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	06/15/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Care Plans - Baseline, which indicated a baseline care plan to meet the resident's immediate health and safety needs should be developed within 48 hours of admission, for one of three sampled residents (Resident 2) who was identified as a high risk for falls.This failure resulted in Resident 2 without safe nursing interventions (actions) to prevent falls for 14 days since admission [DATE] to 4/20/2026), placing the resident at risk for falls, recurrent falls and severe injuries, including hospitalization.Findings: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 metabolic encephalopathy (a change in how the brain works due to an underlying condition) and unspecified chronic (continuing over an extended period of time) bronchitis (inflammation of the lining in the tubes that carry air to and from the lungs).During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 2 rarely/never understood and was not able to be assessed for cognitive patterns (the ability to think, learn, use judgement, and make decisions). Resident 2 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as toileting and oral hygiene. Resident 2 required partial/moderate assistance to perform movements such as rolling from left to right and changing positions from sitting to standing.During a review of Resident 2's Fall Risk Assessment, dated 4/6/2026, the Fall Risk Assessment indicated that Resident 2 was at risk for falls.During a review of Resident 2's Care Plan titled, Resident is at risk for falls with injury related to (r/t) limited mobility, confusion, deconditioning (deterioration), gait/balance problems, incontinence, pain, poor communication/comprehension, poor safety awareness, vision/hearing problems, dated 4/20/2026, indicated the care plan was initiated on 4/20/2026, two weeks after Resident 2 was admitted to the facility (4/6/2026).During a concurrent interview and record review on 6/11/2026 at 2:24 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 2's care plan titled, Resident is at risk for falls with injury r/t limited mobility, confusion, deconditioning, gait/balance problems, incontinence, pain, poor communication/comprehension, poor safety awareness, vision/hearing problems, dated 4/20/2026, and facility's P&P titled, Care Plans - Baseline, dated 3/2022, were reviewed. LVN 1 stated the care plan should have been created immediately to notify other staff and to communicate interventions to prevent falls. LVN 1 stated the facility did not follow its policy to initiate a baseline care plan within 48 hours after admission per facility's P&P, for residents at risk for falls. LVN 1 stated not having a baseline care plan, placed Resident 2 without safety interventions and at risk of a fall.During a concurrent interview and record review on 6/15/2026 at 2:13 p.m., with the Director of Nursing (DON), Resident 2's Fall Risk Assessment, dated 4/6/2026, and care plan tilted, Resident is at risk for falls with injury r/t limited mobility, confusion, deconditioning, gait/balance problems, incontinence, pain, poor communication/comprehension, poor safety awareness, vision/hearing problems, dated 4/20/2026, were reviewed. The DON stated that baseline care plans should be initiated after admission to identify the residents' needs and provide interventions to minimize the risk of Resident 2 (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from falling.During a review of facility's P&P titled, Care Plans - Baseline, dated 3/2022, the P&P indicated, a baseline care plan to meet the resident's immediate health and safety needs should be developed for each resident within 48 hours of admission.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three sampled residents' (Resident 1) environment remained as free of accident hazards as is possible and received adequate supervision to prevent accidents. The facility failed to: 1). Ensure the Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) identified causes of Resident 1's multiple falls and identified new interventions to minimize falls.2). Update Resident 1's care plan after each fall with new interventions for safety and to prevent recurrent falls.3). Implement its policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 7/2017, which indicated to monitor and evaluate the effectiveness of interventions, modify or replace interventions as needed; and evaluate the effectiveness of new or revised interventions.4). Implement its P&P titled, Falls and [NAME] Risk, Managing, dated 3/2018, which indicated, if the resident continues to fall, staff should implement additional or different interventions, re-evaluate the situation whether it was appropriate to continue or change current interventions. These failures resulted in a total of 15 falls (four witnessed falls on 5/17/25, 6/30/2025, 8/18/2025 and 10/16/2025, and 11 unwitnessed falls from 2/7/2025 to 5/4/2026), placing Resident 1 at risk for severe injuries, including hospitalization and death.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included unspecified severe protein-calorie malnutrition (a severe form of undernutrition caused by insufficient intake of both protein and calories, leading to muscle wasting, fat loss, and impaired bodily functions), generalized muscle weakness and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P), dated 11/4/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment, dated 1/28/2025, the fall risk assessment indicated Resident 1 was at risk for falls. During a review of Resident 1's Care Plan Focus (titled), Resident is at risk for falls related to (r/t) aging process, generalized weakness, history (hx) of dementia, and hx of falls, dated 1/28/2025, the care plan goal was for the resident to have no falls through next review period. The care plan interventions included frequent rounds, low bed, call light within reach, and implement facility fall prevention protocol. During a review of Resident 1's Change of Condition (COC) Evaluation documents and Post- Fall Review documents for 2025 and 2026, the COC indicated a total of 11 unwitnessed falls from 2/7/2025 to 5/4/2026 and four witnessed falls on 5/17/25, 6/30/2025, 8/18/2025 and 10/16/2025. During a review of Resident 1's Care Plan titled, The Resident is at risk for unavoidable falls with injury r/t impaired function and mobility, poor safety awareness and on medications which may increase the risk of fall, recurrent falls, dated 2/7/2025, the care plan interventions included to anticipate and meet resident's needs, call light within reach, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair (w/c), follow facility fall protocol, monitor side effects from medications, physical therapy (PT) to evaluate and treat as ordered or as needed (PRN), review information on past falls, attempt to determine cause of falls, record possible root causes and alter, remove any potential causes if possible. The care plan additional intervention dated 4/28/2026 included bilateral floor mat for fall precautions. During a review of Resident 1's care plan titled Res (resident) had a fall, initiated 6/30/2025, the care plan goal indicated the risk for falls will reduce daily and will not have adverse complications from fall. The intervention indicated to implement fall precautions, provide a clutter free environment, non-slippery floor, call light within reach and answer promptly, keep frequently used (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	items within reach and monitor side effects from medications. The care plan was revised with actual falls dated 4/4/2025, 4/24/2025, 5/17/2025, 5/29/2025, 6/30/2025, 8/18/2025, 10/4/2025, 10/16/2025, 10/31/2025, 1/17/2026 and 5/14/2026, adding the following interventions:-On 4/5/2025, the care plan additional interventions indicated laboratory works as ordered by the physician (MD) and notify MD of results.-On 4/24/2025 to 4/25/2025, 5/17/2025, 5/29/2025, 8/7/2025, 10/4/2025, 10/16/2025, 10/31/2025, 1/17/2026 and 5/24/2026, the care plan had no additional and updated interventions for Resident 1's safety and to prevent recurrent falls.-On 8/18/2025, the care plan additional interventions indicated to evaluate and remove environmental hazards, frequent visual check every hour and as needed, monitor for changes in level of consciousness (LOC), place patient on fall precautions and use appropriate signage, keep bed in lowest position with brakes locked and provide mobility aids. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 10/22/2025, the MDS indicated Resident 1 had severe (extreme) cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). Resident 1 was dependent (helper does all the effort) on staff to perform Activities of Daily Living (ADLs) such as toileting hygiene, upper and lower body dressing, and showering/bathing self. Resident 1 required substantial/maximal assistance (helper does more than half the effort) to perform movements such as rolling left and right, changing positions from lying to sitting on side of bed, and chair/bed-to-chair transfer. During an interview on 6/11/2026 at 11:04 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 1 was very confused. When residents are confused and staff does not make rounds, residents could fall and hurt themselves. During an interview on 6/11/2026 at 1:35 p.m., with Occupational Therapist (OT) 1, OT 1 stated Resident 1's cognition was impaired and was at risk for falls when sitting in a wheelchair. Resident 1 required supervision, assistance, cuing and redirection, in getting up from bed and when Resident 1 gets up on his own. During a concurrent interview and record review on 6/11/2026 at 3:30 p.m., with LVN 2, Resident 1's Post Fall Review dated 5/24/2026 at 4:55 p.m., was reviewed. The post fall review indicated Resident 1 was found by a CNA, lying on his back, on the floor mat next to the resident's bed. Resident 1 had bleeding from a sustained laceration on the right eyebrow (no measurement indicated). LVN 2 stated Resident 1's majority of his falls were unwitnessed. Resident 1 was confused and would have been moved closer to nurses station to get more supervision. If there were no available rooms, LVN 2 stated the facility should have provided a one to one (1:1-when an individual staff member is assigned to directly supervise no more than one resident and the staff shall stay within very close proximity to ensure constant supervision and immediate intervention if needed for safety reasons) supervision to Resident 1. LVN 2 stated Resident 1 move quickly at times needing more interventions. If staff were not close to Resident 1, supervision was not enough (unspecified) and could put him at risk for fall. LVN 2 stated it was important for the staff to update the resident's care plan with new interventions. LVN 2 stated if staff conducted frequent checks every hour and resident keeps falling, frequent checking was not effective. During a concurrent interview and record review on 6/15/2026 at 2:13 p.m., with the Director of Nursing (DON), the care plans titled, The resident is at risk for unavoidable falls with injury r/t impaired function and mobility, poor safety awareness and on medications which may increase the risk of fall, dated 2/7/2025, 4/4/2025, 4/5/2025, 4/24/2025, 4/25/2025 and 5/17/2025, were reviewed. The DON stated there were no changes to the resident's care plan interventions after the third fall on 4/24/2025. The DON stated other interventions that could have been added was to do frequent checks but was not documented on Resident 1's care plan dated 4/25/2025. There were no new interventions implemented after Resident 1's fall on 5/17/2025. The DON stated frequent checks were done by different staff passing by Resident 1's room but were not documented in Resident 1's clinical records. The DON stated Resident 1 could have benefited from increased supervision due to how quickly Resident 1 moved at times. The DON stated Resident 1's care plans were not resident-specific and were not updated with interventions to ensure falls were minimized. The DON stated Resident 1's Care Plan titled, At risk for unavoidable fall, dated 2/7/2025 was not appropriate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IDT should have identified new and individualized interventions according to the resident's ambulation (walking) ability, cognition, physical and mental capacity to minimize falls. During a concurrent interview and record review on 6/23/2026 at 3:36 p.m., with the DON, Resident 1's active, discontinued, and completed physician's orders and the P&P titled, Falls and Fall Risk, Managing, dated 3/2018, indicating position-change alarms to assist staff in identifying patterns and routines of the resident, were reviewed. The DON stated position-change alarm are alarms that would go off when a resident changes positions, requiring physician's order. The DON stated the position-change alarm was not used or ordered on Resident 1 because it will not prevent falls. The DON stated the IDT should have identified reasons (causes) why and if the resident had multiple falls and provided the interventions. During a review of the facility's P&P titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated, the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated individualized, resident-centered approach to safety address safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated monitoring the effectiveness of interventions should include ensuring the interventions were implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed; and evaluating the effectiveness of new or revised interventions. During a review of the facility's P&P titled, Falls and [NAME] Risk, Managing, dated 3/2018, the P&P indicated, staff should identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling basing on the previous evaluations and current data. The P&P indicated, staff with the input of the attending physician, should implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If fall recurs despite initial interventions, staff should implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff should try various interventions, based on the assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. The P&P indicated position-change alarms will be used to assist the staff in identifying patterns and routines of the resident, efficacy will be monitored and staff should respond to alarms in a timely manner. If the resident continues to fall, staff should re-evaluate the situation whether it was appropriate to continue or change current interventions. As needed, the attending physician should help the staff reconsider possible causes that may not previously have been identified. During a review of the facility's P&P titled, Dementia - Clinical Protocol, dated 11/2018, the P&P indicated, for individual with confirmed dementia, the IDT should identify a resident-centered care plan to maximize remaining function and quality of life. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT. During a review of the facility's P&P titled, Care plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, the IDT reviews and updates the care plan when the desired outcome is not met.