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	03/18/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report a resident-to-resident altercation for two of four sampled residents (Resident 2 and Resident 4) to the facility's Abuse Coordinator and the California Department of Public Health (CDPH) . This deficient practice created a delay in the investigation by the Abuse Coordinator and CDPH, and had the potential to result in further abuse.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and was readmitted [DATE]. Resident 2's diagnoses included anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable worry or fear that interferes with daily life) and dementia (a progressive state of decline in mental abilities).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 2 had no cognitive impairments (when a person has trouble with memory, thinking, learning, concentration, or decision-making). The MDS indicated Resident 2 could independently perform oral hygiene and dress his upper and lower body.During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 4's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no cognitive impairments. The MDS indicated Resident 4 could independently perform activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Change of Condition (COC) Assessment, dated 1/31/2026, the assessment indicated that on the morning of 1/31/2026, Resident 2 displayed verbal and physical aggression with an anger outburst. The assessment indicated staff observed Resident 2 initiating a physical altercation with Resident 4 without provocation and attempting to strike him for no apparent reason. The assessment indicated both residents were separated to minimize escalation.During an interview on 3/18/2026 at 12:54 PM, with Registered Nurse (RN) 1, RN 1 stated she was the RN on duty on 1/31/2026. RN 1 stated she did not report the altercation that occurred on 1/31/2026 to the Administrator (ADM), the facility's abuse coordinator. RN 1 stated she did not recall reporting the incident to CDPH. RN 1 stated she was to report the altercation to the ADM and CDPH right away. RN 1 stated the purpose of timely reporting was for the safety of the facility's residents.During an interview on 3/18/2026 at 1:36 PM, with the ADM, the ADM stated she was not aware of the altercation that occurred on 1/31/2026 until 3/18/2026. The ADM stated RN 1 should have reported it to her right away, and if she was unavailable, RN 1 could have reported the altercation to the Director of Nursing (DON). The ADM stated the purpose of timely reporting to herself, and CDPH, would be to prevent abuse. The ADM stated that timely reporting was important for resident safety.During a review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised 4/2021, the P&P indicated the facility was to report any allegations of abuse within the timeframes required by federal (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
	056415	A. Building B. Wing	03/18/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements.During a review of the facility P&P titled Abuse, Neglect, Exploitation, and Misappropriation - Reporting and Investigating, revised 9/2022, the P&P indicated that if resident abuse was suspected, the suspicion was to be reported to the facility ADM immediately. The P&P indicated the facility was also to report the suspicion to the state licensing/certification agency immediately or within two hours.

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	03/18/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate a resident-to-resident altercation that occurred on 1/31/2026, for two of four sampled residents (Resident 2 and Resident 4). This deficient practice had the potential to increase the risk for further abuse to occur.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and was readmitted [DATE]. Resident 2's diagnoses included anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable worry or fear that interferes with daily life), and dementia (a progressive state of decline in mental abilities).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 2 had no cognitive impairments (when a person has trouble with memory, thinking, learning, concentration, or decision-making). The MDS indicated Resident 2 could independently perform oral hygiene and dress his upper and lower body.During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 4's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no cognitive impairments. The MDS indicated Resident 4 could independently perform activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Change of Condition (COC) Assessment, dated 1/31/2026, the assessment indicated that on the morning of 1/31/2026, Resident 2 displayed verbal and physical aggression with an anger outburst. The assessment indicated staff observed Resident 2 initiating a physical altercation with Resident 4 without provocation, attempting to strike him for no apparent reason. The assessment indicated both residents were separated to minimize escalation.During an interview on 3/18/2026 at 1:36 PM, with the Administrator (ADM), the ADM stated she was not aware of the altercation that occurred on 1/31/2026. The ADM stated the altercation was not investigated. The ADM stated the purpose of timely investigation was to prevent further abuse and ensure resident safety.During a review of the facility's policy and procedures (P&P) titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised 4/2021, the P&P indicated the facility was to investigate any allegations of abuse within the timeframes required by federal requirements.During a review of the facility P&P titled Abuse, Neglect, Exploitation, and Misappropriation - Reporting and Investigating, revised 9/2022, the P&P indicated that all allegations of abuse were to be thoroughly investigated. The P&P indicated the investigation was to be initiated by the ADM.

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	03/18/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement it's policy and procedure (P&P) titled Resident-to-Resident Altercations, revised 9/2022, following a resident-to-resident altercation on 1/31/2026, for one of four sampled residents (Resident 4). This deficient practice created the potential for Resident 4 to not receive the care and interventions needed after the altercation on 1/31/2026.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 4's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 4's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 4 had no cognitive impairments (when a person has trouble with memory, thinking, learning, concentration, or decision-making). The MDS indicated Resident 4 could independently perform activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).During an interview on 3/18/2026 at 12:54 PM, with Registered Nurse (RN) 1, RN 1 stated on 1/31/2026, another resident attempted to strike Resident 4. RN 1 stated she did not recall notifying Resident 4's physician or documenting the incident in Resident 4's electronic medical record (EMR).During an interview on 3/18/2026 at 1:36 PM, with the Administrator (ADM), the ADM stated she was not aware of the altercation that occurred on 1/31/2026. The ADM stated there was no documentation in Resident 4's EMR indicating his attending physician was notified of the altercation, or that a care plan with interventions was developed to address his possible psychosocial needs after the altercation.During a review of the facility's policy and procedure (P&P) titled Resident-to-Resident Altercations, revised 9/2022, the P&P indicated that if two residents were involved in an altercation, staff were to notify each resident's attending physician. The P&P indicated staff were also to make any necessary changes in the care plan to all of the residents involved, and document all interventions in the resident's clinical record.