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	06/02/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review one of three residents' (Resident 1) quarterly smoking assessment for safety.This failure had the potential not to identify changes in Resident 1's ability to smoke safely, placing the resident at risk for injuriesFindings: 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 encephalopathy (a condition that affects how the brain works causing changes in thinking alertness behavior and consciousness), Diabetes Mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing)and Chronic obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1' Minimum Data Set (MDS- a resident assessment tool) dated 4/29/2026, the MDS indicated Resident had no cognitive (thinking process) impairment. The MDS indicated Resident 1 required set up assistance (helper sets up or cleans up; resident completes activity) from staff for personal hygiene, upper body dressing, oral hygiene and toileting. During a review of Resident 1's care plan titled, At risk for injury related to Smoking, dated 2/6/2026, the goal indicated Resident 1 would have no injuries through next review. During a review of Resident 1's History and physical (H& P) dated 3/4/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a concurrent interview and record review on 6/2/2026 at 2:00 p.m., with Registered Nurse (RN) 1, Resident 1's MDS dated [DATE] was reviewed. RN 1 stated Resident 1's MDS that was reviewed had no quarterly smoking assessment. During interview on 6/2/2026 at 4:00 p.m., with the Director of Nurses (DON), the DON stated the quarterly smoking assessment for Resident 1 was not completed, per the facility smoking policy and stated the missed assessment could be a risk to resident safety. During a review of the facility's policy and procedure (P&P) titled, Smoking Policy- Residents, dated 10/2023, the P&P indicated, the resident's ability to smoke safely are re-evaluated quarterly.

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