STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Palos Post-Acute Care Center	1430 West 6th Street San Pedro, CA 90732

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to ensure residents room temperature was comfortable and safe temperatures (71-81 degrees Fahrenheit [F unit of measurement that is used to measure temperature]) for one of three sampled residents. This failure had the potential to increase the risk of adverse health effects from an uncomfortable environment for the residents (Resident 3). Findings: During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and immunodeficiency (decreased ability of the body to fight infections and other diseases). During a review of Resident 3 ' s Minimum Data Set (MDS- resident assessment tool dated 1/3/2025, the MDS indicated Resident 3 was cognitively intact (a person ' s mental abilities, like thinking, remembering, and reasoning, are fully functional and not significantly impaired). The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene, toileting, and transferring. During an interview on 1/23/2025 at 9:06 a.m., with Resident 3, Resident 3 stated earlier in the week (cannot remember exact date) his room was very hot. Resident 3 stated family member checked the room temperature, and it was 90 F. Resident 3 stated when his room temperature was hot, it made him feel uncomfortable and terrible. During an interview on 1/23/2025 at 10:22 a.m., with the Maintenance Supervisor (MS) 1, the MS 1 stated he only checks room temperatures when he receives complaint from a resident. MS 1 stated on 12/5/2024 at 2:26 p.m., Resident 3 ' s room temperature measured at 82 F. MS stated he adjusted the thermostat (a device that measures temperature) in the hallway but stated it can take a while for the room to feel the adjustment in the thermostat. MS 1 stated facility staff should be monitoring the resident room temperatures daily and maintain a logbook to ensure the rooms are at the right temperature but also for those residents that are unable to speak and tell them if their room was too hot or too cold. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 11:00 a.m., with Maintenance Service (MS) 2, the MS 2 stated he does not check the resident room temperatures daily. During an interview on 1/23/2025 at 12:09 p.m., with the Administrator (ADM), the ADM indicated resident room temperatures are only checked if there was a complaint or an issue. ADM stated resident room temperatures should be monitored daily to ensure the room temperature was correct, especially for those that cannot speak. ADM stated not monitoring the resident room temperatures daily could place the residents at risk for dehydration (abnormally low fluid levels in the body),and affect their body temperatures. During a review of the facility ' s policy and procedure (P&P) titled, Homelike Environment, revised 2/202, the P&P indicated, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include comfortable and safe temperatures (71-81 degrees Fahrenheit). During a review of the facility ' s P&P titled, Maintenance Services, revised 12/2009, the P&P indicated, Functions of the maintenance personnel include maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to protect the residents ' right to be free from physical abuse for one of three sampled residents (Resident 1) when Resident 2 slapped and punched Resident 1 in the face repeatedly on 1/17/2025. The facility failed to: 1. Developed a plan of care for Resident 2 who verbalized to staff that he does not want to have roommates, does not like noise and preferred to be alone in his room when Resident 1 was transferred to Resident 2 ' s room (unknown date). 2. The facility failed to follow policy and procedures titled Identifying Types of Abuse, revised 9/2022, which indicated, Abuse of any kind against residents is strictly prohibited. These failures resulted in Resident 2 slapped and punched Resident 1 in the face repeatedly on 1/17/2025. Resident 1 sustained scattered facial redness on bilateral (both) cheeks, forehead, and nose with complained of pain level three out of 10 on a pain rating scale from zero to ten (a numeric pain scale with zero represents no pain and 10 represents the worst pain imaginable) and verbalized loss of appetite after the incident. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including muscle weakness, fracture (broken bone) right femur (thigh bone) and cellulitis (a skin infection that causes redness and swelling). During a review of Resident 1 ' s Minimum Data Set ([MDS]- resident assessment tool) dated 11/3/2024, the MDS indicated Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 1 required supervision with hygiene, bathing, and dressing. During a review of Resident 1 ' s Change of Condition (COC) dated 1/17/2025 timed at 8:30 p.m., the COC indicated Resident 1 had emotional distress and psychological (relating to the mind, thoughts, feelings, and emotions) distress secondary to a physical altercation (an argument between people). The COC indicated Resident 1 was hit in the face by his roommate, developed scattered facial redness on bilateral cheeks, forehead, and nose with complaint of pain, which was relieved by applying a cold compress, administration of Tylenol (pain medication), and numbing (loss of feeling) cream (unknown). During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility 8/15/2022 with diagnoses including bipolar disorder (mood swings that range from lows of depression to elevated periods of emotional highs), Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 required set-up assistance with eating, oral hygiene, and