfers.Cross Reference F689.Findings:1. During a review of Resident 52's Face Sheet, the Face Sheet indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included generalized muscle weakness, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 52's History and Physical (H&P), dated 3/24/2026, the H&P indicated Resident 52 did not have the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 52's cognition (process of thinking) was severely impaired. The MDS indicated Resident 52 was dependent on staff's assistance with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) such as toileting, bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 52 required maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfers. During a review of Resident 52's Physical Therapy (PT) Progress Report, dated 4/22/2026, the PT Progress Report indicated Resident 52 required maximal assistance with chair/bed-to-chair transfers. During a review of the facility's Special Needs List, updated 5/6/2026, the Special Needs List indicated Resident 52 required the Hoyer Lift (a mechanical device used to lift and/or transfer a person) during transfers.During an observation and interview on 5/6/2026 at 1:41 p.m., with the Director of Staff Development (DSD), outside of Resident 52's room, a pink sticker was observed next to Resident 52's name. The DSD stated stickers were placed next to the resident's name to inform the staff of the resident's safe transferring needs. The DSD stated the pink sticker next to Resident 52's name indicated the Hoyer Lift was needed during transfers. The DSD stated the Hoyer Lift was used when transferring Resident 52 out of the bed to the chair and vice versa.During an interview on 5/6/2026 at 1:57 p.m., with Physical Therapist (PT) 1, PT 1 stated the rehab department evaluated each resident's safe transferring needs and informed the nursing department, who then placed the stickers next to the resident's name. PT 1 stated a resident with maximal assistance required the Hoyer Lift during all transfers because the resident could help a little bit, but the individual assisting did most of the effort. During an interview on 5/6/2026 at 2:08 p.m., with PT 2, PT 2 stated Resident 52 was evaluated, and the rehab department recommended the nursing department to use the Hoyer Lift during all transfers to maximize safety and prevent falls and other injuries. During an interview on 5/6/2026 at 3:07 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated care plans provided the interventions the facility's staff were to follow to treat certain conditions and the goals to be met. LVN 1 stated care plans encompassed everything about each resident. LVN 1 stated the care plans should be specific to ensure no confusion on how to care for the residents. During a concurrent interview and record review on 5/6/2026 at 3:10 p.m., with LVN 1, Resident 52's Care Plan titled, ADL Self Care Performance Deficit, dated 3/23/2026. The Care Plan's goals indicated safe transfers would be performed. The Care Plan's interventions indicated Resident 52's transfers from chair/bed-to-chair required staff participation with transfers. LVN 1 stated staff participation with transfers could be interpreted in different ways. LVN 1 stated Resident 52's care plan was not specific and did not indicate Resident 52's need for the Hoyer Lift during transfers. LVN 1 stated Resident 52's care plan should have been revised to indicate Resident 52's need for the Hoyer Lift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 1 stated due to Resident 52's care plan not indicating the need for the Hoyer Lift during transfers, Resident 52 was at risk for improper transfers which could lead to injury.2. During a review of Resident 10's Face Sheet, the Face Sheet indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included end stage renal disease (irreversible kidney failure), obstructive and reflux uropathy (a blockage in the urinary tract prevents urine from flowing out of the body and will flow backward towards the kidneys), and benign prostatic hyperplasia (BPH- enlargement of the prostate gland in older men).During a review of Resident 10's H&P, dated 2/13/2026, the H&P indicated Resident 10 did not have the capacity to understand and make decisions.During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognition was severely impaired. The MDS indicated Resident 10 required maximal assistance with bathing, upper/lower body dressing, and putting off footwear. The MDS indicated Resident 10 required maximal assistance with chair/bed-to-chair transfers.During a review of Resident 10's PT Progress Report, dated 4/30/2026, the PT Progress Note indicated the chair/bed-to-chair transfers were not attempted due to medical conditions or safety concerns. During a review of the facility's Special Needs List, updated 5/7/2026, the Special Needs List indicated Resident 10 required the Hoyer Lift during transfers.During an interview on 5/7/2026 at 9:30 a.m., with PT 1, PT 1 stated Resident 10 was dependent during his transfers. PT 1 stated he recommended to the nursing department to use the Hoyer Lift for all transfers. PT 1 stated Resident 10 did not put any effort into his transfers therefore to maximize safety; the Hoyer Lift was used. During a concurrent observation and interview on 5/7/2026 at 9:40 a.m., with LVN 5, outside of Resident 10's room, a pink sticker was observed next to Resident 10's name. LVN 5 stated the pink sticker next to Resident 10's name indicated the Hoyer Lift was necessary during transfers. During an interview on 5/7/2026 at 9:42 a.m., with LVN 5, LVN 5 stated care plans were used to identify an issue, create a goal, and implement interventions to obtain the goal. LVN 5 stated every part of the care plan should be resident-specific and detailed.During a concurrent interview and record review on 5/7/2026 at 9:42 a.m., with LVN 5, Resident 10's Care Plan titled, ADL Self Care Performance Deficit, dated 2/11/2026. The Care Plan's goals indicated safe transfers would be performed. The Care Plan interventions indicated Resident 52's transfers from chair/bed-to-chair required physical assistance with transferring. LVN 5 stated Resident 10's care plan was not specific and did not indicate the need for the Hoyer Lift. LVN 5 stated Resident 10 was dependent on staff assistance and required maximal assistance when transferring. LVN 5 stated Resident 10's care plan should have been revised to indicate Resident 10's need for the Hoyer Lift. LVN 5 stated due to Resident 10's care plan not indicating the need for the Hoyer lift during transfers, Resident 10 was at risk for the staff not using the Hoyer lift during transfers, which could lead to injury.During an interview on 5/7/2026 at 11:36 a.m., with the Director of Nursing (DON), the DON stated care plans guided the staff on how to provide care to the residents. The DON stated the care plans should be individualized and specific. The DON stated by not specifying Resident 10 and 52's level of transfer assistance in their care plans, there was a risk of miscommunication on how to perform a safe transfer. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Resident Centered Care Plan, revised 1/2021, the P&P indicated a comprehensive person-centered care plan should be developed and implemented for each resident consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Residents 52 and 58) were free of accidents and hazards by failing to:1. Use a Hoyer Lift (a mechanical device used to lift and/or transfer a person) when Resident 52 was transferred from the shower chair to the bed on 4/29/2026.2. Conduct an Interdisciplinary Team (IDT- a coordinated group of experts from several different fields) meeting after Resident 52 sustained two injuries to the lower left leg from a shower chair-to-bed transfer on 4/29/2026.3. Ensure adequate supervision and timely physician notification occurred after Resident 58 exhibited acute confusion and displayed urgent desire to leave her bed. These deficient practices resulted in Resident 52 sustaining two wounds on her lower left leg and had the potential for additional accidents to occur. These deficient practices also resulted in Resident 58 being found partially sliding from the bed, which placed Resident 58 at risk for injury and delayed physician evaluation and treatment. Resident 58 was subsequently diagnosed with a left upper extremity fracture (broken bone). Cross Reference F580, F657, and F842. Findings: 1. During a review of Resident 52's Face Sheet, the Face Sheet indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included generalized muscle weakness, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 52's Care Plan titled, ADL Self-Care Performance Deficit, dated 3/23/2026, the Care Plan's interventions indicated Resident 52 required staff participation with transfers from the chair/bed-to-chair. During a review of Resident 52's History and Physical (H&P), dated 3/24/2026, the H&P indicated Resident 52 did not have the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 52's cognition (process of thinking) was severely impaired. The MDS indicated Resident 52 was dependent on staff's assistance with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) such as toileting, bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 52 required maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfers. During a review of Resident 52's Physical Therapy (PT) Progress Report, dated 4/22/2026, the PT Progress Report indicated Resident 52 required maximal assistance with chair/bed-to-chair transfers. During a review of Resident 52's Change in Condition (COC), dated 4/29/2026, the COC indicated, on 4/29/2026, Resident 52 sustained an open ecchymosis (a bruise that opens, breaks, or tears) during transfer to the bed. The COC indicated Resident 52's wounds were located on the left lower posterior (area of the leg near the calf) and left lower lateral leg (outer side of the left shin, below the knee and above the ankle). During a review of Resident 52's Surgical Wound Consult Progress Note, dated 4/30/2026, the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Note indicated Resident 52 had a trauma wound (a sudden, severe physical wound caused by an external force requiring immediate medical attention) on the left lower lateral part of her leg. The Progress Note indicated the wound on the left lower lateral part of Resident 52's leg measured 5 centimeters (cm, a unit of measurement) in length, 6cm in width, and 1cm in depth. During a review of Resident 52's Skin Issues Assessment, dated 5/1/2026, the Skin Issues Assessment indicated Resident 52's wound on the left lateral calf measured 3.5cm in length, 0.2cm in width, and 0.1cm in depth. The Skin Issues Assessment indicated Resident 52's wound on the left lateral lower leg measured 5cm in length, 6cm in width, and 1cm in depth. During a review of the facility's Special Needs List, updated 5/6/2026, the Special Needs List indicated Resident 52 required the Hoyer Lift (a mechanical device used to lift and/or transfer a person) during transfers. During an interview on 5/4/2026 at 12:22 p.m., with Responsible Party (RP) 1, RP 1 stated, on 4/29/2026, the facility notified her that Resident 52 sustained trauma injuries to her left leg. RP 1 stated Resident 52's injuries occurred when Resident 52 was transferred to the bed and Resident 52's leg got caught on something. During a concurrent observation and interview on 5/4/2026 at 2:44 p.m., with Treatment Nurse (TN) 1, in Resident 52's room, Resident 52 was lying in bed and Registered Nurse (RN) 1 was at the bedside to assist TN 1 with Resident 52's wound treatment. Resident 52's dressings were removed from her left leg. Two wounds were observed on the lower left leg. The first wound was the shape of a half circle, with irregular edges along the rounded border, closest to the foot. The area of the wound closest to the foot was moist, with a pale pink wound bed, and a small amount of bright red bleeding. The second was located near the left calf. The area of the wound near the calf was covered by thin, pale, purplish-gray, flaps of skin that were fragile in appearance. The skin flaps were wrinkled and did not cover the entire wound. TN 1 stated Resident 52's wounds were classified as a trauma wound and Resident 52 sustained both wounds from the same accident, on 4/29/2026. During an interview on 5/6/2026 at 12:05 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on 4/29/2026, Resident 52 received a shower and after Resident 52 was transferred to the bed, Certified Nursing Assistant (CNA) 2 noticed two wounds on Resident 52's leg. LVN 1 stated CNA 3 assisted CNA 2 with Resident 52's transfer