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	07/09/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 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 ensure a resident was free from misappropriation of personal property when Dietary Aide (DA) 1 agreed to withdraw cash and purchase cigarettes with the use of the resident's debit card for one of three sampled residents (Resident 1). This failure resulted in $8,000 worth of unauthorized cash withdrawals from Resident 1's bank account within a four-day span. This failure also violated Resident 1's right to be free from misappropriation and placed other residents at risk for similar exploitation. Cross-reference F609 and F610. 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 that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one entire side of the body) following a cerebral infarction (an interruption in blood flow to the brain), muscle weakness, and depression (persistent feeling of sadness). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 required partial to moderate assistance (helper does less than half of the effort) for toileting hygiene, bathing, and required supervision when performing oral hygiene, dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P), dated 5/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of the facility's SOC 341 (a report of suspected dependent adult or elder abuse), dated 7/7/2025, the form indicated the facility reported an allegation of elderly financial abuse on 7/7/2025. The form indicated Resident 1 reported he gave his debit card with the pin number written on an envelope to somebody to withdraw money from his account. The form indicated Resident 1 reported more funds were withdrawn than originally requested and were missing. During a review of Licensed Vocational Nurse (LVN) 1's written statement, dated 7/9/2025, the written statement indicated on 6/28/2025, Resident 1 came out of his room yelling, That motherfuck-- stole my money! The statement indicated LVN 1 followed Resident 1 to the kitchen and Resident 1 pointed at Dietary Aide (DA) 1 and stated, It was that guy! The statement indicated DA 1 stated, It wasn't me, my car has been in the shop! Resident 1 explained that he lent his debit card to DA 1 about a week ago so that DA 1 could buy cigarettes for him, and the card was supposed to be returned the same day. The statement indicated DA 1 repeatedly stated his car had been in the shop for a week. The statement indicated LVN 1 proceeded to assist Resident 1 to speak with a bank representative as LVN 1 hand wrote the amounts withdrawn from Resident 1's bank account (as dictated by the bank representative). The statement indicated RN 1 informed the Director of Nursing (DON) of the situation. The statement indicated RN 1 informed LVN 1 that the DON would notify the Administrator (ADM). During an interview on 7/8/2025 at 10:30 a.m. with ADM, the ADM stated DA 1 was suspended on 7/7/2025. During an interview on 7/8/2025 at 10:47 p.m. with Resident 1, Resident 1 stated on 6/25/2025, he provided DA 1 with his debit card and the pin number in an envelope. Resident 1 stated he asked DA 1 to withdraw $100 and buy him (Resident 1) a pack of cigarettes. Resident 1 stated DA 1 returned with two packs of cigarettes and $50. Resident 1 stated when he asked DA 1 for his card back, DA 1 replied the card was in his vehicle. Resident 1 stated he did not report the incident on 6/25/2025 but attempted to speak with DA 1 (6/26/2025), but DA 1 was off duty. Resident 1 stated on 6/27/2025, DA 1 told the resident the debit card was inside of his vehicle. Resident 1 stated DA 1 finally returned the debit card on 6/28/2025. Resident 1 stated he immediately called the bank with the help of LVN 1 to verify the funds in his account. Resident 1 stated he was surprised to learn that $2,000 was withdrawn each day from 6/25/2025 through 6/28/2025, which totaled $8,000. Resident 1 stated this made him so mad that he went to the kitchen, confronted DA 1, and yelled. Resident 1 stated DA 1 remained silent, refused to provide an explanation, and wore a dumb look on his face. Resident 1 stated LVN 1 and RN 1 told him to address the matter on 6/30/2025. Resident 1 stated on 6/30/2025, he made Social Services Director (SSD) 1 aware of the situation and SSD 1 helped Resident 1 file a claim with the bank. Resident 1 stated SSD 1 helped call the police on 7/1/2025. During an interview on 7/8/2025 at 11:13 a.m. with SSD 1, SSD 1 stated on 6/30/2025, Resident 1 reported he provided his debit card and pin number to DA 1 and money was missing. SSD 1 stated she assisted Resident 1 file a claim for the missing money. SSD 1 stated on 7/1/2025, she called the police. SSD 1 stated staff were not allowed to accept a resident's personal debit card to perform cash withdrawals or to purchase items without the presence of the resident. SSD 1 stated she

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 follow their Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, for one out of three sampled residents (Resident 1) by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 1 reported to the California Department of Health (CDPH), ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local authorities within 2 hours on 6/28/2025, after being made aware Dietary Aide (DA 1) was in possession of Resident 1's debit card from 6/25/2025 through 6/28/2025 and a total of $8,000 dollars was withdrawn from Resident 1's bank account without Resident 1's knowledge. 2. Ensure Social Services Designee (SSD) 1 reported to the CDPH, ombudsman, and local authorities on 6/30/2025, when she was first made aware of Resident 1's allegation of misappropriation (illegal use of someone else's money for purposes other than those intended by the rightful owner) of personal funds.3. Ensure Registered Nurse (RN) 1 reported a suspicion of misappropriation of personal funds within 2 hours to the CDPH, ombudsman, and local authorities on 6/28/2025, when RN 1 was made aware Resident 1's funds were missing. These failures resulted in a delay of investigation by CDPH and law enforcement and had the potential to lead to further financial abuse by DA 1 to other residents.