STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA POST-ACUTE CARE	3615 E. IMPERIAL HIWY , LYNWOOD, California, 90262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint Number: 2561849. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was written for the complaint: 2561849. See F842.	F0000	California Post-Acute Care submits this response and plan of correction as part of the requirements under State and Federal Law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if they are relied upon in a manner adverse to the interest of the governmental agencies or third parties for evaluation and appropriate treatment modalities.	7/28/25
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	A. How corrective actions will be accomplished for those residents found to be affected by the deficient practice? a) On 7/25/25, CNA 1's access to PointClickCare (PCC) was reviewed, and CNA1 PCC password was reset by the Administrator to ensure proper access to the electronic documentation system. b) On 7/28/25, CNA 1 documented Resident 5's food intake for all meals to ensure that current data was recorded. c) On 7/26/25, the Director of Nursing (DON) reviewed Resident 5's weights and there was no impact as a result of the documentation failure. d) On 7/25/2025, CNA 1 received a 1:1 in-service training on the importance of timely and accurate documentation of resident food intake after each meal. The training also emphasized the requirement to immediately notify a supervisor, the Director of Staff Development (DSD), or the Administrator if there are any access issues with the PCC system	

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 reverse for further 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
	Administrator	8/15/25

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F0842 SS = D	Continued from page 1 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a) All residents who were identified as having nutritional or weight related issues are at risk due to this deficient practice. b) The DON or Medical Records Director (MRD) conducted a facility-wide audit of oral intake documentation for all residents with nutritional risk or weight-related care plans was initiated on 7/25/25 and completed by 7/28/25. c) There were no additional residents identified with deficiencies related to the documentation of food intake. C. What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recure? a) On 7/28/25, mandatory re-education was provided to all CNAs, LVNs, and RNs on: The importance of accurate, timely documentation of oral intake. The requirement to report immediately if PCC access is unavailable or not functioning b) On 7/28/25, the Director of Staff Development (DSD) reviewed the PCC access status of all CNAs to identify and resolve any issues with login credentials or system access. c) The DON or Medical Records Director will perform random daily audits of oral intake documentation using audit tools for 10 residents daily x3 days, then weekly for 4 weeks, and monthly thereafter for 3 months. Any staff found not documenting resident food intake were immediately re-educated by the DSD or DON.	

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F0842 SS = D	Continued from page 2 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the nursing records were completely and accurately documented by failing to complete the oral intake for one of four residents (Resident 1). This deficient practice had the potential to result in lack of communication between staff and delay and interrupt the provision of care needed to maintain the residents' highest practicable, physical, mental and psychosocial well-being. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was initially admitted to the facility on 10/3/2024 and readmitted on 11/8/2024. Resident 5's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and anemia (a condition where the body did not have enough healthy red blood cells). During a review of Resident 5's History and Physical (H&P), dated 10/4/2024, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS- a mandated resident assessment tool), dated 4/11/2025, the MDS indicated Resident 5 had severe cognitive impairment. The MDS indicated Resident 5 required setup assistance from staff with chair/bed-to-chair transferring; supervision from staff with eating and walking; maximal assistance (helper did more than half the effort) from staff with oral hygiene; and was dependent (helper did all the effort) on staff with toileting hygiene, personal hygiene, and showering/ bathing self. During a review of Resident 5's care plan titled "The	F0842	D. How the facility plans to monitor its performance to make sure the solutions are sustained? a) All audit findings related to oral intake documentation and identified trends will be presented during the monthly QAPI meetings by the Facility Administrator, Director of Nursing (DON), and Medical Records. b) Any patterns of non-compliance will result in immediate corrective actions, including individual coaching, counseling, and re-training of involved staff. c) The QAPI Committee will continue to monitor oral intake documentation compliance for a period of 3 months, or until sustained compliance is achieved	

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F0842 SS = D	Continued from page 3 resident has nutritional problems or potential nutritional problems," dated 5/9/2025, the care plan goals indicated staff maintain adequate nutritional status for Resident 5 as evidenced by Resident 5 consuming at least 75 percent (%) of meals daily. The care plan interventions indicated to monitor, record, and report to the doctor signs and symptoms of malnutrition (lack of sufficient nutrients in the body). During an interview on 7/25/2025 at 10:39 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she did not document Resident 5's oral intake for breakfast nor lunch on 7/24/2025 because she did not have access to the charting system. During a concurrent interview and record review on 7/25/2025 at 12:34 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 5's care plan titled, "The resident has unplanned/ unexpected weight gain," dated 1/9/2025, was reviewed. LVN 1 stated the care plan interventions indicated the CNAs were to monitor and record food intake at each meal and CNAs should document the residents' oral intakes of each meal in the resident charts. LVN 1 stated staff would not know if the residents ate or if the residents had an eating problem if there were no notes documented in the residents' clinical record. During an interview on 7/25/2025 at 12:57 p.m. with the Director of Staff Development (DSD), the DSD stated CNAs should document the percentage the residents consumed after each meal. The DSD stated the purpose of documenting was to monitor the residents' weights and overall health. The DSD stated if the CNAs did not document the meal intakes, the staff would not be able to monitor the trend of the residents' oral intake nor the residents' weight loss and weight gain. The DSD stated if staff did not document, then there was no proof of staff doing the intervention. During a concurrent interview and record review on 7/25/2025 at 1:48 p.m. with the Assistant Director of Nursing (ADON), Resident 5's Nutrition Report, dated 7/25/2025, was reviewed. The report indicated, there was missing documentation on Resident 5's oral intakes for multiple days in 7/2025. The ADON stated, the CNA should document the meal percentage for residents each meal on the Point-of-Care (POC, CNA charting). The ADON stated the purpose of documenting was to monitor	F0842		

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F0842 SS = D	Continued from page 4 residents' oral intake and weights for possible dietary consultation. The ADON stated it was important for the staff to document oral intake percentage for Resident 5. The ADON stated not having access to the POC was not an excuse not to document Resident 5's oral intake percentage on 7/24/2025. During a review of the Job Description for CNA, revised on 10/19/2015, the Job Description indicated, CNA responsibilities included recording the resident's oral intake. During a review of the facility's policy and procedure (P&P) titled "Resident Nutritional Services," dated 4/2018, the P&P indicated, nursing staff would assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. During a review of the facility's P&P titled "Documentation guidelines," dated 11/2021, the P&P indicated, documentation is required for resident's condition and changes in the resident's condition. The P&P indicated, the facility should promptly record as the events or observations occur and be complete, concise, descriptive, factual, and accurately describe services provided to/for the residents.	F0842		