back to bed. LVN 1 stated CNA 2 notified him and when he initially assessed Resident 52's leg, he saw open skin on the top part of Resident 52's leg and a skin flap on Resident 52's calf. During an interview on 5/6/2026 at 12:29 p.m., with CNA 3, CNA 3 stated, on 4/29/2026, CNA 2 requested his assistance to transfer Resident 52 back to bed. CNA 3 stated they did not use the Hoyer Lift during the transfer. CNA 3 stated when he and CNA 2 transferred Resident 52 from the shower chair to the bed, they stood on both sides of Resident 52, held under her arms to assist her to a standing position, and turned her until she sat at the edge of the bed. CNA 3 stated after he and CNA 2 assisted Resident 52 into a sitting position at the edge of the bed, CNA 2 assisted Resident 52 into a lying position on the bed. CNA 3 stated he had his back turned when CNA 2 positioned Resident 52 into a lying position on the bed. CNA 3 stated during Resident 52's transfer from the shower chair to the bed, he did not notice any bleeding or wounds on Resident 52's left leg. During a phone interview on 5/6/2026 at 12:55 p.m., with CNA 2, CNA 2 stated on 4/29/2026, Resident 52 was scheduled to have a shower. CNA 2 stated Resident 52 required a Hoyer Lift for all (continued on next page)

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Downey Post Acute	13007 S. Paramount Blvd. Downey, CA 90242

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers CNA 2 stated she knew showering Resident 52 would take about an hour from start to finish. CNA 2 stated after she showered Resident 52, she asked CNA 3 to assist her in transferring Resident 52 to the bed. CNA 2 stated she and CNA 3 assisted Resident 52 into a standing position from the shower chair to allow Resident 52 to sit at the edge of the bed. CNA 2 stated once Resident 52 was at the edge of the bed, she lifted Resident 52's legs and while supporting Resident 52's back and turned Resident 52 to her right and laid Resident 52 into the bed. CNA 2 stated when she attempted to put Resident 52's pants on, she noticed the injuries to Resident 52's legs and blood on Resident 52's bed frame. CNA 2 stated she did not use the Hoyer Lift to transfer Resident 52 from the shower chair to the bed because she wanted to save time. CNA 2 stated Resident 52 was injured during the transfer and Resident 52's injuries could have been prevented if the Hoyer Lift was used. CNA 2 stated she thought she could safely perform a two-person transfer without the Hoyer Lift because she assisted the rehab staff with that transfer in the past. During an observation and interview on 5/6/2026 at 1:41 p.m., with the Director of Staff Development (DSD), outside of Resident 52's room, a pink sticker was observed next to Resident 52's name. The DSD stated stickers were placed next to the resident's name to inform the staff of the resident's safe transferring needs. The DSD stated the pink sticker next to Resident 52's name indicated the Hoyer Lift was needed during transfers. The DSD stated the Hoyer Lift was used when transferring Resident 52 out of the bed to the chair and vice versa. During an interview on 5/6/2026 at 1:57 p.m., with Physical Therapist (PT) 1, PT 1 stated the rehab department evaluated each resident's safe transferring needs and informed the nursing department, who then placed the stickers next to the resident's name. PT 1 stated a resident with maximal assistance required the Hoyer Lift during all transfers because the resident could help a little bit, but the individual assisting did most of the effort. During an interview on 5/6/2026 at 2:08 p.m., with PT 2, PT 2 stated when the rehab therapist transferred a resident, despite the need of the Hoyer Lift, the transfer was done with another therapist. PT 2 stated the therapists in the rehab department were trained to perform two-person assists safely. PT 2 stated Resident 52 was evaluated, and the rehab department recommended the nursing department to use the Hoyer Lift during all transfers to maximize safety and prevent falls and other injuries. During an interview on 5/6/2026 at 2:39 p.m., with CNA 3, CNA 3 stated when CNA 2 asked for his assistance, he was attending to another resident at that time. CNA 3 stated he knew Resident 52 required the Hoyer Lift during transfers, however, CNA 2 had Resident 52 at the bedside in the shower chair. CNA 3 stated CNA 2 did not have the Hoyer Lift at Resident 52's bedside and he needed to attend to his other resident. CNA 3 stated the Hoyer Lift should have been used to transfer Resident 52 to promote safety and prevent injuries. During an interview on 5/7/2026 at 11:28 a.m., with the Director of Nursing (DON), the DON stated, on 4/29/2026, Resident 52 was transferred from the shower chair to her bed and sustained two wounds on the left leg. The DON stated Resident 52 required the Hoyer Lift during all transfers because Resident 52 was a maximal assist and could not help during transfers. The DON stated CNA 2 and CNA 3 transferred Resident 52 from the shower chair to the bed without the Hoyer Lift therefore Resident 52's leg got caught on the bed frame. The DON stated on 4/29/2026, Resident 52 had a bed with gaps in the bed frame, which allowed for different segments of the bed to be adjusted. The DON stated Resident 52 had fragile skin and was at risk of injuries. The DON stated the two-person assist, without the Hoyer Lift, was not a safe transfer for Resident 52. The DON stated accidents could (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happen during any transfers, however, Resident 52 was not transferred in a way to maximize safety and Resident 52's wounds on her legs could have been prevented. During a review of the facility's Policy and Procedure (P&P) titled, Transfer Assist Program, dated 6/2023, the P&P) indicated residents identified to need a Hoyer Lift with transfers would have a pink sticker next to the resident's door tag. During a review of the facility's Certified Nursing Assistant (CNA) Job Description, dated 12/17/2021, the Job Description indicated CNAs were to perform all assigned tasks in accordance with the facility's policies and procedures, perform restorative and rehabilitative procedures as instructed, and follow all safety precautions in the performance of all duties. 