DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. BUILDING _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA POST ACUTE	909 S LAKE STREET LOS ANGELES, CA 90006

(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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health (Department) during investigation of one Complaint numbered CA00910322 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 identified for the complaint numbered CA00910322 (Refer to Ftag 745).	F 000	California Post Acute submits this response and plan of Correction as part of the requirements under the 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 employee, agents, officers, director, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. The facility desires that this plan of correction be considered the facility's allegation of compliance "Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law". F 745 Provision of Medically Related Social Service CFR(s): 483.40(d) Based on interview, and record review the facility failed to ensure arranging suitable and reliable transportation of the designated resident to and from the dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) center for one of three sampled residents (Resident 1).	
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to ensure arranging suitable and reliable transportation of the designated resident to and from the dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) center for one of three sampled residents (Resident 1). As a result, Resident 1 missed dialysis appointment on 6/25/24, 6/27/24,7/2/24 and family member (FM) had to call transportation to take Resident 1 back to the facility on 7/13/24. This deficient practice had the potential for Resident 1 to build up waste products inside the body, placing the resident at risk for hospital admission or even death.	F 745		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MAE YOUNG	DIRECTOR OF NURING	08/08/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. BUILDING _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA POST ACUTE	909 S LAKE STREET LOS ANGELES, CA 90006

(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
F 745	Continued From page 1 Findings: A review of the Admission Record indicated the facility admitted Resident 1 on 6/7/23 with diagnoses including end stage renal disease (kidneys no longer work to meet the body's need requiring a regular course of dialysis or kidney transplant) and dependence on renal dialysis. A review of the Physician Order dated 6/12/23 at 1:13 p.m., indicated an order for Resident 1 to go for dialysis on Tuesdays at 12:45 p.m., Thursdays at 12:45 p.m., and on Saturdays at 12:45 p.m. The Order indicated transportation would pick-up Resident 1 from the facility at 12 p.m. A review of Resident 1's Care Plan initiated on 7/3/23 indicated Resident 1 needs hemodialysis related to end stage renal disease. The care plan goal indicated Resident 1 would have no signs and symptoms of complications from dialysis. Interventions included Resident 1 receives dialysis three times a week on Tuesdays, Thursdays, and Saturdays. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool)dated 6/11/24 indicated Resident 1 was cognitively intact. Resident 1 needed moderate assistance (helper does less than half the effort) with shower, supervision with oral hygiene, toileting hygiene, upper/lower body dressing, putting on/taking off footwear, personal hygiene, and set-up with eating. A review of the Change of Condition (COC) dated 6/25/24 at 3:42 p.m., indicated on 6/25/24 at 12 p.m., Resident 1 was waiting for transportation to	F 745	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 8/8/2024, Resident 1 transportation and chair time (12:30 PM) was verified by the Social Services Director via phone conference for future dialysis appointments (Tuesday-Thursday -Saturday) pick up time of 11:50 AM and the return time of 4:15 PM. No other issues identified. 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: On 8/6-8/2024, the Quality Assurance Nurse/Designee reviewed and placed a call to Transportation Centers for all 6 residents with Dialysis Appointment, pick up time and return time. No other issues identified. On 8/8/2024, the Director of Nursing provided 1:1 Inservice to SSW (1) regarding Nursing Home Transfer Agreement signed by the facility administrator and the hemodialysis center regional operations director dated 7/11/23, indicated for transportation of designated resident, the facility shall have the responsibility for arranging suitable transportation of the designated resident to and from the center including selection of the mode of transportation, qualified personnel to accompany the designated resident and transportation equipment usually associated with this type of transfer including the use of appropriate life support measures in accordance with the applicable federal and state laws and regulations. Facility shall be responsible for ensuring that the designated resident is medically stable to undergo such transportation, shall be responsible for the designated resident during transfer to and from center, including medical and non-medical emergencies and shall be responsible for all costs of transportation associated with the transfer of the designated resident to and from center and facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. BUILDING _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA POST ACUTE	909 S LAKE STREET LOS ANGELES, CA 90006

