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	04/23/2026

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure there were adequate privacy curtains available in 17 of 33 rooms (Rooms 2, 3, 4, 7, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31). This deficient practice violated the residents' rights to full visual privacy at any given time.Findings: During an observation, on 4/21/2026 at 2:40 p.m., in room [ROOM NUMBER], observed two privacy curtains observed on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:41 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:42 p.m., in room [ROOM NUMBER], observed one privacy curtain on the horizontal track along the foot of the residents' beds. The privacy curtain provided full visual privacy for one of the room's three occupants. During an observation, on 4/21/2026 at 2:42 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:43 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:44 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:45 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:46 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 2:47 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 3:01 p.m., in room [ROOM NUMBER], observed two privacy curtains observed on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 3:04 p.m., in room [ROOM NUMBER], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 3:07 p.m., in room [ROOM NUMBER], observed one privacy curtain on the horizontal track along the foot of the residents' beds. The privacy curtain provided full visual privacy for two of the room's three occupants. During an observation, on 4/21/2026 at 3:10 p.m., in room [ROOM NUMBER], observed one privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for one of the room's two occupants. During an interview on 4/21/2026 at 3:31 p.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated (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
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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that privacy curtains were essential for residents' dignity during care, including dressing, bathing, and treatments. CNA 6 stated the privacy curtains should always be fully functional. During an interview on 4/21/2026 at 3:39 p.m., with the Housekeeping Supervisor (HS), the HS stated privacy curtains protected residents' dignity and comfort. The HS stated that without them, the facility's residents may feel uneasy receiving care, impacting their emotional well-being. During an observation, on 4/22/2026 at 3:30 p.m., in rooms [ROOM NUMBERS], observed two privacy curtains on the horizontal track along the foot of the residents' beds. The privacy curtains provided full visual privacy for two of the room's three occupants. During an observation, on 4/22/2026 at 3:34 p.m., in room [ROOM NUMBER], observed two resident beds along the side of the room. Along the horizontal track, at the foot of Beds A and B (left side of the room), there was one privacy curtain providing full visual privacy to one of the two residents. Along the horizontal track at the foot of Beds C and D (right side of the room), there was one privacy curtain providing full visual privacy to one of the two residents. During an observation, on 4/22/2026 at 3:34 p.m., in room [ROOM NUMBER], observed one privacy curtain on the horizontal track along the foot of the residents' beds. The privacy curtain provided full visual privacy for one of the room's three occupants. During an interview on 4/22/2026 at 1:12 p.m., with the HS, the HS stated the facility was aware there were not enough privacy curtains in place to allow each resident to have full visual privacy. The HS stated the concern was brought up to the facility's Administrator. During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 2/2023, the P&P indicated employees were to treat all residents with respect and dignity. The P&P indicated all facility residents were to be guaranteed certain basic rights, including the right to privacy and a dignified existence.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner of a resident's refusal of a blood laboratory draw for one of six sampled residents (Resident 13). This deficient practice resulted in Resident 13's physician not being informed of Resident 13's refusal, and placed Resident 13 at risk for delayed assessment, treatment, unmanaged change of condition, and potential complications related to medical conditions requiring laboratory monitoring. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included anemia (blood disorder), dementia (a progressive state of decline in mental abilities), syncope (passing out), and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 13's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 13 was dependent (helper does all of the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 13's physician order, dated 4/13/2026, the physician order indicated to collect a complete blood count (CBC- a blood test that measures the main cells in the blood) laboratory test. During a concurrent interview and record review on 4/22/2026 at 2;00 p.m., with the Director of Nursing (DON), Resident 13's medical record and laboratory requisition form (a form used to request or document a laboratory test order), undated, were reviewed. The laboratory requisition form indicated Resident 13's CBC was scheduled to be collected on 4/13/2026. The laboratory requisition form indicated on 4/20/2026 and 4/21/2026, Resident 13's blood specimen was not collected due to patient refusal. The DON stated Resident 13's medical record did not indicate documented evidence showing the physician was notified of Resident 13's refusals on 4/13/2026, 4/20/2026, and 4/21/2026. The DON stated the physician should have been notified each time Resident 13 refused a physician ordered laboratory test. The DON stated the physician needed to be informed so the physician could determine whether the CBC remained medically necessary, whether the laboratory test should be rescheduled, and whether any additional assessment, monitoring, or treatment was needed. The DON stated failure to notify the physician of Resident 13's repeated refusals delayed the physician's ability to review the resident's condition and make timely treatment decisions. The DON stated this placed Resident 13 at risk for delayed assessment, delayed treatment, and unmanaged change in condition related to the medical reason for the ordered laboratory monitoring. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the staff would promptly notify the resident physician of any changes in the resident's medical or mental condition, including treatment refusal on two or more consecutive times.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the nursing staff failed to ensure one of six sampled residents (Resident 90) was free from physical restraints, when bed linen, towels, and pillows were used as a barrier to prevent Resident 90 from falling out the bed. This deficient practice had the potential to restrict Resident 90's freedom of movement, restrict the resident's ability to reposition or exit the bed, and placed Resident 90 at risk for decreased mobility, skin breakdown, and injury. Findings: During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was admitted to the facility on [DATE] with diagnoses that included legal blindness (vision loss), muscle weakness (loss of muscle strength), and metabolic encephalopathy (a change in how your brain works due to an underlying condition). During a review of Resident 90's Minimum Data Set (MDS- a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 90's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 90 was dependent (helper does all of the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 4/20/2026 at 9:55 a.m., with Resident 90, at Resident 90's bedside, Resident 90 was observed lying in bed. The bed linen was covering and tightly positioned along Resident 90's body. The bed linen was tucked under the mattress. Resident 90 stated staff placed pillows and towels on his bed, which restricted him from moving, turning, repositioning, or getting out of bed without staff assistance. During a concurrent observation and interview on 4/20/2026 at 10:33 a.m., with Certified Nursing Assistant (CNA) 1, at Resident 90's bedside, Resident 90 was observed lying in bed. The bed linen was tucked tightly along the side of the resident's body. CNA 1 stated the bed linen was tucked tightly along side Resident 90's body to keep the resident properly positioned in bed and to prevent the resident from moving toward the edge of the bed. CNA 1 stated the bed linen was placed that way to prevent Resident 90 from falling. During a concurrent observation and interview on 4/22/2026 at 11:24 a.m., with the Director of Nursing (DON), at Resident 90's bedside, Resident 90 was observed lying in bed. Bed linen, towels, and pillows were observed between the mattress and bed frame. The DON stated bed linen, towels, and pillows were positioned in a manner that created a barrier and limited Resident 90's ability to freely move or get out of bed without staff assistance. The DON stated the items were placed in a way that limited Resident 90's voluntary movement and functioned as physical restraint. The DON stated residents have the right to be free from physical restraints unless required to treat medical symptoms. The DON stated the staff should not use linen, towels, or pillows to keep a resident in bed or prevent falls. During a review of the facility's policy and procedure (P&P) titled Use of Restraints, revised 4/2017, the P&P indicated restraints should only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls.