2. During an interview on 5/7/2026 at 11:49 a.m., with the DON, the DON stated the Interdisciplinary Team (IDT- a coordinated group of experts from several different fields) met at least quarterly or sooner, if needed. The DON stated additional IDT meetings were conducted if requested by the family, a fall occurred, a change in weight, or other incidents that required the IDT to discuss the circumstances and develop interventions to implement. During a concurrent interview and record review, on 5/7/2026 at 11:53 a.m., with the DON, Resident 52's IDT Change in Condition Care Plan Review, dated 4/29/2026, was reviewed. The Care Plan Review indicated Resident 52's COC, on 4/29/2026, did not require an IDT meeting. The DON stated Resident 52's incident on 4/29/2026, should have had an IDT meeting to include other departments, such as rehab, and RP 1 to discuss the incident and create a plan to prevent the incident from occurring again. The DON stated that without an IDT meeting, there could be miscommunication with RP 1 regarding Resident 52's care and the potential for another incident to occur. During a review of the facility's P&P titled, Change in Condition, revised 4/2025, the P&P indicated, The interdisciplinary team (IDT) shall collaborate with the attending physician, resident, and/or resident representative to review risk factors and the plan of care. The IDT will document this collaboration in the [electronic medical record] EMR in the next scheduled Comprehensive Care Plan Meeting or sooner if deemed necessary by the IDT. 3. During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included a displaced comminuted supracondylar fracture (a severe elbow injury where the humerus bone breaks into multiple pieces, with the bones separating), osteoarthrosis (a progressive disorder of the joints, caused by a gradual loss of cartilage), muscle weakness, and repeated falls. During a review of Resident 58's History and Physical (H&P), dated 3/11/2026, the H&P indicated Resident 58 could make needs known but could not make medical decisions. During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 58 required maximal assistance (helper does more than half the effort) for bed mobility, showering, toileting, and upper body dressing. During a review of Resident 58's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 4/20/2026, timed at 7:00 a.m., and authored by the DON, the note indicated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 58 was caught in the process of sliding from the bed on 4/20/2026 at 7:00 a.m. During a review of Resident 58's General Acute Care Hospital (GACH) Physician Progress Notes, dated 4/24/2026, the notes indicated Resident 58 had left arm swelling, bruising (injury where blood vessels under the skin are damaged and leaked blood without breaking the skin surface), mild redness, pain with elbow range of motion and recently suffered a fall. During a record review of Resident 58's GACH X-Ray (a type of medical imaging) Results, dated 4/24/2026, the results indicated Resident 58's clinical history included a fall, and the final impression indicated an impacted transverse comminuted left distal humeral supracondylar fracture with approximately 1.2 centimeters (a unit of measurement) of medial displacement (a significant shift of the bone fragments). During an observation and interview on 5/5/2026 at 8:10 a.m. with Resident 58, in Resident 58's room, Resident 58 was in her bed with a left arm sling and demonstrated limited movement of the left arm secondary to pain. Resident 58 stated she believed she fell but she could not recall and stated that her granddaughter, Responsible Party (RP) 2, would be able to provide more details. During an interview on 5/5/2026 at 8:29a.m. with RP 2, RP 2 stated Resident 58 sustained a left shoulder and elbow fracture. RP 2 explained, on 4/20/2026, during the daytime, the DON contacted her to come to the facility. RP 2 stated facility staff were unable to clearly explain what had occurred and informed her x-rays would be obtained. RP 2 stated, upon visiting Resident 58 on 4/22/2026, she observed side pads placed on her bed and noted swelling and bruising to Resident 58's left arm. RP 2 stated she later learned Resident 58 had been found hanging off her bed during the early morning hours of 4/20/2026. RP 2 stated Resident 58 was not normally confused, did not typically attempt to get out of bed independently, and required assistance for mobility. During an interview on 5/5/2026 at 1:08 p.m. with LVN 3, LVN 3 confirmed she was Resident 58's nurse on 4/20/2026 during the 11:00 p.m. to 7:00 a.m. shift. LVN 3 stated at approximately 2:00 a.m., Resident 58 exhibited acute confusion, repeatedly threatened to get up from bed, and stated she needed to go to an appointment. LVN 3 stated CNA 4 initiated one-to-one supervision due to Resident 58's confusion and attempts to get out of bed. LVN 3 stated CNA 4 later left for lunch and one-to-one supervision was not maintained. LVN 3 stated that during rounds at approximately 3:00 a.m., she heard Resident 58 moaning and observed Resident 58 in the act of sliding off the bed in an upside down 'L' position with the resident's legs dangling off the left side of her bed. LVN 3 confirmed Resident 58 exhibited increased confusion and experienced an episode of sliding from the bed, both of which represented changes in condition requiring physician notification. LVN 3 stated that she notified the DON regarding the incident but did not notify Physician 1. LVN 3 stated Physician 1 should have been notified to obtain orders and clinical direction related to Resident 58's confusion, safety needs, and interventions. LVN 3 stated one-to-one supervision should have been maintained during CNA 4's lunch break, and stated Resident 58 was at risk for an accident or fall. During an interview on 5/5/2026 at 3:33 a.m. with CNA 4, CNA 4 stated, she recalled Resident 58 in her bed prior to the start of her lunch at approximately 2:00 a.m. or 2:30 a.m. CNA 4 confirmed that she initiated one to one supervision because Resident 58 was confused and telling her roommate that she needed to get out of there. CNA 4 stated she did not endorse Resident 58's condition to another nursing staff member prior to her lunch break and confirmed one-to-one supervision was not maintained during her break. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/2026 at 10:55 a.m. with the DON the DON stated supervision should be maintained when a resident exhibited confusion or attempted to get out of bed. The DON stated CNA 4 should have endorsed Resident 58's condition to other nursing staff before leaving for lunch to ensure safety was maintained. The DON stated LVN 3 should have notified the physician following Resident 58's onset of acute confusion to obtain treatment orders and clinical direction to maintain safety. The DON stated the lack of physician notification and staff to staff communication placed Resident 58 at risk for an accident or fall. During a review of the facility's policy and procedure (P&P) titled, Change in Condition, revised 4/2025, the P&P indicated the facility would ensure each resident received quality of care and services to attain and maintain the highest practicable physician mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. licensed nursing staff would ensure the physician would be notified based on the urgency of the situation. The P&P indicated the nurse would perform and document an assessment of the resident and identify need for additional interventions, through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. During a review of the facility's policy and procedure (P&P) titled, Fall Management System, revised 4/2025, the P&P indicated the facility would provide an environment that remained as free of accident hazards as possible. The P&P also indicated the facility was to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received the volume of oxygen ordered by the physician for one of six sampled residents (Resident 61).This deficient practice resulted in Resident 61 receiving less oxygen than required and had the potential to negatively impact Resident 61's well-being.During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included hypoxia (when the body does not get enough oxygen) and cerebral infarction (a stroke caused by blocked blood flow to the brain). During a review of Resident 61's Physician Orders, dated 8/8/2024, the Physician Orders indicated to administer oxygen at 2 liters (L, a unit of volume measurement) per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen), continuously every shift for shortness of breath. During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 61's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 61 was dependent with toileting, bathing, and lower body dressing. The MDS indicated Resident 61 required oxygen therapy (a medical gas used to help with breathing).During a review of Resident 61's History and Physical (H&P), dated 2/19/2026, the H&P indicated Resident 61 had fluctuating (changing often) capacity to understand and make decisions.During an observation on 5/4/2026 at 8:27 a.m. and 5/4/2026 at 12:02 p.m., in Resident 61's room, Resident 61was observed lying in bed receiving 1L of oxygen via nasal cannula. Resident 61's oxygen nasal cannula was not attached properly in Resident 61's nostrils.During an interview on 4/5/2026 at 11:41 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 61 was on supplemental oxygen to prevent shortness of breath. RNS 1 stated that while Resident 61 was on oxygen therapy, the nasal cannula remains properly positioned in the nostrils to receive continuous oxygen therapy as ordered. RNS 1 stated that improper oxygen delivery may cause shortness of breath, low oxygen levels, and worsening respiratory status.During an interview on 5/6/2026 at 2:00 p.m., with the Director of Nursing (DON), the DON stated failure to provide the ordered 2L oxygen and an improperly positioned nasal cannula, may result in low oxygen levels, shortness of breath, respiratory decline, and risk for harm.During a review of the facility's Policy and Procedure (P&P) titled, Oxygen, Use of, revised 3/2023, the P&P indicated to promote safety in administering oxygen.

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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** Based on observation, interview, and record review, the facility failed to ensure accurate and complete documentation on the Controlled Record for one of one sampled resident (Resident 110). This deficient practice resulted in the inaccurate count of medications remaining in the medication bubble pack (a card used to store medications for the resident) and had the potential to result in the administration of additional doses, drug diversion (the theft or misuse of prescription medications by health care providers for personal use), and/or medication errors.Findings:During a review of Resident 110's Face Sheet, the Face Sheet indicated Resident 110 was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness, peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs), and hypertension (high blood pressure.During a review of Resident 110's Physician Order, dated 5/2/2026, the Physician Order indicated to administer Resident 110 Norco (an opioid medication used to treat pain) 5-325 milligrams (mg, a unit of measurement), by mouth every four hours as needed for moderate to severe pain (pain rated four through ten on the pain scale).During a review of Resident 110's History and Physical (H&P), 5/5/2026, the H&P indicated Resident 110 had the capacity to understand and make decisions.During an observation on 5/5/2026 at 1:48 p.m., at the East Medication Cart, accompanied by Licensed Vocational Nurse (LVN) 1, Resident 110 had two bubble packs (a card used to store medications for the resident) containing Norco 5-325mg and had a total of 37 tablets left. During a concurrent interview and record review on 5/5/2026 at 1:51 p.m., with LVN 1, Resident 110's Controlled Record, dated 5/3/2026 through 5/4/2026, and Medication Administration Record (MAR), dated 5/1/2026 through 5/31/2026, were reviewed. The Controlled Record indicated 38 tablets of Norco 5-325mg should have remained in the bubble packs and the last administration to Resident 110 was on 5/4/2026 at 5:52 p.m. The MAR indicated Norco 5-325mg was administered to Resident 110 on 5/5/2026 at 9:45 a.m. LVN 1 stated there was a discrepancy between the tablets left in the bubble packs and the documentation on the Controlled Record. LVN 1 stated when administering controlled medication (medications heavily regulated due to their risk of addiction and misuse), he was responsible for removing the medication from the bubble pack, document on the Controlled Record, administer the medication, and finally, document on the MAR. LVN 1 stated he administered Norco 5-325mg to Resident 110 at 9:45 a.m. that day but he did not document it on the Controlled Sheet. LVN 1 stated Norco was a controlled medication which needed to be accounted for to ensure nothing was missing. LVN 1 stated without the accurate documentation of the Norco administration, Resident 110 was at risk for double dosing.During an interview on 5/7/2026 at 11:20 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for accurate documentation when administering controlled medications to the residents. The DON stated after LVN 1 removed the Norco 5-325mg tablet from the bubble pack, LVN 1 was responsible for documenting the date, time, quantity on hand, quantity used, and quantity remaining on the Controlled Record. The DON stated accurate documentation was necessary to prevent mishandling and theft. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration- Controlled Medications, revised 10/23/2021, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: date and time of administration, amount administered, and signature of the nurse administering the dose completed after the medication is actually administered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain complete and accurate clinical records for two out of twelve sampled residents (Resident 52 and Resident 58) by failing to: 1. Ensure nursing interventions and pertinent clinical details were documented after Resident 58 exhibited acute confusion and experienced an episode of partially sliding off the bed on 4/20/2026. 2. Ensure a skin assessment included bruising (occurs when small blood vessels near the skin's surface break from an injury) or discoloration to Resident 58's left arm on 4/22/2026. 2. Ensure a skin assessment was documented after Resident 52 sustained two wounds on her left lower leg on 4/29/2026. These deficient practices resulted in incomplete clinical communication regarding Resident 58 and a lack of a baseline skin assessment for Resident 52, which placed both residents at risk for delayed assessment, treatment, inappropriate clinical decision making and lack of continuity of care. Cross Reference F689 and F580. 1.During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included a displaced comminuted supracondylar fracture (a severe elbow injury where the humerus bone breaks into multiple pieces, with the bones separating), osteoarthrosis (a progressive disorder of the joints, caused by a gradual loss of cartilage), muscle weakness, and repeated falls. During a review of Resident 58's History and Physical (H&P), dated 3/11/2026, the H&P indicated Resident 58 could make needs known but could not make medical decisions. During a review of Resident 58's care plan, titled, At risk for Bleeding or Bruising (occurs when small blood vessels near the skin's surface break from an injury) Related to Anticoagulant (blood thinning medication) Therapy, initiated 3/13/2026, the care plan interventions indicated to monitor, document, and report to the physician as needed for signs of bruising. During a review of Resident 58's care plan, titled, Fluid Deficit, initiated 3/24/2026, the care plan interventions indicated to monitor, document, and report to the physician as needed when signs and symptoms of dehydration like new onset confusion was present. During a review of Resident 58's Minimum Data Set ([MDS], a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 58 required maximal assistance (helper does more than half the effort) for bed mobility, showering, toileting, and upper body dressing. During a review of Resident 58's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 4/20/2026, timed at 7:00 a.m., and authored by the Director of Nursing (DON), the note indicated Resident 58 was caught in the process of sliding from the bed on 4/20/2026 at 7:00 a.m. During a review of Resident 58's SBAR Note, dated 4/20/2026, timed at 9:55 a.m., the SBAR note indicated Resident 58 complained of two out of ten acute pain to the left arm and Physician 1 ordered an in-house x-ray (a medical imaging test). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's SBAR Note, dated 4/23/2026, the note indicated Resident 58 was ordered to be transferred to the General Acute Care Hospital (GACH) for further evaluation and treatment for abnormal labs. During a review of Resident 58's GACH Physician Progress Notes, dated 4/24/2026, the notes indicated Resident 58 recently suffered a fall and had left arm swelling, bruising, mild redness, and pain with elbow range of motion. During a record review of Resident 58's GACH X-Ray (medical imaging technique) Results, dated 4/24/2026, the results indicated Resident 58's clinical history included a fall and the final impression indicated an impacted transverse comminuted left distal humeral supracondylar fracture with approximately 1.2 centimeters (a unit of measurement) of medial displacement (a significant shift of the bone fragments). During an observation and interview on 5/5/2026 at 8:10 a.m. with Resident 58, in Resident 58's room, Resident 58 was in her bed with a left arm sling (suspension device to immobilize the elbow) and demonstrated limited movement of the left arm secondary to pain. Resident 58 stated she believed she fell but she could not recall and stated that her granddaughter, Responsible Party (RP) 2, would be able to provide more details. During an interview on 5/5/2026 at 8:29 a.m. with RP 2, RP 2 stated Resident 58 sustained a left elbow fracture. RP 2 stated the DON contacted her on 4/20/2026 during the daytime hours but did not clearly explain what had occurred. RP 2 stated facility staff were unable to clearly explain what had occurred and informed her x-rays would be obtained. RP 2 stated she visited Resident 58 on 4/22/2026 and observed swelling and bruising to Resident 58's left arm. RP 2 stated, on 4/22/2026, she later learned Resident 58 had been found hanging off her bed during the early morning hours of 4/20/2026. RP 2 stated Resident 58 was not normally confused, did not typically attempt to get out of bed independently, and required assistance for mobility. During an interview on 5/5/2026 at 1:08 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 confirmed she was Resident 58's nurse on 4/20/2026 during the 11:00 