(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
F 745	Continued From page 2 take her to dialysis center. Resident 1 continued to wait until 12:45 p.m. when the facility called the transportation company. The COC indicated the driver cancelled the schedule and the transportation company was unable to send another driver. The COC indicated Resident 1 missed the scheduled dialysis on 6/25/24. The dialysis center was notified to reschedule the dialysis for the next day, 6/26/24. A review of the COC dated 6/27/24 at 3:27 p.m., indicated Resident 1 missed the dialysis appointment for 6/27/24. The COC indicated Resident 1 was not ready when the transportation arrived at the facility to pick up Resident 1. At the time when Resident 1 was ready, the transportation left without taking Resident 1. The COC indicated the dialysis was rescheduled for the next day, 6/28/24. A review of the Nursing Progress Note dated 7/2/24 at 1:32 p.m., indicated on 7/2/24 at 11:30 a.m., Resident 1 was ready and waiting for the transportation to pick her up. The Notes indicated after an hour, the facility called the transportation company and " ...it was reported that the ride was cancelled, and they could send another ride " . Resident 1 had dialysis the next day 7/3/24. During an interview on 7/18/24 at 4:14 p.m., the social worker (SW 1) stated Resident 1 completed the dialysis on 7/13/24 but there was no transportation to take Resident 1 back to the facility. SW 1 stated Resident 1's FM was notified, and the FM had to call a transportation company to pick up Resident 1 from the dialysis center to transport Resident 1 back to the facility. During a telephone interview on 7/19/24 at 9:52	F 745	How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficient practice will not recur: On 8/6-8/ 2024, the Quality Assurance Nurse and the Assistant Director of Nursing provided education to Licensed Nurses regarding Nursing Home Transfer Agreement signed by the facility administrator and the hemodialysis center regional operations director dated 7/11/23, indicated for transportation of designated resident, the facility shall have the responsibility for arranging suitable transportation of the designated resident to and from the center including selection of the mode of transportation, qualified personnel to accompany the designated resident and transportation equipment usually associated with this type of transfer including the use of appropriate life support measures in accordance with the applicable federal and state laws and regulations. Facility shall be responsible for ensuring that the designated resident is medically stable to undergo such transportation, shall be responsible for the designated resident during transfer to and from center, including medical and non-medical emergencies and shall be responsible for all costs of transportation associated with the transfer of the designated resident to and from center and facility. Staff on leave, unscheduled, or on vacations will be provided education by the Director of Nursing/ Designee upon prior to active duty. On 8/8/2024, the Medical Records Director will audit Dialysis Transportation (chair time, pick up time and return time) for all 6 residents. Findings will be reported to the Director of Nursing/Designee for immediate actions during the Daily Stand-up meeting (Monday-Friday). The CQI committee will continue to review until such time the deficiency has been proven resolved for 3 months (11/8/2024).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. BUILDING _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA POST ACUTE	909 S LAKE STREET LOS ANGELES, CA 90006

(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
F 745	Continued From page 3 a.m., Resident 1's FM stated the dialysis center informed the FM on 7/13/24 that Resident 1's dialysis was completed and there was no transportation to take Resident 1 back to the facility. FM stated she was worried about how Resident 1 would return to the facility. FM stated she called a transportation company to take Resident 1 back to the facility. During an interview on 7/29/24 at 10:13 a.m., licensed vocational nurse (LVN 1) stated Resident 1 has end stage renal disease and needs to go to dialysis. LVN 1 stated Resident 1 goes to dialysis every Tuesdays, Thursdays, and Saturdays. During an interview on 7/19/24 at 12:04 p.m., the assistant director of nursing (ADON) stated Resident 1 missed the dialysis on 6/25/24 because the transportation company cancelled the scheduled pick-up and was unable to send another driver. ADON stated on 6/27/24 Resident 1 was not ready when the transportation company came to pick up Resident 1 and the driver left. ADON stated there was no documentation on why Resident 1 was not ready. ADON stated on 7/2/24, Resident 1 missed the dialysis because the transportation company cancelled the scheduled pick-up but stated they (the transportation company) could send another driver. The facility tried to call the dialysis center, but no one answered the phone. During an interview on 7/19/24 at 12:48 p.m., the director of nursing (DON) stated the facility was responsible to ensure Resident 1 goes to dialysis on scheduled days. DON further added the facility was responsible to arrange transportation for Resident 1 to take Resident 1 to and from the	F 745	What measures will be put into place or what systemic changes the facility will make sure to ensure that the deficient practice does not recur: On 8/8/2024, the Director of Nursing and the Quality Assurance Nurse will tract any trends or concerns related to the Nursing Home Transfer Agreement signed by the facility administrator and the hemodialysis center regional operations director dated 7/11/23, indicated for transportation of designated resident, the facility shall have the responsibility for arranging suitable transportation of the designated resident to and from the center including selection of the mode of transportation, qualified personnel to accompany the designated resident and transportation equipment usually associated with this type of transfer including the use of appropriate life support measures in accordance with the applicable federal and state laws and regulations. Facility shall be responsible for ensuring that the designated resident is medically stable to undergo such transportation, shall be responsible for the designated resident during transfer to and from center, including medical and non-medical emergencies and shall be responsible for all costs of transportation associated with the transfer of the designated resident to and from center and facility. This will be communicated to the CQI committee for further evaluation and recommendations monthly. If it is determined that we have accomplished the objectives in the POC above and the results are successful, the facility will consider the matter resolved. The QA committee will continue to review until such time the deficiency has been proven resolved for 3 months and/or advised by the CQI committee (11/8/2024).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055461	A. BUILDING _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA POST ACUTE	909 S LAKE STREET LOS ANGELES, CA 90006

(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
F 745	Continued From page 4 dialysis center. A review of the Nursing Home Transfer Agreement signed by the facility administrator and the hemodialysis center regional operations director dated 7/11/23, indicated for transportation of designated resident, the facility shall have the responsibility for arranging suitable transportation of the designated resident to and from the center including selection of the mode of transportation, qualified personnel to accompany the designated resident and transportation equipment usually associated with this type of transfer including the use of appropriate life support measures in accordance with the applicable federal and state laws and regulations. Facility shall be responsible for ensuring that the designated resident is medically stable to undergo such transportation, shall be responsible for the designated resident during transfer to and from center, including medical and non-medical emergencies and shall be responsible for all costs of transportation associated with the transfer of the designated resident to and from center and facility.	F 745	Responsible: The Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Directors are responsible for monitoring and sustaining compliance. Department Heads includes: DSD, Medical Records Director, Social Services Director, Business Office Manager, Dietary, Admissions Designee, Payroll Director, MDS Nurse, Activity Director, and Maintenance/Housekeeping Director. Completion Date: 8/8/2024	