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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 interview and record review, the facility failed to ensure an as needed (PRN) order for Ativan (a psychotropic medication- drug that affects mental processes, moods, and behaviors) was not continued beyond 14 days for one of six sampled residents (Resident 14). This deficient practice placed Resident 14 at risk for continued use of unnecessary psychotropic medication without timely physician reassessment and had the potential for Resident 14 to be chemically restrained by the administration of unnecessary psychotropic medication, and/or suffer extrapyramidal symptoms (a group of movement disorders that can occur because of certain medications, particularly antipsychotics) due to prolonged use.Findings: During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), 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 14's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 14's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 14 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 4/23/2206 at 8:15 a.m., with the Director of Nursing (DON), Resident 14's physician's order dated 3/25/2026 was reviewed. the order indicated Resident 14 was to receive Ativan 0.5 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount), one (1) tablet by mouth every eight (8) hours as needed (PRN) for anxiety (a feeling of fear, dread, and uneasiness). The order indicated to continue for 30 days with a stop date of 4/24/2026. The DON stated Resident 14's order for Ativan exceeded the 14 days PRN psychotropic requirement. The DON stated the resident should be reevaluated every 14 days, and the clinical justification documented if the medication was to continue beyond 14 days. The DON stated there was no documented evidence that the physician completed a required reevaluation or documented clinical justification for the continued use of PRN Ativan beyond 14 days. The DON stated this had the potential to result in the unnecessary use of Ativan without proper clinical review. The DON stated this placed Resident 14 at risk for chemical restraint, over-sedation, confusion, and decreased functional status. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 7/2022, the P&P indicated PRN orders for psychotropic medications are limited to 14 days. The P&P indicated if the attending physician finds it appropriate to extend PRN orders beyond 14 days, they must document the rational and specify the new duration.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a resident assessment tool) accurately reflected the Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level I Screening for one of six sampled residents (Resident 8). This deficient practice resulted in incorrect data being transmitted to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 8's PASRR and had the potential to negatively affect Resident 8's care plan and delivery of necessary care and services.Findings: During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 8's diagnoses included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 1/8/2026, the MDS indicated Resident 8's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 8 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 8's PASRR Level I screening, dated 6/15/2022, the PASRR Level I indicated Resident 8 had a serious mental illness and required a Level II mental health evaluation. During a concurrent interview and record review on 4/21/2026 at 1:17 p.m., with the MDS Nurse (MDSN), Resident 8's MDS, dated [DATE], and PASRR Level II determination report, dated 6/27/2022, were reviewed. The MDS, dated [DATE], section A1500 Preadmission Screening and Resident Review (PASRR) was marked 0- No indicating Resident 8 was not identified as having a serious mental illness. The MDSN stated the MDS was incorrectly completed because Resident 8's PASRR Level II determination report, dated 6/27/2022, identified Resident 8 as having a serious mental illness. The MDSN stated Resident 8's MDS did not accurately reflect the resident's PASARR Level II determination or serious mental illness. The MDSN stated an accurate MDS was necessary to ensure Resident 8's assessment reflected the resident's actual clinical status, PASRR status, serious mental health needs, and services required. The MDSN stated an inaccurate MDS could result in an incomplete assessment, inaccurate care planning, and inappropriate or delayed mental health services. During a review of the facility's policies and procedure (P&P) titled Resident Assessment, revised 10/2023, the P&P indicated everyone who completed the MDS assessment must sign and confirm the accuracy of the information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a care plan addressing the use of Apixaban (an oral anticoagulant [blood thinner] used to prevent stroke and blood clots) and risk for pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) development for two of two sampled residents (Resident 4 and Resident 2).This deficient practice placed Residents 4 and 2 at risk for adverse drug reactions, unmonitored medication use, and the development or worsening of pressure ulcers.Findings: a. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, dysphagia (difficulty swallowing), multiple fractures (broken bone) of the ribs, hyperlipidemia (high cholesterol), rhabdomyolysis (is a serious, potentially life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle), and cerebral infarction (tissue death caused by a severe reduction in brain blood flow due to arterial blockage). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 4 cognitive skills for daily decision making was moderately impaired (ability to think and reason). The MDS indicated Resident 4 was dependent on staff for assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 4's physician's order dated, 3/26/2026, the order indicated to administer Apixaban 5 milligrams (mg, unit of measurement) two times a day. During an interview on 4/23/2026 at 3:26 p.m. with the Director of Nursing (DON), the DON stated it was important to develop a care plan for Resident 4 who was receiving Apixaban. The DON stated that Apixaban is an anticoagulant medication that increases a resident's risk for bleeding and requires an individualized care plan, so staff are aware to monitor for signs and symptoms of bleeding, implement fall precautions, and promptly report any changes in the resident's condition. The DON stated that a care plan provides direction to staff to ensure the resident's safety and to reduce the risk of preventable complications related to anticoagulant therapy. The DON stated that it is important to develop a care plan for a resident identified as being at high risk for pressure ulcer development because the care plan communicates the specific interventions staff must follow to prevent skin breakdown. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2 diagnosis included muscle weakness, dysphagia, gastro esophageal reflux disease (GERD- a condition in which stomach acid flows back into esophagus causing heartburn), protein calorie malnutrition, and type 2 diabetes. During a review of Resident 2's History and Physical (H&P), dated 4/17/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 was dependent on staff for assistance with ADLs. During a review of Resident 2's Initial Skin assessment dated [DATE], the assessment indicated Resident 2 had blanchable redness (a red or pink skin discoloration that turns white (blanches) when pressed and quickly returns to red, indicating temporary blood flow interruption) to the coccyx area (a small triangular bone at the very base of the spinal column, located below the sacrum between the buttocks). During a review of Resident 2's Braden Scale for Predicting Pressure Ulcer Risk Evaluation tool (a tool that assesses sensory perception, moisture, activity, mobility, nutrition, and friction/shear to determine a patient's risk of developing pressure ulcers) dated 1/7/2026, the Braden Scale indicated a score of 14 (moderate risk) for developing pressure ulcers. During a review of Resident 2's Braden Scale for Predicting Pressure Ulcer Risk Evaluation tool (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated, 3/3/2026, the Braden Scale indicated a score of 13 (moderate risk) for developing pressure ulcers. During a review of Resident 2's Braden Scale for Predicting Pressure Ulcer Risk Evaluation tool dated, 4/16/2026, the Braden Scale indicated a score of 12 (high risk) for developing pressure ulcers. During an interview on 4/23/2026 at 3:26 p.m. with the DON, the DON stated that with Resident 2's diagnoses, history, admission skin assessment which identified blanchable redness to the coccyx area, and the resident's Braden Scale scores being 12, 13 and 14, Resident 2 was already at risk for further skin impairment and required interventions such as frequent repositioning, pressure relief measures, skin monitoring, and prompt reporting of any worsening areas to prevent further skin breakdown and pressure ulcers. The DON stated that without an individualized care plan, staff did not consistently implement all the needed preventive interventions, placing Resident 2 at high risk for avoidable skin breakdown and the development of a pressure ulcer. During a review of the facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered dated 3/2022, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep one of six sampled resident's (Resident 90) fingernails trimmed and clean. This deficient practice had the potential to result in a negative impact on Resident 90's quality of life and self-esteem, and had the potential for the development of infection.Findings: During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was admitted to the facility on [DATE]. Resident 90's diagnoses included legal blindness (vision loss), muscle weakness (loss of muscle strength), and metabolic encephalopathy (an altered mental status). During a review of Resident 90's Minimum Data Set (MDS- a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 90's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 90 was dependent (helper does all of the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation and interview on 4/20/2026 at 9:55 a.m., at Resident 90's bedside, Resident 90's fingernails were observed. Resident 90's fingernails were long and untrimmed with black debris underneath the nail bed. During a concurrent observation and interview on 4/20/2026 at 10:33 a.m., at Resident 90's bedside, with Certified Nursing Assistant (CNA) 1, Resident 90's fingernails were observed. Resident 90's fingernails were long and untrimmed with black debris underneath the nail bed. CNA 1 stated Resident 90's fingernails were dirty and required cleaning and trimming. CNA 1 stated nail care was one of the CNA's responsibilities which included trimming and cleaning the resident's fingernails when they become long and dirty. CNA 1 stated residents' nails should be checked daily to ensure the nails remained clean and neat. CNA 1 stated residents sometimes scratch their skin, and if they scratch hard enough, they could break the skin and create an open wound. CNA 1 stated if a resident had dirty fingernails and scratched themselves, this increased the risk of infection. CNA 1 stated having dirty fingernails was unsanitary because the residents use their hands to eat, and any bacteria present could be transferred to their mouth. CNA 1 stated if Resident 90 was to touch shared objects bacteria from under his fingernails could be transferred to those items and potentially to other residents. During an interview on 4/22/2026 at 11:22 a.m., with the Director of Nursing (DON), the DON stated fingernail care was a part of the resident's ADLs routine. The DON stated if a resident had long and dirty fingernails, CNAs were expected to clean and trim them. The DON stated dirty fingernails was not acceptable, as they increased the risk of infection, especially if residents touched food or shared items with others. During an interview with the Infection Preventionist Nurse (IPN) on 4/22/2026 at 4:11 p.m., the IPN stated nail care should be assessed daily. The IPN stated residents who required assistance with cleaning or trimming their nails should be assisted by the CNAs or licensed nurses. The IP stated fingernails were a source of bacteria, and that dirty or untrimmed nails could contribute to the spread of infection, especially among residents who may not be able to maintain their own hygiene. The IP stated routine nail care was an essential part of both personal hygiene and infection control. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails Care, revised 2/2018, the P&P indicated nails care included daily cleaning and regular trimming. The P&P indicated proper nail care aid in prevention of skin problems around the nail bed and to prevent infections.

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	056415	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

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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 observation, interview, and record review, the facility failed to ensure there were bilateral floor mats to the left and right side of the bed and ensure two intravenous (IV, into a vein) needles were properly disposed of for two of 12 sampled residents (Residents 13 and 2). These deficient practices placed Resident 13 at risk for injury, and the potential for unsafe handling of blood-contaminated sharps (devices with sharp points or edges designed to puncture or cut skin), with the potential for accidental needlestick injuries, and serious harm to Resident 2.Findings: a. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included dementia (a progressive state of decline in mental abilities), syncope (passing out), and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 13's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 13 was dependent (helper does all of the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 13's care plan titled The resident is at risk for falls with injury., dated 2/7/2025, the care plan indicated staff were to follow the facility's fall precaution protocol. During a review of Resident 13's physician order, dated 11/3/2025, the physician order indicated to apply bilateral floor mats for fall precaution. During an observation on 4/20/2026 at 9:30 a.m., and 2:13 p.m., at Resident 13's bedside, Resident 13 was observed lying in bed. A floor mat was observed on the right side of Resident 13's bed. There was no floor mat observed on the left side of Resident 13's bed. During an observation on 4/21/2026 at 12:41 p.m., at Resident 13's bedside, Resident 13 was observed lying in bed. A floor mat was observed on the right side of Resident 13's bed. There was no floor mat observed on the left side of Resident 13's bed. During a concurrent observation and interview on 4/22/2026 at 11:24 a.m., at Resident 13's bed side, with the Director of Nursing (DON), Resident 13 was observed lying in bed. A floor mat was observed on the left side of the bed. The DON stated there was no floor mat to the right side of Resident 13's bed. The DON stated Resident 13 was at risk for falls and required interventions to reduce the risk of injury. The DON stated Resident 13 could sustain injuries, including bruising, skin tears, pain or fracture, if the resident were to fall onto the floor without a floor mat in place. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, managing, revised 2/7/2024, the P&P indicated the nursing staff would identify interventions for each resident's risks to prevent falls and reduce complications. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted on [DATE] and re-admitted on [DATE]. Resident 2 diagnoses included muscle (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness, dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD- a condition in which stomach acid flows back into the esophagus causing heartburn), protein calorie malnutrition, and type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar). During a review of Resident 2's History and Physical (H&P), dated 4/17/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 was dependent on staff with ADLs. During a concurrent observation and interview on 4/20/2026 at 9:35 a.m., Resident 2 was observed lying in bed under a blanket. Two used intravenous (IV) starter needles containing visible blood were observed on top of the blanket. Resident 2 stated that a nurse had come in earlier that morning to start an IV. Resident 2 stated she was unaware that the used needles had been left on top of her blanket. Resident 2 stated that the dirty needles should have been thrown away and not left on top of her. During a concurrent observation and interview on 4/20/2026 at 9:38 a.m., inside Resident 2's room, with Registered Nurse (RN) 2, the two IV needles were observed on top of Resident 2. RN 2 stated that under no circumstances, the used needles should not have been left on top of Resident 2. RN 2 stated that it was the responsibility of the licensed nurse performing the procedure to ensure all used sharps were immediately and properly disposed of in an approved sharps container upon completion of the IV insertion. RN 2 stated that the IV was initiated by a contracted IV specialist, and that the specialist left the used needles behind instead of disposing of them appropriately. RN 2 stated that leaving contaminated sharps in the resident's immediate environment was not consistent with infection control practices or facility expectations and presents a potential safety risk, including exposure to bloodborne pathogens and risk of accidental injury to the resident or staff. During an interview on 4/22/2026 at 11:22 a.m., with the Director of Nursing (DON), the DON stated that under no circumstances should used needles be left in a resident's immediate environment. The DON stated that all used sharps must be immediately and safely disposed of in an approved sharps container by the licensed nurse or healthcare professional performing the procedure once completed. The DON stated that the IV was initiated by a contracted IV specialist who reportedly failed to properly dispose of the used needles and left them on top of Resident 2's blanket. The DON indicated that this practice is unacceptable, not consistent with facility infection control protocols, and represents a serious breach in standard precautions. The DON stated that leaving contaminated sharps within a resident's bed area placed the resident at risk for potential exposure to bloodborne pathogens and created an immediate safety hazard for both the resident and staff. The DON stated that the facility's expectations included ensuring all contracted clinical staff followed facility policies regarding infection control and sharps disposal. During a review of the facility's P&P, titled Waste Disposal dated 1/2012, the P&P indicated Disposal of all infectious and regulated waste shall be in accordance with applicable federal, state, and local regulations. Immediately after use, sharps shall be disposed of in closable, puncture resistant, disposable containers that are leak-proof on the sides and bottom and are labeled or color-coded. These containers shall be easily accessible to personnel and located in the immediate area of use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P, titled Peripheral IV Catheter Insertion dated 2/2022, the P&P indicated Discard stylet and syringes in sharps container.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nutritional supplements, as ordered, to two of three sampled residents (Resident 41). This deficient practice placed Resident 41 at risk of not receiving her required amount of calories, protein, and other nutrients, increasing her risk for weight loss and other complications related to malnutrition.Findings: During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was originally admitted to the facility on [DATE]. Resident 41's diagnoses included dysphagia (difficulty swallowing), moderate protein-calorie malnutrition, cachexia (a condition that causes significant weight loss and muscle loss), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 41 did not have cognitive impairments (ability to think and reason). The MDS indicated Resident 41 required set-up/clean-up assistance from staff to eat. The MDS indicated Resident 41 sustained weight loss in the last six months. During a review of Resident 41's care plan titled Resident is at risk for potential nutrition problem, created 4/6/2022 and revised 3/5/2026, the care plan indicated Resident 41's goal of care included consumption of 100 percent (%) of her supplements. The care plan indicated staff were to provide and serve Resident 41's supplements as ordered. a. During a review of Resident 41's physician order, dated 1/31/2026, the order indicated that starting on 2/1/2026, staff were to provide Resident 41 with a Magic Cup/Nutritional Treat (a high-calorie, high-protein nutritional supplements with 290 calories, 9 grams of protein, and more than 20 vitamins, designed to fight malnutrition or those with involuntary weight loss) twice a day with lunch and dinner. During an observation on 4/21/2026 at 12:57 p.m., at Resident 41's bedside, Resident 41's lunch tray was observed. There was no Magic Cup or other substitute nutritional supplement observed. During an interview on 4/21/2026 at 1:23 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 41 did not receive her Magic Cup, as ordered, as part of her lunch tray. b. During a review of Resident 41's physician order, dated 3/5/2026, the order indicated staff were to provide Resident 41 with a sugar-free high protein nourishment, three times a day, at 10:00 a.m., 2:00 p.m., and at bedtime. During a concurrent observation and interview on 4/22/2026 at 10:27 a.m., at Resident 41's bedside, Resident 41's bedside was observed. No supplements or snacks were observed on Resident 41's bedside table, in the bed, or on her bedside dresser. Resident 41 stated she did not receive a snack or supplement that morning. During an interview on 4/22/2026 at 10:30 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated she was responsible for distributing the 10:00 a.m. nourishments. CNA 3 stated she did not provide a 10:00 a.m. nourishment to Resident 41. During an interview on 4/22/2026 at 2:47 p.m., with the Registered Dietician (RD), the RD stated the kitchen was experiencing issues with the software that printed the tray tickets (a printed document, often computerized, that outlines a resident's specific diet order, food preferences, allergies, and adaptive equipment needed for a meal). The RD stated tray tickets were transcribed by hand due to the software issue, which could have resulted in Resident 41's Magic Cup not being included with her lunch tray. The RD stated the kitchen also had a delayed delivery of sugar-free nourishment shakes, which were ordered for Resident 41. The RD stated she approved Resident 41 to receive a regular shake instead, to ensure she received a 10:00 a.m. supplement. The RD stated the Magic Cup and sugar-free nourishment provided Resident 41 with additional protein and calories, and stated the expectation was for Resident 41 to receive her supplements as ordered. The RD stated missed supplements could increase Resident 41's potential for weight loss and/or malnutrition. During a review of the facility's policy and procedure (P&P) titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, revised 9/2017, the P&P indicated the staff and physician were to identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 demonstrated appropriate medication administration, documentation, and communication with the healthcare team, and failed to ensure licensed nursing staff used warm purified water when flushing (a medical procedure using a sterile sodium chloride [saline, salt and water] solution to clear, maintain, and prevent blockage in intravenous [IV- in a vein] catheters) a gastrostomy (G-tube- medical device inserted through the abdominal wall into the stomach to deliver nutrition, fluids, and medications directly, bypassing the mouth and esophagus) for two of six sampled residents (Resident 57 and Resident 2). This deficient practice did not respect Resident 57's right to be informed of and be involved in the care he was receiving. This deficient practice also had potential to negatively impact Resident 57's care from missed medications and inaccurate medical records and communication amongst his care team. This deficient practice also had the potential to place Resident 2 at risk for adverse outcomes, including inappropriate flushing practices, infection, and compromised G-tube function, and demonstrated a failure to ensure safe and appropriate care in accordance with established protocols.Findings: a. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included depression (mental mood disorder characterized by a persistent feeling of sadness, loss of interest in activities, and low energy), type 2 diabetes mellitus (DM II, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN, high blood pressure), hyperlipidemia (an excess of fats in the blood that increases risk of heart attack and stroke), benign prostatic hyperplasia (BPH, a non-cancerous, age-related enlargement of the prostate gland), a broken left leg bone, and muscle wasting and atrophy (the wasting, decrease in size, or physiological degeneration of cells, tissues, or organs, often resulting from disease, nerve damage, or lack of physical use). During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 57 had moderate cognitive impairment (problems with memory, language or judgment). The MDS indicated Resident 57 did not have disorganized thinking (e.g., unclear or illogical flow of ideas) or an acute change in mental status. The MDS indicated Resident 57 required set-up/clean-up assistance from staff to eat and drink. During an observation on 4/23/2026 at 8:15 a.m., outside of Resident 57's room, Licensed Vocational Nurse (LVN) 2 dispensed the following medications from Medication Cart 1 into a medication cup (a small, 1-ounce-sized container designed for safe, accurate dispensing of liquid or pill medication), totaling 10 tablets and/or capsules: Amlodipine (an anti-HTN medication).Aspirin chewable (a medication to reduce the risk of heart attacks or strokes by preventing blood clots).Docusate sodium (a stool softener).Apixaban (a medication used to reduce the risk of stroke and blood clots).Losartan potassium (an anti-HTN medication).Duloxetine hydrochloride (a medication to treat depression).Metformin (a medication to treat DM II).Finasteride (a medication to treat BPH).Multivitamin with minerals.Vitamin D3 (Cholecalciferol, crucial nutrient that enhances calcium absorption for strong bones and boosts muscle health). During an observation on 4/23/2026 at 8:28 a.m., at Resident 57's bedside, observed LVN 2 use a plastic spoon to collect three tablets from the medication cup, then brought the spoon to Resident 57's mouth. LVN 2 did not inform Resident 57 of what the three tablets were. Resident 57 took the three tablets with water. LVN 2 used the plastic spoon to collect three more tablets from the medication cup and Resident 57 stated he did not want any more medications. LVN 2 told Resident 57, You have to take your medicine, and brought the plastic spoon back to Resident 57's mouth. Resident 57 declined the medication. LVN 2 offered to administer the remaining medication with chocolate pudding, and Resident 57 stated he would like the pudding, but did not want the medication. LVN 2 did not inform Resident 57 what the seven remaining (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications were or the risks of refusing to take them. During an observation on 4/23/2026 at 8:34 a.m., LVN 2 exited Resident 57's room with the medication cup containing five (5) tablets and two (2) capsules. During an interview on 4/23/2026 at 8:35 a.m., with LVN 2, LVN 2 stated she did not know which three medications she administered and did not know which seven medications remained in the medication cup. LVN 2 stated she did not inform Resident 57 of the medications she administered, or of the names, risks, and/or benefits of the medications he refused. LVN 2 stated she could not explain the risks and/or benefits of the medications because she could not identify each capsule or tablet by their appearance once placed in the medication cup. LVN 2 stated she would need to compare the remaining five (5) tablets and two (2) capsules to Resident 57's blister packs (organized, sealed pharmacy packaging that sorts pills by day and time), and Medication Cart 1's multi-dose bottles of aspirin, multivitamin with minerals, and vitamin D3, to identify what was refused. During a review of Resident 57's Electronic Medication Administration (EMAR) Medication Administration Notes, dated 4/23/2026 from 8:32 a.m. to 8:52 am., the notes indicated LVN 2 explained the risks and benefits for the seven medications Resident 57 refused. The notes indicated Resident 57 refused the following seven (7) medications: Duloxetine hydrochloride 30 milligrams (mg, a unit of dose measurement).Docusate sodium 100 mg.Metformin 850 mg.Losartan potassium 50 mg.Apixaban 5 mg.Amlodipine 10 mg.Aspirin 81 mg. During an observation on 4/23/2026 at 9:09 a.m., at Nurse's Station 1, LVN 2 was observed calling Nurse Practitioner (NP) 1, the advanced practice provider (APP, healthcare professionals who are not physicians but perform similar duties, such as diagnosing, treating, and prescribing medication) for Resident 57's primary physician. LVN 2 told NP 1 that Resident 57 was educated on the risks and benefits of seven medication the residents refused. During a review of Resident 57's progress note, dated 4/23/2026 at 9:14 a.m., documented by LVN 2, the progress note indicated Resident 57 refused his medication. The progress note indicated LVN 2 offered the medication three times and explained the risks and benefits but Resident 57 continued to refuse. The progress note indicated LVN 2 explained what the medications indicated use were. During an interview on 4/23/2026 at 11:17 a.m., with LVN 2, LVN 2 stated Resident 57 was not informed of the medications during administration. LVN 2 stated Resident 57 was not provided with the opportunity to make an informed decision to accept or refuse the medications. LVN 2 stated that her progress notes and communication with NP 1 did not accurately reflect the care provided. During an interview on 4/23/2026 at 2:17 p.m., with the Director of Nursing (DON), the DON stated LVN 2 was to separate each of Resident 57's medications into a separate medication cup to make them easier to identify during the medication administration process. The DON stated LVN 2 was to identify each medication and explain its indication to Resident 57 prior to administration. The DON stated that if Resident 57 refused the medication, LVN 2 was responsible for explaining the benefits of the medication, and the risks associated with refusal. The DON stated LVN 2's documentation of the medication administration process should reflect the care provided. The DON stated care that was not provided should not be documented as done. During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 2/2023, the P&P indicated staff were to ensure residents' rights were guaranteed, including their right to be informed of their care planning and treatment, and be supported by the facility in exercising their rights. During a review of the facility's P&P titled Administering Medications, revised 4/2023, the P&P indicated medications were to be administered in a safe and timely manner, and as prescribed. During a review of the facility's job description for Charge Nurse (LVN), undated, the job description indicated the LVN was required to chart nurse's notes in an informative and descriptive manner that reflects the care provided to the residents, as well as the resident's response to the care. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2's diagnoses included muscle weakness, dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD- a condition in which stomach acid flows back into esophagus causing heartburn), protein calorie malnutrition, and type 2 diabetes (a chronic (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition where the body resists insulin or fails to produce enough, causing high blood sugar). During a review of Resident 2's History and Physical (H&P), dated 4/17/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making (the ability to think and process information) was moderately impaired. The MDS indicated Resident 2 was dependent on staff for assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's Physician Order dated 4/16/2026, the order indicated to flush Resident 2's tube feeding with 30 milliliter (ml- a metric unit of volume) before and after medication. During a concurrent observation and interview on 4/20/2026 at 10:28 a.m., with Registered Nurse (RN) 2, in Resident 2's room, observed Resident 2 lying in bed. A saline flush was observed connected to the Lopez valve (a three-way stopcock device attached to the G-tube to manage feeding, medication administration, and gastric decompression securely) of the G-tube. RN 2 stated that the saline flush should not be attached to Resident 2's G-tube. RN 2 stated that using a saline flush to irrigate the G-tube following feedings or medication administration was not in accordance with facility protocol. During an interview on 4/23/2026 at 3:26 p.m., with the DON, the DON stated that facility protocol required staff to flush G-tubes with the appropriate prescribed solution, typically (water), before and after feedings and medication administration to maintain tube patency and reduce the risk of complications. The DON stated that attaching a saline flush to the G-tube and utilizing it for routine flushing was not in accordance with facility policy or accepted standards of nursing practice. The DON stated that nursing staff were expected to follow physician orders and established protocols when performing G-tube care, and that deviation from these practices could place the residents at risk for adverse outcomes, including irritation, infection, and improper tube function. During a review of the facility's P&P, titled Administering Medications through an Enteral Tube dated 11/2018, the P&P indicated Use warm purified water for diluting medications and for flushing.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Hydrocodone-Acetaminophen (a medication used to treat pain) was administered according to the physician ordered parameters (specific, measurable, and objective clinical criteria set by a healthcare provider that dictate when a medication should be given, withheld, or adjusted) for one of six sampled residents (Resident 7). This deficient practice resulted in Resident 7 receiving Hydrocodone-Acetaminophen outside the physician-ordered parameter and had the potential for unnecessary opioid (narcotics, medications prescribed by doctors to treat persistent or severe pain) use, adverse medication effects, oversedation (when a patient receives an excessive amount of sedative agents, resulting in a deeper level of consciousness than intended), respiratory depression (when you breathe too slowly or too shallowly), constipation (occurs when your bowel movements become less frequent and stools become difficult to pass), and medication-related harm. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7 diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), gout (joint pain), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and end stage renal disease (ESRD- irreversible kidney failure). During a review of Resident 7's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 7's cognition (the ability to think and process information) was intact. The MDS indicated Resident 7 was independent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 7's care plan titled Pain, revised 7/11/2025, the care plan indicated to administer Hydrocodone-Acetaminophen as ordered by the physician. During a review of Resident 7's physician order, dated 3/30/2026, the physician order indicated to administer Hydrocodone-Acetaminophen 5-325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth every eight (8) hours as needed for severe pain of 7-10 on a pain scale (pain scale 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-10= severe pain). During a concurrent interview and record review on 4/22/2026 at 10:47 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 7's Medication Administration Record (MAR), dated 4/1/2026 through 4/22/2026, was reviewed. The MAR indicated Resident 7 was administered Hydrocodone-Acetaminophen 5-325 mg for the following pain levels on the following dates:4/2/2026- pain level of 5 out of ten.4/4/2026- pain level of 6 out of ten.4/5/2026- pain level of 6 out of ten.4/6/2026- pain level of 6 out of ten.4/9/2026- pain level of 6 out of ten.4/10/2026- pain level of 6 out of ten. 4/14/2026- pain level of 6 out of ten.4/15/2026- pain level of 5 out of ten.4/16/2026- pain level of 5 out of ten.4/17/2026- pain level of 6 out of ten.4/19/2026- pain level of 5 out of ten.4/18/2026- pain level of 5 out of ten.4/20/2026- pain level of 6 out of ten.4/21/2026- pain level of 5 out of ten.4/22/2026- pain level of 6 out of ten. LVN 1 stated Hydrocodone-Acetaminophen should be administered according to the physician's order and within the ordered parameters. LVN 1 stated Hydrocodone-Acetaminophen was administered when Resident 7's documented pain level did not meet the ordered parameters for severe pain. LVN 1 stated this placed Resident 7 at risk for unnecessary opioid use, overdose, adverse medication effects, and medication related harm. During an interview on 4/22/2026 at 11:22 a.m., with the Director of Nursing (DON), the DON stated Hydrocodone-Acetaminophen was administered when Resident 7's pain level was less than 7-10, which was outside the ordered parameters. The DON stated that administering Hydrocodone-Acetaminophen outside the ordered parameters was not consistent with the physician's order and resulted in unnecessary administration of opioid pain medication. The DON stated this placed Resident 7 at risk for unnecessary opioid exposure, oversedation, confusion, and adverse medication effects. During a review of the facility's policy and procedure (P&P) titled Administering Medications, revised 4/2023, the P&P indicated medications were to be administered in accordance with the physician's orders.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (%) for one of five randomly selected residents. The outcome was ten (10) medication errors out of 29 opportunities for errors, resulting in an observed medication administration error rate of 34.48%.Findings: During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included depression (mental mood disorder characterized by a persistent feeling of sadness, loss of interest in activities, and low energy), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN, high blood pressure), hyperlipidemia (an excess of fats in the blood that increases risk of heart attack and stroke), benign prostatic hyperplasia (BPH, a non-cancerous, age-related enlargement of the prostate gland), a broken left leg bone, and muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue). During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 57 had moderate cognitive impairment (problems with memory, language or judgment). The MDS indicated Resident 57 did not have disorganized thinking (e.g., unclear or illogical flow of ideas) or an acute change in mental status. The MDS indicated Resident 57 required set-up/clean-up assistance from staff to eat and drink. During an observation on 4/23/2026 at 8:15 a.m., outside of Resident 57's room, Licensed Vocational Nurse (LVN) 2 dispensed the following medications from Medication Cart 1 into a medication cup (a small, 1-ounce-sized container designed for safe, accurate dispensing of liquid or pill medication), totaling 10 tablets and/or capsules: Amlodipine (an anti-HTN medication).Aspirin chewable (a medication to reduce the risk of heart attacks or strokes by preventing blood clots).Docusate sodium (a stool softener).Apixaban (a medication used to reduce the risk of stroke and blood clots).Losartan potassium (an anti-HTN medication).Duloxetine hydrochloride (a medication to treat depression).Metformin (a medication to treat DM II).Finasteride (a medication to treat BPH).Multivitamin with minerals.Vitamin D3 (Cholecalciferol, crucial nutrient that enhances calcium absorption for strong bones and boosts muscle health). During an observation on 4/23/2026 at 8:28 a.m., at Resident 57's bedside, observed LVN 2 use a plastic spoon to collect three tablets from the medication cup, then brought the spoon to Resident 57's mouth. LVN 2 did not inform Resident 57 of what the three tablets were. Resident 57 took the three tablets with water. LVN 2 used the plastic spoon to collect three more tablets from the medication cup. Resident 57 stated he did not want any more medications. LVN 2 told Resident 57, You have to take your medicine, and brought the plastic spoon back to Resident 57's mouth. Resident 57 declined the medication. LVN 2 offered to administer the remaining medication with chocolate pudding. Resident 57 stated he would like the pudding but did not want the medication. LVN 2 did not inform Resident 57 what the seven remaining medications were or the risks of refusing to take them. During an observation on 4/23/2026 at 8:34 a.m., LVN 2 exited Resident 57's room with the medication cup containing five (5) tablets and two (2) capsules. During an interview on 4/23/2026 at 8:35 a.m., with LVN 2, LVN 2 stated she did not know which three medications she administered to Resident 57 and did not know which seven medications remained in the medication cup. LVN 2 stated she would needed to compare the remaining five (5) tablets and two (2) capsules to Resident 57's blister packs (organized, sealed pharmacy packaging that sorts pills by day and time), and Medication Cart 1's multi-dose bottles of aspirin, multivitamin with minerals, and vitamin D3, to identify which medications Resident 57 refused. LVN 2 stated she did not inform Resident 57 of what medications were administered. LVN 2 stated she did not inform Resident 57 of the names, risks, and/or benefits of the medications he refused. During a review of Resident 57's Electronic Medication Administration (EMAR) Medication Administration Notes, dated 4/23/2026 from 8:32 a.m. to 8:52 am., the notes indicated Resident 57 refused the following seven (7) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications: Duloxetine hydrochloride, 30 milligrams (mg, a unit of dose measurement), for depression.Docusate sodium, 100 mg, for constipation.Metformin, 850 mg, for DM.Losartan potassium, 50 mg, for HTN.Apixaban, 5 mg, for prevention of blood clots.Amlodipine, 10 mg, for HTN.Aspirin, 81 mg, for prevention of cerebrovascular accident (CVA, loss of blood flow to a part of the brain). The notes indicated LVN 2 explained risks and benefits for all seven medications, and that [Resident 57] still refused. During an interview on 4/23/2026 at 11:17 a.m., with LVN 2, LVN 2 stated staff were to inform the resident of what medications they were receiving when administering medications. LVN 2 stated it was the resident's right to be informed of the medications they were receiving. LVN 2 stated Resident 57 was not adequately informed of the medications she administered, or of the medications he refused. LVN 2 stated Resident 57 was not provided with the opportunity to make an informed decision to accept or refuse the medications. During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 2/2023, the P&P indicated staff were to ensure residents' rights were guaranteed, including their right to be informed of their care planning and treatment, and be supported by the facility in exercising their rights. During a review of the facility's P&P titled Administering Medications, revised 4/2023, the P&P indicated medications were to be administered in a safe and timely manner, and as prescribed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food properly in the kitchen when one bag of hamburger buns, two bags of wheat bread, ground Italian seasoning, plain salt, soy sauce, and powdered thickener were unlabeled and undated. This deficient practice had the potential to place the residents at risk for foodborne illness (is a sickness caused by eating that has harmful bacteria) or contamination (harmful germs get in food and unsafe to eat). Findings: During an observation on 4/20/2026 at 8:21 a.m. and at 11:53 a.m., in the facility kitchen, observed one bag of hamburger buns and two bags of wheat bread were observed open, unlabeled, and undated. Ground Italian seasoning, plain salt, soy sauce and powdered thickener were observed unlabeled and undated. During a concurrent observation and interview on 4/20/2026 at 12:10 p.m., with Dietary Aide (DA) 1, DA 1 stated the hamburger buns, two bags of wheat bread, ground Italian seasoning, plain salt, soy sauce, and powdered thickener were improperly stored. DA 1 stated that proper labeling and dating were important to prevent foodborne illness among residents. During an interview on 4/21/2026 at 10:22 a.m. with the Registered Dietician (RD), the RD stated unlabeled and undated or poorly stored food may lead to salmonella (a type of bacteria (germ) that causes a common foodborne infection known as salmonellosis) in residents. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised 11/2022, the P&P indicated, the facility dry food storage follows safe handling practices, with all items labeled and dated.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure two large trash containers located in the kitchen were maintained in a closed position. This deficient practice had the potential to contribute to environmental contamination, pest infestation, odors and unsanitary conditions that could negatively impact the health and safety of residents, staff, and visitors.Findings: During an observation on 4/20/2026 at 8:15 a.m. and at 12:02 p.m., in the facility kitchen, observed two large trash containers uncovered. The trash containers were filled to capacity with open fruit cans, empty bottles, soiled paper towels and wet meat bags. During a concurrent observation and interview on 4/20/2026 at 12:06 p.m. with Dietary Aide (DA 1), in the kitchen, two large trash containers were observed uncovered. DA 1 stated kitchen trash containers must remain closed when not in use at all times to prevent pests and to keep the facility safe. During an interview on 4/21/2026 at 10:22 a.m. with the Registered Dietician (RD), the RD stated open trash cans in the kitchen could attract pests, promote bacterial growth, and increase risk of cross contamination that could lead to foodborne illness among residents with low immune systems (is a body defense that fights germs). During an interview on 4/22/2026 at 3:02 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated trash bins must stay closed at all times to prevent pests and germs. During a review of the facility's policy and procedure (P&P) titled Waste Disposal, revised 1/2012, the P&P indicated the facility regulated waste disposal shall be placed in closable leak proof containers to ensure waste was properly disposed. The P&P indicated waste containers should be replaced routinely and not allowed to overfill.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) documentation was maintained and readily available in the resident's medical record for review for two of six sampled residents (Residents 1 and 8). This deficient practice resulted in incomplete medical records for Residents 1 and 8 and limited access to required PASRR documentation. Findings: a. 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 depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of worry, nervousness). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 1's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review on 4/21/2026 at 2:00 p.m., in the presence of the MDS Nurse (MDSN), Resident 1's medical record was reviewed. Resident 1's records did not include evidence that the PASAR Level I screening, and Level II determination, was maintained and readily available for review. b. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 8's diagnoses included depression. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decision making was intact. The MDS indicated Resident 8 required moderate (helper does less than half the effort) assistance from staff for ADLs. During a concurrent interview and record review on 4/21/2026 at 2:20 p.m., with the MDSN, Resident 8's medical record was reviewed. The MDSN stated Resident 8's medical record did not include evidence that PASRR Level I, and Level II determination, was maintained and available for review. During an interview on 4/21/2026 at 2:59 p.m., with the MDSN, the MDSN stated PASRR documentation should be maintained in the resident's record and available upon request. The MDSN stated he was responsible for maintaining complete resident record and ensuring required documents, including PASRR information, was available in the resident's medical record. The MDSN stated the facility failed to ensure Residents 1 and 8's record contained readily available PASRR documentation. The MDSN stated this resulting in an incomplete medical record and limited the facility's ability to readily verify that required PASRR documentation was maintained and available for review. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation, revised 7/2017, the P&P indicated the resident's medical, physical, functional or psychological condition shall be documented in the resident's medical record. The P&P indicated resident's medical record will be complete and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the required personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) was worn while providing high-contact care to three of five sampled residents (Resident 6, Resident 94, and Resident 103) on enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs]). This deficient practice increased the potential for spread of infection to Residents 6, 94, and 103.Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's diagnoses included immunodeficiency (a state where the immune system's ability to fight infectious diseases and cancer is compromised or absent) due to drugs, presence of a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), muscle wasting and atrophy (the wasting away or decrease in size of a body part, tissue, or organ, resulting from disease, malnutrition, disuse, or hormonal changes), and generalized muscle weakness. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 6 had moderately impaired cognitive skills for daily decision making (noticeable declines in memory, language, or thinking abilities that exceed age-related norms). The MDS indicated Resident 6 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 6's care plan titled Resident requires enhanced barrier precautions (EBP) related to the use of tube feeding, dated 3/30/2026, the care plan indicated staff were to wear a gown and gloves during high contact resident care activities, including dressing and hygiene, to prevent development of a multidrug-resistant organisms (MDRO)-related infection. During an observation on 4/20/2026 at 8:52 a.m., outside of Resident 6's room, observed signage posted informing staff and visitors of the need to wear a gown and gloves during high-contact resident care activities. There was a blue, circular shaped sticker next to Resident 6's name on the nameplate outside of the room. There was a cart stocked with disposable gowns and gloves. During an observation on 4/20/2026 at 9:18 a.m., at Resident 6's bedside, Certified Nursing Assistant (CNA) 2 was observed placing a basin of water at Resident 6's bedside while wearing a pair of disposable gloves. CNA 2 stated she was going to perform a bed bath for Resident 6. CNA 2 closed Resident 6's privacy curtain and started Resident 6's bed bath. CNA 2 did not put on a disposable gown prior to beginning the bath. 2. During a review of Resident 94's admission Record, the admission Record indicated Resident 94 was originally admitted to the facility on [DATE]. Resident 94's diagnoses included muscle wasting and atrophy, generalized muscle weakness, and dementia (a progressive state of decline in mental abilities). During a review of Resident 94's MDS, dated [DATE], the MDS indicated Resident 94 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 94 was dependent on staff for lower body dressing, and substantial to maximal assistance from staff for rolling from left to right in bed. During a review of Resident 94's care plan titled Resident requires EBP related to infection or colonization with multi-drug-resistant organism ESBL-producing Enterobacterales, dated 2/5/2026, staff were to wear a gown and gloves during high contact resident care activities, including dressing and linen changes. During an observation on 4/20/2026 at 10:59 a.m., at Resident 94's bedside, CNA 7 and a second unidentified CNA were observed performing a linen change for Resident 94. The two CNAs removed Resident 94's pants, repositioned him in bed, and assisted Resident 94 to put on a new pair of pants. Neither CNA was wearing a disposable gown. 3. During a review of Resident 103's admission Record, the admission Record indicated Resident 103 was admitted to the facility on [DATE]. Resident 103's diagnoses included dysphagia (difficulty swallowing) with gastrostomy. During a review of Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	103's MDS, dated [DATE], the MDS indicated Resident 103 had severely impaired cognition. The MDS indicated Resident 103 was fully dependent on staff for all ADLs. During a review of Resident 103's care plan titled At risk for MDRO colonization [due to] the use of indwelling device (feeding tube), dated 3/20/2025, the care plan indicated staff were to wear appropriate PPE during high contact care. During a review of Resident 103's care plan titled The resident has impaired immunity related to: presence of indwelling medical device - [gastrostomy tube], dated 8/8/2025, the care plan indicated staff were to implement enhanced barrier precautions. During an observation on 4/21/2026 12:44 p.m., at Resident 103's bedside, Licensed Vocational Nurse (LVN) 1 checked Resident 103's gastrostomy tube placement and administered medications while wearing disposable gloves and no gown. During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, dated 4/2024, the P&P indicated staff were to implement targeted gown and glove use during high contact resident care activities. During a review of the facility's P&P titled Administering Medications, revised 4/2023, the P&P indicated staff were to follow established facility infection control procedures for the administration of medications, as applicable.