p.m. to 7:00 a.m. shift. LVN 3 stated at approximately 2:00 a.m., Resident 58 exhibited acute confusion, repeatedly threatened to get up from bed, and stated she needed to go to an appointment. LVN 3 stated CNA 4 initiated one-to-one supervision due to Resident 58's confusion and attempts to get out of bed. LVN 3 stated CNA 4 later left for lunch and one-to-one supervision was not maintained. LVN 3 stated that during rounds at approximately 3:00 a.m., she heard Resident 58 moaning and observed Resident 58 in the act of sliding off the bed in an upside down 'L' position with the resident's legs dangling off the left side of her bed. LVN 3 confirmed Resident 58 exhibited increased confusion and experienced an episode of sliding from the bed. LVN 3 stated that she notified the DON regarding the incident; however, she did not complete documentation regarding Resident 58's acute confusion, nursing interventions, implementation of one-to-one supervision, or incident involving partially sliding from the bed. LVN 3 stated it was important to document all nursing intervention and changes in condition to ensure Resident 58's medical record remained complete and accurate for other healthcare providers involved in Resident 58's care. 2. During a concurrent interview and record review on 5/5/2026 at 3:03 p.m. with LVN 4, Resident 58's Nursing Progress Notes, SBAR Notes, and Changes in Condition Notes, dated 4/22/2026, were reviewed. The records did not indicate Resident 58 had bruising to the left arm. LVN 4 stated it was important to notify the physician of all changes of condition and ensure appropriate monitoring and (continued on next page)

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	055519	A. Building B. Wing	05/07/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Change in Condition, revised 4/2025, the P&P indicated the licensed nursing staff would perform and document an assessment of the resident and identify need for additional interventions, through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. During a review of the facility's LVN Job Description (undated), the job description indicated the LVN was to chart nurses' notes in a professional and appropriate manner that timely, accurately and thoroughly reflected the care provided to the residents, as well as the resident's response to the care. The Job Description indicated to chart the following: All reports of accidents/incidents involving residents. All changes in resident condition and the response to those changes. Chart all communications with the residents attending physician regarding the resident, the residents treatment, or the response to that treatment. The Job Description indicated to perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations. 3. During a review of Resident 52's Face Sheet, the Face Sheet indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included generalized muscle weakness, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 52's H&P, dated 3/24/2026, the H&P indicated Resident 52 did not have the capacity to understand and make decisions. During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52's cognition was severely impaired. The MDS indicated Resident 52 was dependent on staff's assistance with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) such as toileting, bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 52 required maximal assistance with chair/bed-to-chair transfers. During a review of Resident 52's Change in Condition (COC), dated 4/29/2026, the COC indicated, on 4/29/2026, Resident 52 sustained an open ecchymosis (a bruise that opens, breaks, or tears) during transfer to the bed. The COC indicated Resident 52's wounds were located on the left lower posterior (area of the leg near the calf) and left lower lateral leg (outer side of the left shin, below the knee and above the ankle). During a review of Resident 52's Surgical Wound Consult Progress Note, dated 4/30/2026, the Progress Note indicated Resident 52 had a trauma wound (a sudden, severe physical wound caused by an external force requiring immediate medical attention) on the left lower lateral part of her leg. The Progress Note indicated the wound on the left lower lateral part of Resident 52's leg measured 5 centimeters (cm, a unit of measurement) in length, 6cm in width, and 1cm in depth. During an interview on 5/4/2026 at 12:22 p.m., with RP 1, RP 1 stated, on 4/29/2026, the facility (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified her that Resident 52 sustained trauma injuries to her left leg. RP 1 stated Resident 52's injuries occurred when Resident 52 was transferred to the bed and Resident 52's leg got caught on something. During a review of Resident 52's Skin Issues Assessment, dated 5/1/2026, the Skin Issues Assessment indicated Resident 52's wound on the left lateral calf measured 3.5cm in length, 0.2cm in width, and 0.1cm in depth. The Skin Issues Assessment indicated Resident 52's wound on the left lateral lower leg measured 5cm in length, 6cm in width, and 1cm in depth. During a concurrent observation and interview on 5/4/2026 at 2:44 p.m., with Treatment Nurse (TN) 1, in Resident 52's room, Resident 52 was lying in bed and Registered Nurse (RN) 1 was at the bedside to assist TN 1 with Resident 52's wound treatment. Resident 52's dressings were removed from her left leg. Two wounds were observed on the lower left leg. The first wound was the shape of a half circle, with irregular edges along the rounded border, closest to the foot. The area of the wound closest to the foot was moist, with a pale pink wound bed, and a small amount of bright red bleeding. The second was located near the left calf. The area of the wound near the calf was covered by thin, pale, purplish-gray, flaps of skin that were fragile in appearance. The skin flaps were wrinkled and did not cover the entire wound. TN 1 stated Resident 52's wounds were classified as a trauma wound and Resident 52 sustained both wounds from the same accident, on 4/29/2026. During an interview on 5/6/2026 at 12:05 p.m., with LVN 1, LVN 1 stated, on 4/29/2026, Resident 52 received a shower and after Resident 52 was transferred to the bed, Certified Nursing Assistant (CNA) 2 noticed two wounds on Resident 52's leg. LVN 1 stated CNA 3 assisted CNA 2 with Resident 52's transfer back to bed. LVN 1 stated CNA 2 