STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056415	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 46505 Based on observation, interview, and record review, the facility failed to ensure the intervention, as indicated in one of five sampled residents' (Resident 1) care plan titled, Resident has excessive tendencies of crawling and climbing out her bed, was impelmented. This deficient practice had the potential cause injury to Resident 1. 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 cerebral infarction (a medical condition that occurs when blood flow to the brain is blocked, causing brain cells to die), alzheimer's disease (a brain disorder that destroys memory, thinking, and the ability to carry out daily tasks), and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 1's History and Physical (H&P), dated 5/3/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2024, the MDS indicated Resident 1 rarely understood others and was rarely understood by others. The MDS indicated Resident 1 had severe cognitively impairment. The MDS indicated Resident 1 required set up assistance from staff for activities of daily living such as eating, partial assistance from staff for oral and personal hygiene and upper and lower body dressing, and substantial assistance from staff for toileting hygiene, showering, and putting on and taking off footwear. The MDS indicated Resident 1 required partial assistance from staff for rolling left and right, sitting to lying, lying to sitting on side of bed, and sitting to standing and chair to bed and toilet transfer and walking were not attempted due to medical condition or safety concerns. (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: 056415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's care plan, titled Resident has excessive tendencies of crawling and climbing out her bed, sitting on the floor, and crawling on the floor in her room. May be related to history of alzheimer's dementia, and anxiety (intense, excessive, and persistent worry and fear about everyday situations) manifested by restlessness and inability to stay still. The resident is at increased risk of falling, dated 9/26/2024, the intervention indicated to place mattress on floor next to bed, on one side of bed, for fall and safety precautions, due to resident's tendency of repetitivel climbing and crawling out of bed and crawling on floor, in her room, and to assist resident back to bed or her wheelchair once seen on floor crawling. During a review of Resident 1's order summary report (MD orders), dated 11/27/2024, the MD orders indicated to place mattress on floor, next to bed on one side of bed, for fall and safety precautions, due to Resident 1's tendencies of excessive and repetitive climbing and crawling out of bed and crawling on floor, in her room. During a concurrent observation and interview on 11/27/2024 at 2:42 p.m. with the Director of Nursing (DON), Resident 1 was observed on the floor underneath a bed by the window. The DON called Licensed Vocational Nurse (LVN 1) to the room to help assess and lift Resident 1 from the floor to a chair. The mattress on by Resident 1's bed was leaned against the curtain separating Resident 1 from her roommate. The DON stated Resident 1 tended to try and crawl out of bed. During a concurrent interview and record review on 11/27/2024 at 4:45 p.m. with the DON, Resident 1's care plan, titled Resident has excessive tendencies of crawling and climbing out her bed, sitting on the floor, and crawling on the floor in her room. May be related to history of Alzheimer's Dementia, and anxiety manifested by restlessness and inability to stay still. The resident is at increased risk of falling, dated 9/26/2024 was reviewed. The DON stated the mattress was leaning against Resident 1's nightstand and was not on the floor next to Resident 1's bed. The DON stated having the mattress on the floor next to Resident 1's bed was for safety. The DON stated the mattress on the floor as indicated in the care plan intervention was not followed. The DON stated, Resident 1 could get hurt. During a review of the facility's policy and procedure (P&P), titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated the staff should identify and implement relevant interventions to minimize serious consequences of falling. During a review of the facility's P&P, titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated a comprehensive care plan should include timetables to meet the resident's physical, psychosocial and functional needs, should be implemented for each resident.