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was easily accessible for one of six sampled residents (Resident 40), who had left-sided weakness. This deficient practice placed Resident 40 at risk for unmet care needs, delayed staff response, falls, injury, and inability to request assistance when needed. Findings: During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left side of the body and cortical blindness (a neurological vision impairment). During a review of Resident 40's Minimum Data Set (MDS- a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 40's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 40's care plan titled ADLs Self-Care and Mobility Deficit, dated 4/7/2021, the care plan indicated Resident 40 had impaired function and mobility and required assistance with ADLs. The care plan indicated staff would ensure Resident 40's call light was within reach and available for the resident to use when assistance was needed. During an observation on 4/20/2026 at 9:50 a.m., at Resident 40's bedside, Resident 40 was observed lying in bed. A call light was attached to the left side of the bed. The call light was not within Resident 40's reach. During a concurrent observation and interview on 4/21/2026 at 9:05 a.m., in Resident 40's room, Resident 40 was observed lying in bed. The call light was placed on the left side of Resident 40's bed out of reach. Resident 40 was calling out help, help, help'. Resident 40 stated he could not reach or activate the call light and needed staff assistance for pain medication. Resident 40 stated he could not activate the call light with his left hand. Resident 40 stated he used the right hand more effectively due to left-sided weakness. During a concurrent observation and interview on 4/23/2026 at 10:50 a.m., at Resident 40's bedside, with Licensed Vocational Nurse (LVN) 1, Resident 40's call light was observed on the resident's left side and out of reach. LVN 1 stated Resident 40 had left-sided weakness and required the call light to be placed within reach on the resident's right, stronger side. LVN 1 stated if the call light was placed on the left side or not within reach, Resident 40 would not be able to use the call light to request staff assistance. LVN 1 stated staff were responsible for ensuring each resident's call light was accessible, within reach, and appropriate for the resident's physical limitations before leaving the resident's bedside. LVN 1 stated the call light should have been placed on Resident 40's right side so the resident could safely and effectively call for assistance. LVN 1 stated this placed Resident 40 at risk for potential delayed staff assistance, falls, injury, and pain. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, undated, the P&P indicated staff would ensure the resident's call light was within reach when the resident was in bed and ensure residents were able to use it.

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	04/23/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment when:1. The area around a circle floor drain cover in the hallway was cracked, uneven, and chipped with an irregular edge.2. There was no signage posted in a visible location, inside or outside of a resident room, to inform residents, staff, and visitors that oxygen was in use.These deficient practices placed the safety of all facility residents, staff, and visitors at risk due to trip hazards and potential fire hazard. Findings: a. During an observation on 4/20/2026 at 9:28 a.m., on 4/21/2026 at 1:18 p.m., and on 4/22/202 at 3:50 p.m., in the hallway by the kitchen door, a circle floor drain cover was observed cracked, uneven, and chipped with an irregular edge. During a concurrent observation and interview on 4/22/2026 at 3:56 p.m., with the Maintenance Supervisor (MS), in the hallway, observed the drain diameter measured 5.5 to 6 inches, with cracked flooring extending 0.5 to 1 inch outward from the edge. The MS stated cracked and uneven flooring near the drain posed a tripping risk for residents. The MS stated if the drain was not fixed quickly, the damage could worsen and lead to serious injury. The MS stated residents were at risk for trips, falls, and potential injury if the repairs were delayed. During an interview on 4/23/2026 at 8:55 a.m., with the Director of Nursing (DON), the DON stated uneven flooring could cause residents to trip and fall, leading to possible injuries such as bruises (mark on skin that turns purple or blue) or fractures (a break or crack in a bone). During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk Managing, revised 2/7/2024, the P&P indicated, environmental factors that increase the risk of falls include obstacles (things that block) in the walking path. b. During a review of Resident 99's admission Record, the admission Record indicated Resident 99 was originally admitted to the facility on [DATE]. Resident 99's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), acute (sudden) and chronic (long-term) respiratory failure with hypercapnia (a critical condition where the lungs cannot remove enough carbon dioxide from the blood through breathing). During a review of Resident 99's Minimum Data Set (MDS, a resident assessment tool), dated 4/9/2026, the MDS indicated Resident 99 had severely impaired cognitive skills for daily decision making (a profound loss of intellectual capacity that disrupts daily life, necessitating substantial supervision or care for safety and daily activities). The MDS indicated Resident 99 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 99 received continuous oxygen therapy. During an observation on 4/20/2026 at 8:52 a.m., outside of Resident 99's room, observed no oxygen signage posted outside of Resident 99's room. During an observation on 4/20/2026 at 9:12 a.m., in Resident 99's room, Resident 99 was observed asleep in bed. Resident 99 was receiving oxygen therapy via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at two (2) liters per minute (a (continued on next page)

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	056415	A. Building B. Wing	04/23/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit of measuring oxygen flow rate). There was no oxygen signage posted at Resident 99's bedside. During an observation on 4/20/2026 at 10:30 a.m., outside of Resident 99's room, observed no oxygen signage posted outside of Resident 99's room. During an interview on 4/22/2026 at 3:13 p.m., with the DON, the DON stated oxygen signage was to be posted for safety purposes due to the risk of fires related to the use of oxygen. During a review of the facility's P&P titled Oxygen Administration, revised 2/2024, the P&P indicated staff were to place no smoking signage on the outside of the room entrance door. The P&P indicated staff were to place an Oxygen in Use sign in a designated place on or over the resident's bed.

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	056415	A. Building B. Wing	04/23/2026

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the required room size measurement of 80 square feet ([sq. ft.])- a unit of measurement) of room space per resident in rooms with multiple residents. This deficient practice could potentially not provide residents with privacy and could potentially affect residents' health and safety.Findings: During a review of the facility's Census, dated 4/20/2026, the Census indicated two rooms (Rooms 3, and 4) had the capacity for four residents in each room. During observations made throughout the course of the survey from 4/20/2026 to 4/23/2026, there were no adverse effects that pertained to the residents' care provided by the facility staff, residents' privacy, health, and safety related to the provided living space of less than 80 square (sq.) feet (ft.) per resident. During a review of the facility's Client Accommodation Analysis form, dated 4/23/2026, the form indicated two rooms did not meet the 80 sq. ft. requirement. The form indicated rooms [ROOM NUMBERS] provided less than 80 sq. ft. per resident:room [ROOM NUMBER]: Measured 272 sq. ft.room [ROOM NUMBER]: Measured 272 sq. ft. During a facility tour observation and concurrent interview on 4/23/2026 at 11:25 a.m., with the Administrator (ADM), rooms [ROOM NUMBERS] were observed and reviewed. rooms [ROOM NUMBERS] had sufficient space for residents to move in and out of the rooms and there was space for the residents' beds, bedside tables, and care equipment. The ADM stated rooms [ROOM NUMBERS] measured less than 80 sq. ft. per resident. The ADM stated the reduced room size could create a risk of decreased space for residents, staff, and equipment, and could cause residents to feel uncomfortable if the rooms were not properly arranged and monitored. The ADM stated the facility would ensure that residents' health, safety, comfort and access to care were not adversely affected.