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	10/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary care and services for one (1) of two (2) sampled residents (Resident 4). The facility failed to: 1.Reassess Resident 4 after a low blood pressure reading of 90/42 millimeter of mercury (mm/Hg unit of pressure) on 10/15/2025 at 8:29 a.m. and failing to recheck vital signs (measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate) prior to sending the resident to dialysis at approximately 11 a.m., on 10/15/2025.2.Notify the physician of a foul-smelling odor observed from Resident 4's right Achilles wound during wound care treatment on 10/14/2025.These failures had the potential to delay necessary care and treatment and increased the risk of hospitalization for Resident 4.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including end stage renal disease, (ESRD-irreversible kidney failure) diabetes mellitus with foot ulcer (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis(a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow), obesity(excessive body fat that increases the risk of health problems), acquired absence of left leg below knee, dementia (a progressive state of decline in mental abilities), and acute osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the left foot and ankle. During a review of Resident 4's Minimum Data set (MDS- a resident assessment tool) dated 10/15/2025, the MDS indicated Resident 4 had some difficulty in daily decision making and required substantial/ maximal assistance (helper does more than half the effort) with toilet transfer, bathing, dressing, personal hygiene and toileting hygiene. During a review of Resident 4's Care Plan titled Resident 4 was At risk or high and low blood pressure related to hypertensive chronic kidney disease (when high blood pressure damaged the kidneys overtime causing them to gradually lose their ability to filter waste from the blood) initiated on 3/25/2024, the Care Plan's goals indicated Resident 4's blood pressure will be maintained within normal range of 90/60 mm/Hg to 140/95 mm/ Hg. The Care interventions included administering of midodrine (medicine used to treat symptomatic orthostatic hypotension (low blood pressure that occurs upon standing up causing symptoms like dizziness or lightheadedness) 2.5 milligrams (mgs.- unit of measurement) one tablet by mouth two times a day every Tuesday, Saturday and Saturday for hypotension (low blood pressure) and checking vital signs , blood pressure before administration of medication per physician order. The Care Plan interventions indicated to observe for signs and symptoms of low blood pressure such as dizziness, lightheadedness, cold, clammy skin (cool, damp and sweaty skin), pale skin, fatigue and rapid breathing and check effectiveness of the medication and to notify the physician accordingly. During a review of Resident 4's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember] behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 10/15/2025 timed at 2:19 p.m., the COC indicated Resident 4 was transferred to general acute hospital (GACH) due to hypotension from the dialysis center. The COC indicated the blood pressure was 90/42 mm/Hg, pulse rate was 70 beats per minute and respiratory rate (number of breaths per minute) was 18 per minute (normal range is 12 to 20 breaths per minute) taken on 10/15/2025 at 8:29 a.m. The COC indicated the facility received a call from a family member (FM) informing them that Resident 4 was transferred to GACH from the dialysis center due to low blood pressure. During a review of Resident 4's Progress Notes dated 10/15/2025 timed at 2:38 p.m., the Progress Notes indicated Resident 4 left the facility at 11:45 a.m. for dialysis. During a review of Resident 4's GACH Medical Record titled, Emergency Department (ED) Triage. dated 10/15/2025 at 1:43 p.m., the ED Triage indicated Resident 4's BP was 72/41 mm/Hg when the resident arrived in the emergency room. During a review of Resident 4's GACH Medical Records titled, ED Note-Provider dated 10/15/2025 at 6:50 p.m., ED Note-Provider indicated Resident 1 was presented with hypotension prior to getting dialysis at the dialysis center. During a telephone interview on 10/29/2025 at 12:55 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that Resident 4 had low blood pressure on 10/15/2025 at 8:29 a.m. LVN 4 stated she administered Midodrine but did not recheck the resident's blood pressure or other vital signs after administration or prior to the resident being sent to dialysis. LVN 4 stated that she did not notify the physician, as she had already given Midodrine and assumed the low blood

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure a safe environment and provide adequate supervision to prevent accident for one of three sampled residents (Resident 1). The facility failed to:1. Supervise Resident 1 and Resident 2 on 10/11/2025 at approximately 7:00 p.m., while they were smoking on the patio according to Resident 1 and 2's Smoking Assessment Forms.2.Secure the door leading to the smoking patio after the last scheduled smoking time at 6 p.m.3.Ensure Certified Nursing Assistants (CNA) 2 redirect Resident 2 to the resident's room instead of leaving Resident 2 unattended in the smoking patio on 10/11/2025. 4.Ensure CNA 1 was aware of Resident 1's whereabout on 10/11/2025 at 7 p.m.These failures resulted in Resident 2 throwing a plastic coffee mug at the right side of Resident 1's head. Resident 1 sustained a bump on the right side of the head and complained of a headache rated of 3 out of 10 on a 0 to 10 numeric pain scale (0 = no pain, 1 to 3 = mild pain, 4 to 6 = moderate pain and 7 to 10 = severe pain). Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life), repeated falls, recurrent major depressive disorder(mental health condition characterized by repeated episodes of major depression[persistent feeling of sadness, loss of interest and changes in daily functioning]) and unspecified fracture (broken bone) of shaft of left tibia(a break in the long part of the bone below the knee and above the ankle).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 9/5/2025, the MDS indicated Resident 1 had intact cognition (ability to think, understand, learn, and remember) and required substantial assistance (helper does more than half the effort) with bathing, chair/bed to chair transfer (ability to transfer to and from a bed to chair) and sit to stand(ability to come to a standing position from sitting in a chair).During a review of Resident 1's Smoking Safety Screen(screening tool that evaluates a person's ability to smoke without putting themselves or others at risk) dated 10/6/2025, the Smoking Safety Screen indicated Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) determined Resident 1 was safe to smoke with supervision and required a smoking apron (a protective, fire retardant garment worn over the lap and torso to safeguard against accidental burns from cigarettes). During a review of Resident 1's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 10/11/2025 and timed at 9:07 p.m., the COC indicated Resident 1 approached Licensed Vocational Nurse (LVN) 1 and asked for pain medication because her head hurt. The COC indicated Resident 1 stated Resident 2 threw a plastic cup and hit her head outside the patio. The COC indicated LVN 1 assessed Resident 1's head and observed a bump on the right side of the head. The COC indicated Resident 1 complained of a headache rated at 3 out of 10. The COC indicated Resident 1 received pain medicine (Tylenol) and an ice pack for the bump on the right side of the head.During a review of Resident 1's Progress Note dated 10/11/2025 and timed at 10:48 p.m. , the Progress Notes indicated Resident 1 approached LVN 1 for pain medicine because her head hurt. The Progress Note indicated LVN 1 assessed Resident 1' s head and observed a bump on the right side of the head. The Progress Note indicated LVN 1 administered pain medicine and applied an ice pack on the right side of Resident 1's head.During a review of Resident 1's Progress Note dated 10/13/2025 timed at 1:38 p.m., the Progress Note indicated Resident 1 complained of head discomfort with pain rated at 5/10 and the resident requested to be sent to the general acute hospital (GACH). The Progress Note indicated Resident 1 received oxycodone (medication used to treat moderate to severe pain) 10 milligrams(mgs.- unit of measurement) for pain and an ice pack applied on the resident's head. The Progress Note indicated Resident 1's physician was notified, and the staff was to monitor and observe Resident 1.During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 10/14/2025 , the MAR indicated on 10/13/2025 at 3:38 p.m., Resident 1 complained of a pain on Resident 1's head rated at 8/10 and was given oxycodone 10 milligrams. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities)