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	06/23/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was not administered antipsychotic medication (medication affecting mood, thoughts, feelings, and behavior) without a confirmed clinical diagnosis.This deficient practice had the potential for Seroquel (an antipsychotic medication) to be used unnecessarily and inappropriately to manage Resident 1's combative behavior.Cross Reference F684.Findings:During a review of Resident 1's admission Record (Face Sheet, front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (process of thinking) was moderately impaired. The MDS indicated Resident 1 did not have physical (hitting, kicking, or pushing) or verbal (threatening, screaming, or cursing at others) behavioral symptoms towards others. The MDS indicated Resident 1 was dependent on staff assistance with oral hygiene, toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 1's History and Physical (H&P), dated 3/27/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Change in Condition Evaluation (COC), dated 6/12/2026, the COC indicated, on 6/12/2026, while a certified nursing assistant (CNA) assisted Resident 1 into clean clothing the resident became verbally aggressive and threated physical violence towards the CNA, stating he would ?punch the CNA in the face.' The COC indicated the primary clinician recommended to monitor Resident 1, notify of any changes in condition or behavior, and administer Haldol (an antipsychotic medication which affects mood, thoughts, feelings, and behavior) 5 milligrams (mg, a unit of measurement) one time and Seroquel (an antipsychotic medication) 25mg every 12 hours.During an observation on 6/23/2026 at 10:20 a.m., in Resident 1's room, a CNA was observed assisting Resident 1 with dressing. Resident 1 was observed calm and pleasant towards the CNA.During a phone interview on 6/23/2026 at 11:46 a.m., with Registered Nurse (RN) 2, RN 2 stated, on 6/12/2026, he asked the CNA to change Resident 1's adult brief and overhead Resident 1 raise his voice. RN 2 stated he entered the room to assist the CNA and Resident 1 became agitated and threatened to punch the CNA. RN 2 stated Resident 1 had never been aggressive towards the staff or other residents before. RN 2 stated Resident 1 was redirectable and calmed down after RN 2 gave Resident 1 a snack. RN 2 stated he notified Nurse Practitioner (NP) 1 who ordered Haldol and Seroquel for Resident 1. RN 2 stated he did not recall if NP 1 ordered a psychiatric consult (a medical evaluation by a physician specializing in mental health).During a concurrent interview and record review on 6/23/2026 at 12:25 p.m., with Licensed Vocational Nurse (LVN) 4, Resident 1's Physician Order, dated 6/12/2026, was reviewed. The Physician Order indicated to administer Seroquel 25mg by mouth, twice a day for agitation manifested by combative behavior. LVN 4 stated Resident 1's Seroquel order did not indicate a medical diagnosis which (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manifested Resident 1's combative behavior. LVN 4 stated Resident 1's Seroquel order should have been clarified to ensure Seroquel was given for the appropriate reason and they exhausted other potential causes such as an infection. LVN 4 stated Resident 1 could be irritable at times, however, she never observed Resident 1 become agitated and aggressive. LVN 4 stated Resident 1 was redirectable when irritated such as providing a quiet environment, rest, and snacks. LVN 4 stated Resident 1's combative behavior was new. LVN 4 stated antipsychotic medications were ordered by the physician or NP to treat a medical diagnosis and manage manifested behaviors. LVN 4 stated ensuring a medical diagnosis was present was essential to know if the medication was effective and to know exactly the cause of the behaviors. During a phone interview on 6/23/2026 at 1:02 p.m., with NP 1, NP 1 stated, on 6/12/2026, she was covering for Resident 1's attending physician when RN 2 notified her at approximately 3 a.m. of Resident 1's threat of punching the CNA. NP 1 stated she informed RN 2 to try and deescalate the situation and received a message at approximately 6 a.m. of Resident 1's recurring behavior. NP 1 stated she was familiar with Resident 1's behavior and the licensed nurses informed her of Resident 1's occasional aggressive behavior towards them. NP 1 stated she ordered Seroquel 25mg every 12 hours to treat Resident 1's aggressive and combative behavior. NP 1 stated Resident 1's attending physician was scheduled to be back on duty on 6/15/2026 and assumed the attending physician would review and make any necessary changes to Resident 1's medications. NP 1 stated she also ordered for a psychiatric evaluation to assess Resident 1's aggressive behavior and oversee Resident 1's medication regimen. NP 1 stated antipsychotic medication should be used to treat a medical diagnosis to provide the necessary and appropriate indication for the medication treatment. NP 1 stated she ordered Seroquel 25mg to treat Resident 1's combative behavior to prevent someone from getting hurt. NP 1 stated Resident 1's medical diagnoses should have been evaluated and clarified to ensure Seroquel 25mg was necessary to treat Resident 1's combative behavior.During an interview on 6/23/2026 at 2:59 p.m., with the Director of Nursing (DON), the DON stated antipsychotic medication required an indication and manifested behavior to ensure the staff knew the reason for the medication. The DON stated the attending physician or NP could order the antipsychotic medication and the psychiatrist would follow up. The DON stated the psychiatrist would assess Resident 1 and determine the resident's diagnosis and whether the medication regimen was appropriate. The DON stated it was important to ensure Resident 1's behavior was caused by a psychiatric diagnosis or something else. The DON stated a urinalysis (evaluation of the urine for signs of infection or kidney issues) and urine culture (test to grow and identify the specific bacteria causing the urine infection) were completed and Resident 1 was concurrently treated for a urinary tract infection (UTI- an infection in the bladder/urinary tract).During a review of the facility's Policy and Procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, revised 3/2019, the P&P indicated medications prescribed for behavioral symptoms required documented rationale for use and potential underlying cause of the behavior. During a review of the facility's P&P titled, Psychotropic Medication Use, dated 7/2022, the P&P indicated, Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record.

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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 observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was seen by the psychiatrist after exhibiting combative behavior and prescribed antipsychotic medication (medication affecting mood, thoughts, feelings, and behavior).This deficient practice had the potential for Resident 1's combative behavior to be mismanaged.Cross Reference F605.Findings:During a review of Resident 1's admission Record (Face Sheet, front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (process of thinking) was moderately impaired. The MDS indicated Resident 1 did not exhibit physical (hitting, kicking, or pushing) or verbal (threatening, screaming, or cursing at others) behavioral symptoms towards others. The MDS indicated Resident 1 was dependent on staff assistance with oral hygiene, toileting, bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 1's History and Physical (H&P), dated 3/27/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Change in Condition Evaluation (COC), dated 6/12/2026, the COC indicated, on 6/12/2026, a certified nursing assistant (CNA) assisted Resident 1 into clean clothing and Resident 1 became verbally aggressive and threated physical violence towards the CNA, stating he would 'punch the CNA in the face.' The COC indicated the primary clinician recommended to monitor Resident 1, notify of any changes in condition or behavior, and administer Haldol (an antipsychotic medication which affects mood, thoughts, feelings, and behavior) 5 milligrams (mg, a unit of measurement) one time and Seroquel (an antipsychotic medication) 25mg every 12 hours.During a review of Resident 1's Physician Order, dated 6/12/2026, the Physician Order indicated to administer Seroquel 25mg by mouth, twice a day for agitation manifested by combative behavior.During a review of Resident 1's Care Plan titled, The Resident Became Verbally Aggressive, dated 6/12/2026, the care plan indicated for a psychiatric consult (a medical evaluation by a physician specializing in mental health) as indicated.During a review of Resident 1's electronic health record (eHR), dated 6/12/2026 through 6/23/2026, the eHR did not indicate psychiatric notes regarding Resident 1's behaviors.During a phone interview on 6/23/2026 at 11:46 a.m., with Registered Nurse (RN) 2, RN 2 stated, on 6/12/2026, he asked the CNA to change Resident 1's adult brief and overhead Resident 1 raise his voice. RN 2 stated he entered the room to assist the CNA and Resident 1 became agitated and threatened to punch the CNA. RN 2 stated Resident 1 had never been aggressive towards the staff or other residents before. RN 2 stated Resident 1 was redirectable and calmed down after RN 2 gave Resident 1 a snack. RN 2 stated he notified Nurse Practitioner (NP) 1 who ordered Haldol and Seroquel for Resident 1. RN 2 stated he did not recall if NP 1 ordered a psychiatric consult (a medical evaluation by a physician specializing in mental health).During an interview on 6/23/2026 at 12:25 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 1 could be irritable at times, however, she never observed Resident 1 become agitated and aggressive. LVN 4 stated Resident 1 was redirectable when irritated such as providing a quiet environment, rest, and snacks. LVN 4 stated Resident 1's combative behavior was new.During a concurrent interview and record review on 6/23/2026 at 12:41 p.m., with LVN 4, Resident 1's Physician Orders, active on 6/23/2026, was reviewed. The Physician Orders did not indicate a psychiatric consult was to be done. LVN 4 stated a psychiatric consult should have been ordered and carried out because Resident 1 exhibited new combative behavior and was receiving Seroquel. LVN 4 stated a psychiatrist was more knowledgeable about Resident 1's behavior and diagnoses and would be able to assess and manage Resident 1's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications appropriately. LVN 4 stated the psychiatrist would determine whether Resident 1's behavior was caused by a psychiatric diagnosis or something else such as an infection.During a phone interview on 6/23/2026 at 1:02 p.m., with NP 1, NP 1 stated, on 6/12/2026, she was covering for Resident 1's attending physician when RN 2 notified her at approximately 3 a.m. of Resident 1's threat of punching the CNA. NP 1 stated she informed RN 2 to try and deescalate the situation and received a message at approximately 6 a.m. of Resident 1's recurring behavior. NP 1 stated she was familiar with Resident 1's behavior and the licensed nurses informed her of Resident 1's occasional aggressive behavior towards them in the past. NP 1 stated she ordered Seroquel 25mg every 12 hours to treat Resident 1's aggressive and combative behavior. NP 1 stated Resident 1's attending physician was scheduled to be back on duty on 6/15/2026 and assumed the attending physician would review and make any necessary changes to Resident 1's medications. NP 1 stated she also ordered for a psychiatric evaluation to assess Resident 1's aggressive behavior and oversee Resident 1's medication regimen. NP 1 stated she ordered Seroquel 25mg to treat Resident 1's combative behavior and prevent someone from getting hurt. NP 1 stated a psychiatrist should have been consulted to ensure Seroquel was appropriate to manage Resident 1's combative behavior. During an interview on 6/23/2026 at 2:18 p.m., with the Social Services Director (SSD), the SSD stated when a physician or NP ordered a psychiatric consult, the licensed nurse was responsible for informing her to ensure the psychiatrist came to assess the resident. The SSD stated the psychiatrist would determine the cause for Resident 1's combative behavior and manage Resident 1's medications. During a review of the facility's Policy and Procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, revised 3/2019, the P&P indicated, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.