notified him and when he initially assessed Resident 52's leg, he saw open skin on the top part of Resident 52's leg and a skin flap on Resident 52's calf. LVN 1 stated upon assessing Resident 52's wounds, he called TN 1 to provide first-aid treatment (immediate, temporary care given). During a phone interview on 5/6/2026 at 12:55 p.m., with CNA 2, CNA 2 stated, on 4/29/2026, Resident 52 was scheduled to have a shower. CNA 2 stated she and CNA 3 assisted Resident 52 into a standing position from the shower chair to allow Resident 52 to sit at the edge of the bed. CNA 2 stated once Resident 52 was at the edge of the bed, she lifted Resident 52's legs and while supporting Resident 52's back and turned Resident 52 to her right and laid Resident 52 into the bed. CNA 2 stated when she attempted to put Resident 52's pants on, she noticed the injuries to Resident 52's legs and blood on Resident 52's bed frame. CNA 2 stated Resident 52 was injured during the transfer. During an interview on 5/7/2026 at 8:21 a.m., with TN 1, TN 1 stated, on 4/29/2026, LVN 1 notified him that Resident 52 sustained two wounds on her left lower leg after an accident during Resident 52's transfer from the shower chair to the bed. TN 1 stated when he entered Resident 52's room, he assessed Resident 52's wounds, cleansed the wounds, and applied a dry dressing. TN 1 stated he provided basic first aid wound treatment to the wounds until additional he received additional orders from the physician. TN 1 stated Resident 52's wounds were located on the left lateral lower leg and the left posterior lower leg. TN 1 stated the wound specialist classified the wounds as trauma wounds because they were not the typical skin tear (wound caused by friction or force that separates the top layer of the skin from the lower layer). TN 1 stated Resident 52 sustained new skin injuries and his assessment should be in Resident 52's medical record. During a concurrent interview and record review on 5/7/2026 at 8:29 a.m., with TN 1, Resident 52's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin Issue Assessment, dated 4/29/2026, was reviewed. The Skin Issue Assessment indicated Resident 52 had a lower abdominal surgical wound. The Skin Issue Assessment did not indicate Resident 52 had two wounds on her lower left leg. TN 1 stated he should have documented his assessment on Resident 52's wounds because wounds could change very quickly. TN 1 stated the initial assessment would be used as a baseline to compare the healing process, whether the wounds were healing or declining. TN 1 stated without a detailed assessment of Resident 52's wounds, the facility was unable to determine if any changes occurred. TN 1 stated an assessment was documented by the wound specialist the following day and by the other treatment nurse two days later, however the wounds could have changed in the 24-to-48-hour time. TN 1 stated the facility had no way of determining if any changes occurred. During an interview on 5/7/2026 at 11:44 a.m., with the Director of Nursing (DON), the DON stated when Resident 52 sustained her wounds on the lower left leg, TN 1 should have documented the description and measurements of the wounds. The DON stated timely documentation would allow the facility and the wound specialists monitor the progress of Resident 52's wounds from the beginning. The DON stated without the documented assessment, the facility did not have a baseline of how big the wounds were or the wounds characteristics. During a review of the facility's Policy and Procedure (P&P) titled, Documentation, revised 1/2023, the P&P indicated the purpose of documentation was to provide a complete account of the resident's care, signs and symptoms, and the process of the resident's care. The P&P indicated nursing personnel would record the physical and mental status of the resident. The P&P indicated documentation was a source of all the resident's changes. During a review of the facility's P&P titled, Skin and Wound Monitoring and Management, revised 4/2025, the P&P indicated, Areas of breakdown, excoriation (skin that has been scraped, scratched, or worn away), discoloration, or other unusual findings (either initially identified at the time of admission or as a new finding) must be documented in the nursing notes or on the appropriate weekly assessment form.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that Resident 65's bedroom was equipped with a privacy curtain to ensure full visual privacy for one of six sampled residents (Resident 65). This deficient practice had the potential to violate the resident's right to visual privacy and dignity during personal care and activities of daily living. Findings:During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 65's diagnoses included spinal stenosis (is when the spaces in the spine become narrow and press on the nerves) and muscle weakness.During a review of Resident 65's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 65's cognition (process of thinking) was intact. The MDS indicated Resident 65 was independent with toileting, bathing, and lower body dressing. During a review of Resident 65's History and Physical (H&P), dated 4/11/2026, the H&P indicated Resident 65 had the capacity to understand and make decisions.During an observation on 5/4/2026 at 10:52 a.m., a wrong size privacy curtain was observed on the horizontal track along the foot of Resident 65's bed. The privacy curtains provided full visual privacy for two of the room's three occupants.During an interview on 5/5/2026 at 10:22 a.m., with Resident 65, Resident 65 stated, the incomplete privacy curtain does not bother him.During an interview on 5/6/2026 at 10:01 a.m., with the Housekeeper (HK), the HK stated the privacy curtain along Resident 65's bed was the wrong size and may affect the resident's visual privacy and dignity (feeling respected).During an interview on 5/6/2026 at 2:45 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated privacy curtains are important to protect the resident's privacy and dignity during care and may cause the resident to feel uncomfortable. During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 4/2025, the P&P indicated employees were to treat all residents with respect and dignity. The P&P indicated all facility residents and staff are continually informed and aware of resident rights.