

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Granada Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3565 E Imperial Hwy 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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely develop a comprehensive care plan for one out of three sampled residents (Resident 1), who refused to wear a hearing aid (a small electronic device worn in or behind the ear to amplify [increase] sounds, designed to help people with hearing loss). This failure had the potential for miscommunication and Resident 1's needs not being met. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included systolic (congestive) heart failure ([CHF], a heart disorder that causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 1's care plan titled, Resident has difficulty hearing staff, dated 11/9/2022, the care plan indicated Resident 1 received hearing aids. The care plan goal indicated for Resident 1 to be able to hear effectively during conversation. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 6/2/2025, the MDS indicated Resident 1 had moderate cognitive (ability to think, remember and solve problems) impairment. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for Activities of Daily Living (ADLs) such as showering/bathing self and putting on/taking off footwear. The MDS indicated Resident 1 had minimal difficulty in hearing (in some environments such as when a person speaks softly or setting is noisy).During a concurrent observation and interview on 8/11/2025 at 10:20 a.m. with Resident 1 in Resident 1's room, Resident 1 stated, she could not hear and was observed not wearing hearing aids. During a concurrent observation and interview on 8/11/2025 at 10:36 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 1's room, CNA 1 was observed speaking directly into the resident's ear. CNA 1 stated, Resident 1 refused to wear her hearing aids. During an interview on 8/11/2025 at 2:46 p.m. with the Social Services Director (SSD), the SSD stated she offered Resident 1 hearing aids in the past and the resident refused to wear them. During a concurrent interview and record review on 8/12/2025 at 11:03 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 1's care plan titled, Resident has difficulty hearing staff, dated, 11/9/2022 was reviewed. LVN 2 stated that Resident 1 often refused to wear their hearing aid and communicated with Resident 1 by speaking closer to Resident 1's ear. LVN 2 stated that hearing aids were part of Resident 1's care and her refusal should have been care-planned when constant refusal was identified, however was not done.During an interview on 8/12/2025 at 2:41 p.m. with the Director of Nursing (DON), the DON stated, staff should have initiated a care plan to address Resident 1's refusal to wear her hearing aid when the problem was first identified. During a review of 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. The P&P also indicated, The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>(continued on next page)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Residents 1 and 2), received proper treatment and assistive devices to maintain hearing abilities by failing to: Assist Resident 1 when the resident reported her hearing aids did not work properly Assist Resident 2 when the resident reported he had concerns with hearing and ensure Resident 2 was assessed by the Otolaryngologist ([ENT doctor] specializing in the care for ear, nose and throat conditions) routinely. These failures had the potential for Residents 1 and 2 not being able to hear adequately during conversations with staff and other residents and could lead to misunderstanding or miscommunication between the residents and staff. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included systolic (congestive) heart failure ([CHF], a heart disorder that causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 1's care plan titled, Resident has difficulty hearing staff, dated 11/9/2022, the care plan indicated Resident 1 received hearing aids. The care plan goal indicated for Resident 1 to be able to hear effectively during conversation. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 6/2/2025, the MDS indicated Resident 1 had moderate cognitive (ability to think, remember and solve problems) impairment. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for Activities of Daily Living (ADLs) such as showering/bathing self and putting on/taking off footwear. The MDS indicated Resident 1 had minimal difficulty in hearing (in some environments such as when a person speaks softly or setting is noisy). During a concurrent observation and interview on 8/11/2025 at 10:20 a.m. with Resident 1 in Resident 1's room, Resident 1 stated, she could not hear and was observed not wearing hearing aids. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 2's diagnoses included metabolic encephalopathy (a change in the brain's function due to an underlying cause). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident did not have cognitive impairment. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steading and/or contact guard assistance) for ADLs such as bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed), and transfers. The MDS indicated Resident 2 had minimal difficulty in hearing and did not use a hearing aid or hearing appliance. During a concurrent observation and interview on 8/11/2025 at 11:49 a.m., with Resident 2 in Resident 2's room, Resident 2 stated, he couldn't hear as well as he used to and believed he needed hearing aids. Resident 2 stated he had informed the Social Services Director (SSD) (date/time not specified) of his concern regarding his hearing but had not received any follow-up. During a concurrent interview and record review on 8/12/2025 at 9:52 a.m., with Medical Records (MR), Resident 2's ENT Doctor exams were reviewed. MR stated Resident 2's most recent ENT exam was on 9/24/2024. During an interview on 8/12/2025 at 10:29 a.m. with Certified Nurse Assistant (CAN) 1, CNA 1 stated Resident 1 notified her that her hearing aids did not work and had informed Licensed Vocational Nurse (LVN) 2 and the SSD (date not specified). During an interview on 8/12/2025 at 11:03 a.m. with LVN 2, LVN 2 stated he was not aware of Resident 1's report that the resident's hearing aids did not work. LVN 2 stated Resident 1 was hard-of-hearing and had seen Resident 1 without her hearing aids and had to communicate with the resident by coming in closer while speaking with her. During a concurrent interview and record review on 8/12/2025 at 12:12 p.m., with the SSD, Resident 1's hearing exam, dated 5/18/2025, Resident 2's hearing exam, dated 9/25/2024, and Social Service Progress Notes for Resident 2 were reviewed. SSD stated all residents should be seen routinely by the ENT doctor every six months or at least twice a year. The SSD stated Resident 2 should have been seen by the ENT doctor on 05/2025 however the resident was not. The SSD also stated there was no documentation to indicate why Resident 2 was not seen by the ENT in 05/2025. The SSD stated there should have been documentation from Social Services to ensure Resident 2's hearing needs were assessed routinely. During an interview on 8/12/2025 at 2:24 p.m., with the Director of Nursing (DON), the DON stated CNAs should report and document any concerns with resident hearing devices as soon as they're identified so the resident's devices could be fixed as needed. During a review of facility's undated Job Description for Director of Social Services, the job description indicated, General Duties and Responsibilities</p>		