STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 supervise one of six sampled residents (Resident 1), who was assessed as a high risk for falls by: a. Ensuring staff familiarity with Resident 1 ' s routine when Resident 1 was moved to a new room with a new set of care givers. b. Implement Resident 1 ' s Interdisciplinary Team ([IDT]- refers to a team of different healthcare professionals who work together to create a personalized care plan for a patient)-Fall Progress Notes interventions that indicated: b.1.Not to leave Resident 1 in the wheelchair unattended. b.2.When Resident 1was up in a wheelchair, activity staff or nursing staff would either escort Resident 1 to the activity room or return Resident 1 to bed. b.3.If Resident 1 was in his wheelchair in his room, or the hallway activity staff would endorse to nursing staff. c. Appropriately re-assesses Resident 1 each time he falls to monitor effectiveness on the interventions. This deficient practice resulted for Resident 1 experienced an unwitnessed fall on 5/13/2025 and was subsequently transferred and admitted to the general acute care hospital (GACH) for seven days. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including muscle weakness, dementia (a decline in mental abilities that affects memory, thinking, and the ability to perform daily tasks) and history of falling. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 5/24/2025, the MDS indicated Resident 1 ' s cognitive (functions of the brain such as to think, pay attention, process information, and remember things) skills for daily decision making were severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, and putting on/ taking off footwear. During a review of Resident 1 ' s Situation-Background-Assessment-Recommendation (SBAR- tool used by health care workers to provide a framework for communication between members of the health care team) for Falls, the SBAR indicated the following: 1. On 3/26/2025, Resident 1 had a witnessed fall. 2. On 4/4/2025, Resident 1 had a witnessed fall. 3. On 5/13/2025, Resident 1 had an unwitnessed fall. During a review of Resident 1 ' s Morse Fall Assessments (a tool used to predict the likelihood of a patient falling in a healthcare setting), dated 3/27/25, the Morse Fall Assessments indicated Resident 1 ' s score was 65, representing a high risk for fall. During a review of Resident 1 ' s Morse Fall Assessments dated 4/4/2025, 4/13/2025, 4/20/2025, 5/13/2025, 5/20/2025 and 5/25/2025, the Morse Fall Assessments indicted the resident ' s score was as followed: 1. On 4/4/2025 the score was 55. 2. On 4/13/2025 the score was 50. 3. On 4/20/2025 the score was 55. 4. On 5/13/2025, 5/20/2025 and 5/25/2025 the was scored 55. The score 45 to 125 represented a high risk for fall. During a review of Resident 1 ' s IDT Fall Progress Notes, dated 3/27/2025, the IDT Fall Progress Notes indicated that Resident 1 was witnessed sliding down from his wheelchair to the floor. the IDT ' s interventions for fall prevention included: a. Activity staff or nursing staff toescort Resident 1 on a wheelchair to the activity room or return Resident 1 to bed. During a review of Resident 1 ' s IDT-Fall Progress Notes, dated 4/7/2025, the IDT-Fall Progress Notes indicated that Resident 1 had a witnessed fall on 4/4/2025, the IDT ' s intervention included: a. Not to leave Resident 1 in the wheelchair unattended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s IDT-Falls Progress Notes, dated 5/26/2025, the IDT-Fall Progress Notes indicated Resident 1 found sitting on top of floor mat, and there was risk factor which Resident 1 was in a new room with new set of caregivers that were unaware of his routine. During a review of Resident 1 ' s care plan titled, History of falling,created on 3/26/2025, and last revised on 5/20/2025, the care plan interventions indicated activity staff to endorse resident to nursing staff when resident in room or hallway in wheelchair, and staff to place resident in wheelchair near the nurse ' s station whenin the hallway. During a review of Resident 1 ' s SBAR-Falls dated 5/13/2025, the SBAR indicated that Resident 1 had an unwitnessed fall. The SBAR indicated Certified Nurse Assistant ([CNA] (Unknown) found Resident 1 on the floor laying down on his right side outside his room by the hallway. The SBAR indicated that Resident 1 had wheeled himself back to his room from the activity room (unsupervised). The SBAR indicated, Resident 1 sustained small bump on right side of his forehead (no measurements of the bump were documented), and the physician ordered to transfer Resident 1 to the GACH. During a review of Resident 1 ' s History and Physical (H&P) from the GACH, dated 5/13/2025, the H&P indicated that Resident 1 was admitted to the GACH because of head trauma hematoma (a pool of blood within the tissues) to the forehead area and further observation, neurology (medical specialty that treats the nervous system) consult requested to rule out seizure (a sudden, temporary disturbance in brain activity that can cause a range of effects, from brief lapses in awareness to convulsions), loss of consciousness and other medical comorbidities in the resident. During a review of Resident 2 ' s admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including adult failure of thrive (a syndrome characterized by a decline in an older adult's physical, cognitive, and/or social functioning) and difficulty in walking. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive (functions of the brain such as to think, pay attention, process information, and remember things) skills for daily decision making were severely impaired. The MDS indicated Resident 2 required supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with eating, partial assistance (helper does more than half the effort) with oral hygiene, was dependent (helper does all the effort) with toileting hygiene, showering, upper body dressing, lower body dressing, and putting on/ taking off footwear. During an observation on 6/11/2025 at 12:38 p.m., in Resident 1 ' s room, Resident 1 was sitting in his wheelchair eating lunch. There was no staff member supervising him as indicated in his care plan dated 5/20/2025. There were no visible indicators reflecting Resident 1 ' s high risk for falls inside the room, outside the door, or on Resident 1 himself. During a concurrent observation and interview on 6/11/2025 at 12:47 p.m. with Certified Nurse Assistant (CNA) 1 in front of Resident 2 ' s room, observed CNA 1 assisting Resident 2 back to bed from the wheelchair after lunch. CNA 1 stated it was hard for her to supervise Resident 1 while she was tending to the other residents she was assigned to. CNA 1 stated it would be helpful to have a 1:1 caregiver for Resident 1 to prevent Resident 1 from getting out of his wheelchair unassisted and risking further falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/11/2025 at 3:16 p.m. with RN 1, Resident 1 ' IDT Falls Progress notes, dated 5/26/2025 was reviewed. RN 1 stated that Resident 1 fell due to being in a new room with new set of care givers when he fell on 5/25/2025. During a concurrent interview and record review on 6/11/2025 at 3:16 p.m. with Registered Nurse (RN) 1, Resident 1 ' s SBAR-Falls, dated 5/13/2025 and 5/26/2025 were reviewed. RN1 stated that Resident 1 was left unsupervised in the hallway, leading to a fall on 5/13/2025. RN 1 stated that the activity staff(unknown) should have communicated Resident 1 ' s whereabouts to the nursing staff. RN 1 stated Resident 1 had an unwitnessed fall again on 5/25/2025, Resident 1 was in a new room with new set of care givers. RN 1 indicated that staff monitor Resident 1 at 30-minute intervals. However, this frequency may not be sufficient given Resident 1 ' s impaired cognitive function and increased risk of recurrent falls. RN 1 stated that the falls on 5/13/2025 and 5/25/2025 were preventable, as staff were aware of Resident 1 ' s condition and behaviors and should have prioritized Resident 1 ' s safety by closely monitoring him. During an interview and record review on 6/12/2025 at 11:33 a.m. with RN 2, Resident 1 ' s Care Plan for Falls from 3/26/2025, 5/3/2025, and 5/20/2025 were reviewed. RN 2 stated that Resident 1 is at high risk for falls, and staff are required to monitor him when he goes to the activity room. Afterward, they must either return him to his room and put him in bed or bring him to the nursing station for care endorsement. RN 2 stated that on 5/13/2025, staff did not adhere to the care plan when Resident 1 wheeled himself back from the activity room without supervision, resulting in a fall. RN 2 mentioned that the fall could have been prevented. During an interview on 6/12/ 2025 at 1:13 p.m., the Activity Director (AD) explained that activity staff help residents who are at high risk of falling to move from the activity room to the front station, where they hand them over to the nursing staff for continuous monitoring. The AD stated that facility staff identify high fall risk residents based on verbal information from the nursing staff. She also mentioned that she attended IDT meetings and was fully aware of Resident 1 ' s history of falls. The AD confirmed that she verbally informed the activity staff about Resident 1's high risk for falls; however, there was no written communication regarding this matter. During a review of Resident 1 ' s SBAR-Falls dated 5/25/2025, the SBAR indicated that a Activity Staff (unknown) found Resident 1 on top of the floor mat by his bed, in sitting position. During a review of Resident 1 ' s IDT-Falls Progress Notes, dated 5/26/2025, the IDT-Falls Progress Notes indicated that Activity staff (Unknown) found Resident 1 found sitting on top of a floor mat. The IDT -Falls Progress Note indicated Resident 1 was in a new room with a new set of caregivers that were unaware of his routine and that was a risk factor for Resident 1 falling. During an interview on 6/12/2025 at 3:58 p.m., with RN 2, RN 2 stated that while all residents are at risk of falls, some have a significantly higher risk and require additional attention, these residents should be prioritized and consistently provided with reminders. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled, Safety and Supervision of Residents, revised 2/2025, the P&P indicated that, the interdisciplinary care team shall analyze information obtained from assessments and observations to identify any risk for individual residents. And implementing interventions to reduce accident risks include communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training, ensuring that interventions are implemented, and documenting interventions. The P&P also indicated that staff to monitor the effectiveness of interventions include ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effective of new or revised interventions. Resident supervision is a core component of the system approach to safety, the type and frequency of resident supervision is determined by the individual resident ' s assessed needs. During a review of the facility ' s P&P title, Falls and Fall Risk, Managing, dated 3/2020, the P&P indicated,If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant, if underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.