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 that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one entire side of the body) following a cerebral infarction (an interruption in blood flow to the brain), muscle weakness, and depression (persistent feeling of sadness). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 required partial to moderate assistance (helper does less than half of the effort) for toileting hygiene, bathing, and required supervision when performing oral hygiene, dressing, and personal hygiene. During a review of the facility's SOC 341 (a report of suspected dependent adult or elder abuse), dated 7/7/2025, the form indicated the facility reported an allegation of elderly financial abuse on 7/7/2025. The form indicated Resident 1 reported he gave his debit card with the pin number written on an envelope to somebody to withdraw money from his account. The form indicated Resident 1 reported more funds were withdrawn than originally requested and were missing. 1. During a review of Licensed Vocational Nurse (LVN) 1's written statement, dated 7/9/2025, the statement indicated on 6/28/2025, Resident 1 came out of his room yelling That motherfuck-- stole my money! The statement indicated LVN 1 followed Resident 1 to the kitchen and Resident 1 pointed at Dietary Aide (DA) 1 and stated, It was that guy! The written statement indicated DA 1 stated, It wasn't me my car has been in the shop! Resident 1 explained that he lent his debit card to DA 1 about a week ago so that DA 1 could buy cigarettes for him, and the card was supposed to be returned the same day. The statement indicated DA 1 repeatedly stated his car had been in the shop for a week. The statement indicated RN 1 informed the Director of Nursing (DON) and informed LVN 1 that the DON would notify the Administrator (ADM). During an interview on 7/8/2025 at 10:47 p.m. with Resident 1, Resident 1 stated on 6/25/2025, he provided DA 1 with his debit card and the pin number in an envelope. Resident 1 stated he asked DA 1 to withdraw $100 and buy him (Resident 1) a pack of cigarettes. Resident 1 stated DA 1 returned with two packs of cigarettes and $50. Resident 1 stated the other $50 was missing and when Resident 1 asked DA 1 for his card back, DA 1 responded by stating the card was in DA 1's vehicle. Resident 1 stated DA 1 did not return Resident 1's debit card and the remaining $50. Resident 1 stated he did not report the incident on 6/25/2025 and attempted to speak with DA 1 the following day (6/26/2025) but DA 1 was off duty. Resident 1 stated on 6/27/2025, DA 1 stated the debit card was inside of his vehicle and returned on 6/28/2025. Resident 1 stated he immediately called the bank with the help of LVN 1 to verify the funds in his account. Resident 1 stated he was surprised to learn that $2,000 was withdrawn each day from 6/25/2025 through 6/28/2025, which totaled $8,000. Resident 1 stated this made him so mad that he went to the kitchen, confronted DA 1, and yelled. Resident 1 stated DA 1 remained silent, refused to provide an explanation, and wore a dumb look on his face. Resident 1 stated LVN 1 and RN 1 told him to address the matter on 6/30/2025. Resident 1 stated on 6/30/2025, he made Social Services Director (SSD) 1 aware of the entire situation the morning of 6/30/2025 and SSD 1 helped Resident 1 file a claim with the bank. Resident 1 stated SSD 1 helped call the police on 7/1/2025. 2. During an interview on 7/8/2025 at 11:13 a.m

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 follow their Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, for one out of three sampled residents (Resident 1) by failing to initiate and conduct a timely investigation into an allegation of misappropriation of resident property and missing funds when the following occurred: 1. Licensed Vocational Nurse (LVN) 1 was made aware on 6/28/2025, of an allegation that Dietary Aide (DA 1) was in possession of Resident 1's debit card from 6/25/2025 through 6/28/2025 and a total of $8,000 in unauthorized cash withdrawals from Resident 1's bank account occurred from 6/25/2025 through 6/28/2025. 2. Registered Nurse (RN) 1 was made on 6/28/2025 Resident 1's debit card and funds were missing. 3. Social Services Designee (SSD) 1 was made aware, on 6/30/2025, Resident 1's funds were missing. These failures resulted in a delay of protective measures for Resident 1. This failure also resulted in a delay of disciplinary action against DA 1 which had the potential to lead to further financial abuse by DA 1 to other residents.Cross reference F602 and F609Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one entire side of the body) following a cerebral infarction (an interruption in blood flow to the brain), muscle weakness, and depression (persistent feeling of sadness) During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. 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The statement indicated Licensed Vocational Nurse (LVN) 1 followed Resident 1 to the kitchen and Resident 1 pointed at Dietary Aide (DA) 1 and stated, It was that guy! The statement indicated DA 1 replied, It wasn't me, my car has been in the shop! Resident 1 explained that he lent his debit card to DA 1 about a week ago so that DA 1 could buy cigarettes for him, and the card was supposed to be returned the same day. The statement indicated DA 1 repeatedly stated his car had been in the shop for a week. The statement indicated LVN 1 proceeded to assist Resident 1 to speak to a representative from his bank and LVN 1 hand wrote the amounts withdrawn from Resident 1's bank account (as dictated by the bank representative). The statement indicated RN 1 made the Director of Nursing (DON) aware of the situation and RN 1 informed LVN 1 that the DON would notify the Administrator (ADM). 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