dressing. During a review of Resident 2 ' s COC dated 4/11/2024 timed at 5:24 p.m., the COC indicated Resident 2 opened the bathroom door while roommate (unknown) was inside. The COC indicated roommate closed the bathroom door, Resident 2 got upset opened the bathroom door purposely causing to hit the roommate. During a review of Resident 2 ' s COC dated 1/17/2025 timed at 8:35 p.m., the COC indicated Resident 2 admitted to hitting Resident 1 in the face because Resident 1 talks too much. During a review of Resident 2 ' s Physician Order Summary Report, the Physician the Order Summary Report indicated an dated 12/27/2024 for Seroquel (medication that treats mental health condition) for bipolar (mood swings that range from the lows of depression to elevated periods of emotional highs) disorder manifested by fluctuation (a constant back and forth change in something) of mood from being pleasant to having a loud sudden spontaneous angry outburst toward staff and others. During a review of Resident 2 ' s Physician Order Summary Report, the Physician the Order Summary Report dated 12/27/2024 indicated an order to monitor Resident 2 ' s episodes of bipolar affective manifested by fluctuation of mood from being pleasant to having a loud sudden spontaneous angry outburst toward staff and others which impedes Resident 2 ' s health condition. During a review of Resident 2 ' s Care Plan titled Alteration in mood and behavior related to bipolar disorder, Alzheimer ' s Disease, and psychosis revised on 8/26/2024, the goals included interacting peacefully in social situations and the resident will not have behavioral episodes. The Care Plan interventions included monitoring the resident ' s interactions with other residents to prevent offensive behaviors. During an interview on 1/22/2025 at 10:41 a.m., with Resident 1, Resident 1 stated Resident 2 repeatedly slapped and punched him because he was talking to him while he was lying defenseless in his bed. Resident 1 stated this incident made him feel terrible. Resident 1 stated his face was reddened from the slaps and punches he took from Resident 2. Resident 1 stated he was given Tylenol as his face was hurting. During an interview on 1/22/2025 at 2:21 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 did not like having roommates, does not like noise, and preferred to be alone in his room. LVN 1 stated Resident 2 would be calm one minute and then suddenly snap. LVN 1 stated that Resident 2 has been known to be aggressive with other residents if they were talking a lot or were loud. During a concurrent interview and record review on 1/22/2025 at 2:44 p.m., with Registered Nurse Supervisor (RNS), Resident 2 ' s care plan titled Resident 2 had a history of aggressive behavior towards others . was reviewed. RNS stated the incident could have been prevented if Resident 2 was given a private room or transferred to a higher level of care like general acute care hospital (GACH) for evaluation of Resident 2 ' s aggressive behavior. RNS stated Resident 2 benefiting from being in a private room because of his unpredictable behavior toward other residents and staff was not care-planned but should have been. RNS stated Resident 1 had loss of appetite after the incident on 1/17/2025 with Resident 2. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2025 at 3:14 p.m., with the Director of Nursing (DON), the DON stated Resident 2 was easily getting angry and irritated. The DON stated the incident could have been prevented if Resident 2 was transferred out of the facility for evaluation of his aggressive behavior in the past with other residents. The DON stated Resident 2 was a higher risk for hurting another residents. The DON stated Resident 1 developed redness in his face from being slapped and punched in the face, complaint of pain and a loss of appetite after the incident on 1/17/2025. During an interview on 1/23/2025 at 3:38 p.m., with LVN 2, LVN 2 stated Resident 2 told her he hit Resident 1 because he (Resident 1) talks too much. LVN 2 stated Resident 1 developed redness to his face from the incident and was provided with cold compress to the face. LVN 2 stated that this was the second time Resident 2 has had an altercation with a resident. LVN 2 stated Resident 2 resided in the room alone without the roommate. LVN 2 stated Resident 1 was transferred to Resident 2 ' s room (cannot remember when) because the facility felt it was safe because Resident 1 was quiet and was s not talking much. LVN 2 stated Resident 2 does not like to have roommates, and this could have been prevented if Resident 1 was not cohorted with Resident 2 in one room, d and Resident 2 was monitored closely for aggressive behavior towards staff and residents. LVN 2 stated Resident 2 should have been transferred to a higher level of care because of his history of aggressive behavior and sudden outbursts of anger which was scary toother residents. During a review of the facility ' s policy and procedure (P&P) titled, Identifying Types of Abuse, revised 9/2022, the P&P indicated, Abuse of any kind against residents is strictly prohibited. It is understood by the leadership in this facility that preventing abuse requires staff education, training, and support, and a facility-wide culture of compassion and caring. During a review of the facility ' s P&P titled, Resident-to-Resident Altercations, revised 9/2022, the P&P indicated, Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family, members, visitors, or to the staff .Behaviors that may provoke a reaction or others include verbally aggressive behavior .physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects.