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	04/23/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to maintain resident confidentiality when Respiratory Therapist (RT) 1 left the computer with the electronic health record (EHR) open and a clipboard with notes containing a list of resident names fully exposed and unattended in the facility hallway.This deficient practice violated the residents' right to privacy and confidentiality.Findings:During an observation on 4/20/2026 at 10:55 am in the facility hallway, there was an unattended computer screen and a clipboard displaying the names and personal health information of several residents sitting on a bedside table, unattended, in the hallway.During a concurrent observation and interview on 4/20/2026 at 11:00 am with RT 1, RT 1 exited a resident's room and sat down at the table containing the computer and clipboard. RT 1 stated he left to visit a resident and accidentally left both his computer screen and clipboard open and unattended in the hallway. RT 1 stated he should have closed the computer screen and turned the clipboard over, since both contained personal health information about several residents, which must remain private and confidential. During an interview on 4/23/2026 at 1:53 pm with the Director of Nursing (DON), the DON stated facility resident's information should always be kept private and confidential. The DON stated the computer screen and clip board with residents' information should not have been left open to public view. The DON stated that all residents' information must be kept confidential and secure to protect and respect residents' rights. During a review of the facility's Policies and Procedures (P/P) titled Protected Health Information (PHI), Management and Protection of, revised 2021, the P/P indicated it was the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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
	055297	A. Building B. Wing	04/23/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not meet standards of quality when licensed staff failed to follow or clarify physician medication orders for three of three residents (Residents 54, 97, and 76):1. For Resident 54, facility failed to separate the administration of Ferrous Sulfate and Minocycline to prevent medication interactions.2. For Residents 54, 97, and 76 facility failed ensure enteral feeding was ordered held before and after administration of phenytoin via gastrostomy tube.This deficient practice had the potential for medication or food interactions which could result in decrease in antibiotic effectiveness for Resident 54 and for Residents 54, 97, and 76 potential to result in seizure activity, decline in resident's condition, or hospitalization. Findings:1. During a medication administration (pass) observation in Station 2, at Medication Cart (Med Cart) C on 4/22/2026 at 8:24 AM with a Licensed Vocational Nurse (LVN) 9, LVN 9 prepared a total of 13 medications that included the following four (4) medications for Resident 54: a. 7.5 ml of Ferrous Sulfate Liquid 220 mg/5 ml (330 mg total) poured out into a medication cupb. 15 ml of Multivitamins with Mineralsˆ Liquid was poured out into a medication cup without shaking the medication bottle prior to pouringc. Eight (8) ml of Phenytoin Oral Suspension 125 mg/ 5 ml (200 mg total) was poured into a medication cup without shaking the medication bottle prior to pouringd. Two tablets of Minocycline 50 mg (100 mg total) was crushed and placed into a medication cup During a medication administration (pass) observation on 4/22/2026 at 9:08 AM with LVN 9, after preparing the medications LVN 9 entered Resident 54's room, turned off the enteral feeding pump, checking g-tube placement, providing initial water flush, administered each medication that included but was not limited to Ferrous Sulfate, Minocycline, and Phenytoin. LVN 9 immediately after medication administration via g-tube turned back on Resident 54's enteral feeding pump.During a review of Resident 54's admission record, the admission record indicated Resident 54 was admitted to the facility 7/12/2023 and readmitted on [DATE] with diagnoses that included seizures Idiopathic epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures, from unknown causes), epileptic syndromes with seizures of localized onset (seizures starting in one brain region), anemia (low red blood cells), Encounter for attention to gastrostomy, and dependence on respiratory (ventilator-a machine that helps a person breathe) status. During a review of Resident 54's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:ˆa. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 2/3/2026.b. Phenytoin Oral Suspension 100 milligram (mg, unit of measurement mass) per 4 milliliters (ml, unit of measurement volume), give 8 ml via g-tube two times a day for diagnosis of seizure (8ml = 200 mg), dated 2/3/2026c. Ferrous Sulfate Liquid 220 mg/ 5 ml, give 7.5 ml via g-tube one time a day for diagnosis of anemia (7.5 ml = 330 mg). Give with food, dated 2/3/2026.d. Minocycline Oral Tablet 100 mg, give one (1) tablet via g-tube two times a day for s/p (status post/ after) lesion removal ([MOHS surgery] [NAME] Micrographic Surgery, surgical technique used to treat skin cancer, thin layers of cancer-containing skin are progressively removed and examined until only cancer-free tissue remains) of the L-side (left side) of nose for 14 days, dated 4/16/2026.During a review of Resident 54's April 2026 Medication Administration Record (MAR) indicated by documentation and licensed nurses initials that Resident 54 was administered Ferrous Sulfate and Minocycline daily at the schedule 9 AM administration time for 18 days between 4/5/2026 through 4/18/2026.During an interview with the Director of Nursing (DON) on 04/22/2026 at 12:05 PM, the DON stated there was a potential interactions between ferrous sulfate and Minocycline and should not be given together, because iron binds to minocycline. During a telephone interview on 4/22/2026 at 2:35 PM, with Pharm 1 in the presence of the DON, Pharm 1 stated Resident 54's minocycline and ferrous sulfate should be separated as the two medications affect the absorption of each other.During a telephone interview on (continued on next page)

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	04/23/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/22/2026 at 2:56 PM with facility's dispensing pharmacist (Pharm 2) in the presence of the DON, Pharm 2 stated Resident 54's ferrous sulfate was not on the resident's profile. Pharm 2 stated Resident 54's minocycline 100 mg twice a day should not be given together with ferrous sulfate.2a. During a concurrent observation, interview, and record review on 4/22/2026 at 9:43 AM with LVN 9 stated that he was not sure if the g-tube feeding should be started immediately after administering phenytoin. LVN 9 reviewed Resident 54's phenytoin order and stated the order does not give instructions to hold feeding. During a concurrent interview and record review on 4/22/2026 at 9:56 AM with the Director of Nursing (DON) in the presence of LVN 9, the DON stated that enteral feeding must be held one hour before and one hour after administration of phenytoin. The DON stated the information to hold enteral feeding was not included on the physician order or on the prescription label to guide the nurse during medication administration. During a concurrent interview and record review on 4/22/2026 at 10:43 AM with the DON, the DON reviewed residents on Dilantin via g-tube and stated the facility have three residents on Dilantin, Resident 54, Resident 97, and Resident 76. The DON stated he will have to communicate to the medication nurses to hold the g-tube feeding before and after Dilantin administration by at least an hour.During a telephone interview on 4/22/2026 at 10:36 AM with the facility's Consultant Pharmacist (Pharm 1) in the presence of the DON. Pharm 1 stated enteral feeding should be held between one to two hours before and after phenytoin administration for better medication absorption and effectiveness. Pharm 1 stated enteral feeding may cause the phenytoin not to be absorbed well, may not be as effective, and the phenytoin level may not be therapeutic to be the most effective and the resident may need more phenytoin to reach an effective level for seizure control.2b. During a review of Resident 97's admission record, the admission record indicated Resident 97 was admitted to the facility 7/8/2023 and readmitted on [DATE] with diagnoses that included seizures, epilepsy, and encounter for attention to gastrostomy. During a review of Resident 97's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:^a. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 4/16/2026.b. Phenytoin Oral Suspension 100 mg/4 ml, give 8 ml via g-tube three times a day related to epilepsy (8ml = 200 mg). Shake Suspension Well, dated 4/17/2026 During a review of Resident 97's Dilantin (phenytoin) laboratory results with a collection and report date of 2/24/2026, indicated Dilantin result as 7.0 micrograms (mcg, unit of measurement mass)/ml with reference range of 10.0 mcg/ml - 20.0 mcg/ml and was flagged as low (L).During a concurrent record review and interview on 4/22/2026 at 10:43 AM with the DON, Resident 97's current physician order for Dilantin was reviewed. The DON stated for Resident 97 there was no parameter on the order to hold enteral feeding before and after Dilantin administration. 2c. During a review of Resident 76's admission record, the admission record indicated Resident 76 was admitted to the facility 3/13/2017 and readmitted on [DATE] with diagnoses that included seizures, coma (a state of deep unconsciousness in which a person cannot be awakened), and encounter for attention to gastrostomy During a review of Resident 76's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for Phenytoin Oral Suspension 125 mg/ 5 ml, give 4 ml via g-tube three times a day for seizures (4 ml = 100 mg), dated 1/27/2026During a concurrent record review and interview on 4/22/2026 at 11:09 AM with the DON, Resident 76's current physician order for Dilantin was reviewed. The DON stated for Resident 76 there was no order to hold enteral feeding before and after Dilantin administration. During an interview on 4/22/2026 at 11:11 AM, with the DON, the DON reviewed and provided a drug reference titled, Management of phenytoin with enteral tube feeding, dated 11/2012, published by Mental Health Clinician, that indicated phenytoin absorption is reduced when given concomitantly with tube feeding to such an extent that phenytoin serum levels may be reduced as much as 50 % to 75 %, leaving the patient at risk for seizures.Ideally, the feeds should be held one to two hours before or after each phenytoin dose with adequate tube flushes before and after phenytoin administration.During a review of the facility's Policy and Procedures (continued on next page)

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	04/23/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(P&P) titled, Administering Medications, dated 4/2019, the P&P indicated to provide safe administration of medications for residents in the facility. The P&P indicated, Medications are administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:a. Enhancing optimal therapeutic effect of the medicationb. Preventing potential medication or food interactions. During a review of the facility's P&P titled, Administering Medication through an Enteral Tube, dated 11/2018, the P&P indicated, Check compatibility with feeding tube formula:a. If the resident is on continuous tube feedings and the medication(s) are to be given on an empty stomach and/or are associated with medication-feeding formula incompatibility, stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administrationb. Recommended timeframes between medication and enteral formula administration should be determined by manufacturers of these products, or specified in the order.

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	04/23/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion (ROM, full movement potential of a joint) for one of six sampled residents (Residents 44) with ROM and mobility (ability to move) concerns by failing to: 1. Ensure Restorative Nursing Aide (nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) 1 (RNA 1) provided passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 44's both wrists and hands and applied splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 44's both hands in accordance with physician's orders.2. Objectively measure Resident 44's ROM limitations in both hands during the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, dated 5/15/2025.3. Assess Resident 44's mobility during the Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 7/22/2025. These deficient practices had the potential for Resident 44 to experience a further decline in ROM resulting in worsening contractures (loss of motion of a joint associated with stiffness and joint deformity) and have a further decline in physical functioning. Findings:1. During an observation on 4/20/2026 at 12:30 pm in Resident 44's room, Resident 44 was lying in bed, sleeping. Resident 44's both elbows were bent and resting on the chest. Resident 44 was holding a yellow and red colored ball in each hand.During an observation on 4/21/2026 at 1:44 p.m. of Resident 44's RNA session, in Resident 44's room, Resident 44 was sitting in a geri-chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) by the window with both elbows bent and resting on the chest, both wrists bent, and both hands positioned in fists. RNA 1 stated all of Resident 44's joints in both legs and both arms were tight and required increased time with exercises to help Resident 44 relax during ROM exercises. RNA 1 assisted with PROM exercises to Resident 44's both shoulders and both elbows. RNA 1 did not assist Resident 44 with PROM exercises to both wrists and both hands. RNA 1 assisted Resident 44 with PROM exercises to Resident 44's both legs, applied splints to Resident 44's both legs after exercises were complete, stated she was finished with the RNA session, and exited Resident 44's room. RNA 1 did not apply hand roll splints to Resident 44's both hands. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including anoxic brain injury (injury to the brain caused by lack of oxygen), functional quadriplegia (complete inability to move due to severe physical disability or medical condition), and contractures of the right knee and unspecified joints (where two bones meet).During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 44 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 44 was dependent (helper does all the effort) in hygiene, toileting, bathing, dressing, rolling to both sides, and transfers (moving from one place to another). The MDS indicated Resident 44 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs.During a review of Resident 44's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/31/2025, for RNA to provide PROM exercises to Resident 44's both, five times a week.During a review of Resident 44's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/31/2025, for RNA to apply hand rolls to Resident 44's both hands for six hours, five times a week.During a concurrent observation, interview and record review on 4/21/2026 at 11:05 am with RNA 1, RNA 1 reviewed Resident 44's RNA physician's orders, dated 7/31/2025, and (continued on next page)

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	04/23/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed Resident 44 had RNA orders for RNA to provide PROM exercises to Resident 44's both arms and apply hand roll splints to Resident 44's both hands. RNA 1 stated PROM exercises to both arms meant physically assisting Resident 44 with PROM exercises to the entire arm, including the shoulders, elbows, wrists, and fingers of the hand. RNA 1 confirmed she did not assist with PROM exercises to Resident 44's both wrists and hands and did not apply hand roll splints to Resident 44's both hands because she forgot. RNA 1 stated Resident 44's both hands were the stiffest joints of the body and needed ROM and splinting to prevent contractures. RNA 1 returned to Resident 44's room to assist with ROM exercises to Resident 44's both hands and wrists. After assisting with ROM exercises, RNA 1 placed a yellow ball into each of Resident 44's hands. RNA 1 stated she was supposed to put hand rolls in Resident 44's both hands according to the RNA order but could not find the treatment nurse and thought rolled up towels and balls were more appropriate because it helped manage Resident 44's hand hygiene and odor. RNA 1 stated a hand roll splint was rolled up gauze (thin, breathable cloth material often used to bandage wounds) obtained from the treatment nurse, not actual splints. RNA 1 stated she often placed rolled up towels, soft stress balls, and/or gauze rolls into Resident 44's hands depending on what was available to her at the time despite RNA order being written specifically for hand roll splints. RNA 1 exited Resident 44 to look for the treatment nurse and returned with 2 packages of rolled up gauze. RNA 1 removed the yellow ball from each of Resident 44's hands, removed the gauze rolls from their packages, and applied the gauze rolls into each of Resident 44's hands. RNA 1 stated it was important to provide ROM and splints as ordered to prevent joint stiffness and contractures and prevent injury.During a concurrent interview and record review on 4/21/2026 at 2:09 pm with the Director of Rehabilitation (DOR), the DOR stated the Rehabilitation Department (Rehab) created the RNA programs based on a resident's needs. The DOR stated RNAs were to carry out RNA exercises and splint application as ordered. The DOR reviewed Resident 44's RNA physician's orders, dated 7/31/2026, and confirmed Resident 44 had RNA orders for PROM exercises to Resident 44's both arms and application of hand roll splints to Resident 44's both hands. The DOR stated if an RNA order was written for PROM exercises to both arms, it was expected the RNA provide PROM exercises to the entire arm, which included the shoulder, elbow, wrist, and fingers of the hand. The DOR stated hand rolls were cylindrical splints placed in the palm of a resident's hand and secured to the hand with an elastic strap. The DOR stated hand roll splints were used to help prevent contractures by keeping the hand in a proper position. The DOR stated if an order was written for RNA to apply hand roll splints to a resident's hands, it was expected the RNA apply the hand roll splint, not a gauze roll, towel roll, or ball. The DOR stated gauze rolls, towel rolls, and balls were not appropriate items to be placed in Resident 44's both hands as they were not assessed and recommended by Rehab and could potentially cause harm if placed into Resident 44's hands without a formal assessment. The DOR stated if RNA did not provide PROM exercises to Resident 44's both wrists and hands and apply hand roll splints to Resident 44's both hands as ordered, it could result in a decline ROM and activities of daily living (ADL, basic activities such as eating, dressing, toileting), worsening contractures, and skin breakdown (tissue damage caused by friction, shear, moisture, or pressure).During an interview on 4/23/2026 at 1:53 pm with the Director of Nursing (DON), the DON stated RNAs assisted residents in the facility with activities such as ROM exercises and splinting to ensure the residents maintained their current level of function and did not experience a functional decline after discharge from skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant). The DON stated it was important for RNA to provide exercises as ordered to prevent injury and potential declines in ROM and function.2. During an observation on 4/20/2026 at 12:30 pm in Resident 44's room, Resident 44 was lying in bed, sleeping. Resident 44's both elbows were bent and resting on the chest. Resident 44 was holding a yellow and red colored ball in each hand.During an observation on 4/21/2026 at 1:44 p.m. in Resident 44's room, Resident 44 was sitting in a gerichair by the window with both elbows bent and resting on the chest, both wrists bent, and both hands positioned in fists.During a review of Resident 44's OT Evaluation (continued on next page)

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	04/23/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and Plan of Treatment (OT Eval), dated 5/15/2025, the OT Eval indicated Resident 44's ROM of both hands were impaired.During a concurrent interview and record review on 4/22/2026 at 1:42 pm with the DOR, the DOR stated the facility monitored for changes in joint ROM by Joint Mobility Assessments (JMA, a brief assessment of a resident's ROM in both arms and both legs) conducted by Rehab upon admission and quarterly and by staff report. The DOR stated PTs and OTs used goniometers (instrument used for the precise measurement of angles) to measure joint mobility to objectively (unbiased, based on facts) determine a resident's baseline ROM and detect changes in joint ROM. The DOR stated any limitations in joint ROM observed in an OT or PT evaluation should be measured with a goniometer and documented in the evaluation because it was an objective way of establishing a resident's ROM baseline and monitoring for changes in ROM. The DOR reviewed Resident 44's OT Eval, 5/15/2025, and confirmed Resident 44's ROM of both hands were documented as impaired. The DOR stated Resident 44's ROM impairments of both hands should have been measured with a goniometer since they were limited but were not. The DOR stated Resident 44's baseline ROM of both hands were not determined due to lack of objective measurements in the OT evaluation which in turn affected staff's ability to monitor and detect any changes in ROM.During an interview on 4/23/2026 at 1:53 pm with the DON, the DON stated the facility monitored changes in ROM by staff report, observations during daily care, and JMAs done quarterly and annually by Rehab. The DON stated it was important for staff to objectively measure ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor changes and provide the appropriate services to address any declines. 3. During an observation on 4/21/2026 at 1:44 p.m. of Resident 44's RNA session, in Resident 44's room, Resident 44 was sitting in a gerichair by the window with both elbows bent and resting on the chest, both wrists bent, and both hands positioned in fists. RNA 1 stated all of Resident 44's joints in both legs and both arms were tight and required increased time with exercises to help Resident 44 relax during ROM exercises. RNA 1 stated Resident 44 was unable to move by himself and required total assistance for mobility and re-positioning. During a review of Resident 44's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/16/2025, for Rehab Therapies (PT, OT) to evaluate and treat Resident 44.During a review of Resident 44's PT Evaluation and Plan of Treatment (PT Eval), dated 7/22/2025, the PT Eval indicated the reason for the PT Eval was due to a new onset of ROM decline and the need for re-establishing a maintenance program with the focus on RNA training for safe handling (techniques used to move, lift, and reposition patients without causing strain or injury to the patient or person assisting with mobility). The PT Evaluation did not include an assessment of Resident 44's mobility.During a concurrent interview and record review on 4/22/2026 at 1:42 pm with the DOR, the DOR stated a PT evaluation was a comprehensive (inclusive, including everything necessary) assessment of a resident's level of function, ROM, and mobility which included rolling to both sides, changing positions, transfers (moving from one place to another), walking, and gait (manner of walking). The DOR reviewed Resident 44's PT Eval, dated 7/22/2025, and confirmed PT did not assess Resident 44's mobility. The DON stated the mobility assessment was an essential part of a PT Eval and should have been evaluated to determine Resident 44's baseline level of function which enabled staff to appropriately monitor for any changes, improvements, and/or declines. The DOR stated one of the reasons for the PT Eval referral was to re-establish the RNA program and educate the RNAs in safe handling techniques which included bed mobility, positioning, and transfers. The DOR stated that PTs cannot effectively teach RNAs how to safely move and handle residents unless the residents' mobility was first assessed by the PT. The DOR stated the lack of a mobility assessment in a PT evaluation could lead to ineffective instruction of safe handling techniques and inability to determine changes, improvements, or declines in mobility.During an interview on 4/23/2026 at 1:53 pm with the DON, the DON stated Rehab and nursing assessed a resident's mobility. The DON stated if mobility was not formally assessed as indicated, it could result in a decline in a resident's function due staff's inability to effectively monitor and detect changes in (continued on next page)

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	04/23/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobility. During a review of the facility's undated Job Description titled, Restorative Nursing Aide (RNA), the Job Description indicated RNAs assisted the therapists in administering treatment plans to residents under the general supervision of the DON or assigned RNA lead. The Job Description indicated essential responsibilities and job functions of the RNA included ensuring equipment was used correctly and safely in performing resident care, providing therapists with observations, feedback, resident problems, risks to resident safety and resident feedback related to care and treatment responses, recognizing limits of training to avoid evaluation treatment and giving instructions and directions to resident/family in care and management of care.During a review of the facility's undated P/P titled, Splint Application, the P/P indicated a splint was a device that was placed on a resident's limb to help improve or correct performance or prevent further deformity. The P/P indicated therapy assessed the resident for the appropriate splint and set up a program for application. The P/P indicated the residents with splints would be monitored by RNAs or Certified Nursing Assistants under the supervision of a licensed nurse to ensure correct usage and optimal splint condition. During a review of the facility's Policy and Procedure (P/P) titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive the treatment and services to increase and/or prevent a further decrease in ROM. The P/P indicated the care plan would be developed by the interdisciplinary team based on comprehensive assessment and include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The P/P indicated the interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws an practice acts. The P/P indicated the documentation of the resident's progress toward the goals and objective would be include attempts to address any changes or decline in the resident's condition or needs. Cross reference to F726

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	04/23/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Cross Reference to F688 Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide (nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) 1 (RNA 1) was competent to provide RNA services to one of six sampled residents (Resident 44) by failing to ensure RNA 1 was competent to correctly identify and apply hand roll splints (device or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 44's both hands in accordance with physician's orders and was qualified to modify the RNA splinting program. These failures had the potential to cause Resident 44 and residents receiving RNA services in the facility to experience pain, injury, skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), ROM decline leading to contracture (loss of motion of a joint associated with stiffness and joint deformity) development, and a decline in physical functioning.Findings:During an observation on 4/20/2026 at 12:30 pm in Resident 44's room, Resident 44 was lying in bed, sleeping. Resident 44's both elbows were bent and resting on the chest. Resident 44 was holding a yellow and red colored ball in each hand.During an observation on 4/21/2026 at 1:44 p.m. of Resident 44's RNA session, in Resident 44's room, Resident 44 was sitting in a gerichair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) by the window with both elbows bent and resting on the chest, both wrists bent, and both hands positioned in fists. RNA 1 stated all of Resident 44's joints in both legs and both arms were tight and required increased time with exercises to help Resident 44 relax during range of motion (ROM, full movement potential of a joint) exercises. RNA 1 assisted with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 44's both shoulders, both elbows, and both legs. RNA 1 did not apply hand roll splints to Resident 44's both hands.During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including anoxic brain injury (injury to the brain caused by lack of oxygen), functional quadriplegia (complete inability to move due to severe physical disability or medical condition), and contractures of the right knee and unspecified joints (where two bones meet).During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 44 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 44 was dependent (helper does all the effort) in hygiene, toileting, bathing, dressing, rolling to both sides, and transfers (moving from one place to another). The MDS indicated Resident 44 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs.During a review of Resident 44's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/31/2025, for RNA to apply hand rolls to Resident 44's both hands for six hours, five times a week.During a concurrent observation, interview and record review on 4/21/2026 at 11:05 am with RNA 1, RNA 1 reviewed Resident 44's RNA physician's orders, dated 7/31/2025, and confirmed Resident 44 had RNA orders for RNA to apply hand roll splints to Resident 44's both hands. RNA 1 stated a hand roll splint was rolled up gauze (thin, breathable cloth material often used to bandage wounds) obtained from the treatment nurse, not actual splints. RNA 1 confirmed she did not apply hand rolls to Resident 44's both hands as ordered because she forgot. RNA 1 returned to Resident 44's room and placed a yellow ball into each of Resident 44's hands after assisting with ROM exercises to Resident 44's both wrists and hands. RNA 1 stated she was supposed to put hand rolls in Resident 44's both hands according to the RNA order but could not find the treatment nurse and thought rolled up towels and balls were more appropriate because it helped manage Resident 44's hand hygiene and odor. RNA 1 stated she often placed rolled (continued on next page)

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	04/23/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	up towels, soft stress balls, and/or gauze rolls into Resident 44's hands depending on what was available to her at the time despite the RNA order being written specifically for hand roll splints. RNA 1 stated Resident 44's family member constantly brought various items from home to place into Resident 44's hands and left them in a bag at Resident 44's bedside. RNA 1 stated RNA 1 sometimes used the items brought into the facility by Resident 44's family member in place of the hand rolls without notifying the Director of Rehabilitation (DOR) or nursing because she thought the family preferred them. RNA 1 stated the Rehabilitation Department (Rehab) created and modified the RNA program as needed. RNA 1 stated the specific types of splints RNAs were supposed to carry out with the residents were written on the RNA order. RNA 1 stated RNAs were supposed to follow exactly what the RNA orders indicated and were not allowed to modify the RNA program because RNAs were not qualified to do so. RNA 1 stated the PT and OT were the only staff qualified to modify the RNA program because they had the training and qualifications to do so. RNA 1 stated she should have notified the Rehabilitation Department (Rehab) and/or a licensed nurse and waited for therapy to re-assess Resident 44 and modify the RNA program as appropriate if she wanted to modify the RNA program but did not. RNA 1 stated if RNAs did not follow the RNA program as ordered, did not know the differences in splint types, and modified the RNA program without the proper qualifications, it could potentially cause harm to the residents.During a concurrent interview and record review on 4/21/2026 at 2:09 pm with the Director of Rehabilitation (DOR), the DOR stated the Rehab created the RNA programs based on a resident's needs. The DOR stated RNAs were to carry out RNA orders, which included splint application as ordered. The DOR reviewed Resident 44's RNA physician's orders, dated 7/31/2026, and confirmed Resident 44 had RNA orders for the application of hand roll splints to Resident 44's both hands. The DOR stated hand rolls were cylindrical splints placed in the palm of a resident's hand and secured to the hand with an elastic strap. The DOR stated hand roll splints were used to help prevent contractures by keeping the hand in a proper position. The DOR stated if an order was written for RNA to apply hand roll splints to a resident's hands, it was expected the RNA apply the hand roll splint, not a gauze roll, towel roll, or ball. The DOR stated gauze rolls, towel rolls, and balls were not appropriate items to be placed in Resident 44's both hands as they were not assessed and recommended by Rehab and could potentially cause harm if placed into Resident 44's hands without a formal assessment. The DOR stated a licensed Occupational Therapist (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) and/or Physical Therapist (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) established and modified the RNA program as needed. The DOR stated specific splints were recommended for each individual resident based on the therapist's assessment and the resident's functional abilities and needs. The DOR stated RNAs were supposed to carry out the RNA program as ordered and could not modify the RNA program because they were not qualified to do so. The DOR stated if an RNA was not competent in the different splint types and modified the RNA program independently, it could potentially cause harm and injury to the residents in the facility.During an interview on 4/23/2026 at 11:13 am with the Director of Staff Development (DSD), the DSD stated she supervised the RNAs. The DSD stated the RNAs in the facility were Certified Nursing Assistants (CNA) with specialized training in RNA services. The DSD reviewed Resident 44's physician's order, dated 7/31/2025, and confirmed Resident 44 had an RNA order for RNA to apply hand rolls to Resident 44's both hands. The DSD stated hand rolls were cylindrical splints placed in the palm of a resident's hand and secured with elastic. The DSD stated gauze rolls, towel rolls, and balls were not hand rolls and should not be placed in Resident 44's both hands since the RNA order was for hand roll splints. The DSD stated RNAs were supposed to follow exactly what the RNA order indicated and could not deviate from the order or modify the RNA program because they were not qualified to do so. The DSD stated PT and/or OT were the only qualified staff who were able to modify an RNA program and must be notified if an RNA program required modification. The DSD stated if RNAs modified the RNA program independently and were not competent in the different types (continued on next page)

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	04/23/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of splints as ordered, it could result in resident harm, injury, and functional decline. During an interview on 4/23/2026 at 1:53 pm with the Director of Nursing (DON), the DON stated the RNA treatment plan was determined by the licensed therapists and implemented by the RNAs as prescribed on the RNA order. The DON stated the RNAs were supposed to follow exactly what the RNA order indicated. The DON stated if an RNA program required modification, the RNA must notify a licensed nurse, PT, and/or OT who in turn would re-assess the resident and modify the RNA program if appropriate based on the resident's needs. The DON stated RNAs were not qualified and competent to modify an RNA program because they did not have the proper training and expertise. The DON stated if RNAs modified the RNA program independently, it could negatively impact the safety of the residents and staff in the facility. The DON stated it was important RNAs were competent in the types of splints ordered to ensure the correct splints were applied to a resident as incorrect splint application could result in injury and ROM decline. During a review of the facility's Policy and Procedure (P/P), titled Staffing, Sufficient and Competent Nursing, revised 8/2022, the P/P indicated the facility provided sufficient numbers of nursing staff with the appropriate skills and competency necessary to providing nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. During a review of the facility's undated Job Description titled, Restorative Nursing Aide (RNA), the Job Description indicated RNAs assisted the therapists in administering treatment plans to residents under the general supervision of the DON or assigned RNA lead. The Job Description indicated essential responsibilities and job functions of the RNA included ensuring equipment was used correctly and safely in performing resident care, providing therapists with observations, feedback, resident problems, risks to resident safety and resident feedback related to care and treatment responses, recognizing limits of training to avoid evaluation treatment and giving instructions and directions to resident/family in care and management of care, and referring questions and concerns relating to treatment goals, plans, assessments, and progress to the therapist(s).During a review of the facility's undated P/P titled, Splint Application, the P/P indicated a splint was a device that was placed on a resident's limb to help improve or correct performance or prevent further deformity. The P/P indicated therapy assessed the resident for the appropriate splint and set up a program for application. The P/P indicated the residents with splints would be monitored by RNAs or Certified Nursing Assistants under the supervision of a licensed nurse to ensure correct usage and optimal splint condition.

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	04/23/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe medication administration and accurate accountability of all controlled medications (medications with a high potential for abuse) for three of seven sampled residents (Resident 30, 50, and 58) reviewed during controlled medication storage inspection by failing to:A. Document the removal of Oxycodone with Acetaminophen (a pain medication combining oxycodone, an opioid, and acetaminophen, a non-opioid analgesic) for administration to Resident 30 on the Controlled Drug Record (CDR, a detailed record that tracks the receipt, administration, disposal, and inventory of controlled substances [use are regulated by law due to its potential for abuse, dependence, or harm]).B. Document the removal of Hysingla Extended Release (ER) (a long-acting opioid pain medication containing hydrocodone, used to manage severe pain requiring around-the-clock treatment) and Hydrocodone with Acetaminophen (a pain medication combining oxycodone, an opioid, and acetaminophen, a non-opioid analgesic) for Resident 50 on the CDR.C. Document the removal of Modafinil (a medication that promotes wakefulness) on the CDR. D. A Licensed Vocational Nurse (LVN) 3 did not sign the shift change audit (a brief review of medication and documentation at the end of a work shift) form in the presence of the outgoing nurse or covering nurse prior to taking possession Medication Cart (MedCart) 3 on Station 2. This deficient practice increased the risk for lack of controlled medication accountability. This failure created a discrepancy between Resident 30, 50, and 58's Medication Administration Record (MAR, a record of each medication given, including dosage, time, and the person administering) and the CDR on 4/22/2026. This failure increased the risk for the licensed nurses (in general) not to be able to readily identify controlled medication loss, drug diversion (illegal distribution or use of prescription drugs), or medication errors.Findings:During a concurrent medication storage area inspection, record review, and interview on 4/22/2026 between 12:46 PM through 1:12 PM on Station 1 at MedCart A, with LVN 10, the following controlled medication discrepancies were identified:A. During a review of Resident 30's admission record, the admission record indicated Resident 30 was admitted to the facility 3/4/2026 with diagnoses that included pain in right and left leg, low back pain, and chronic pain.During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 3/8/2026, the MDS indicated Resident 30's cognitive skills (thought process and ability to reason or make decisions) was intact. During a review of Resident 30's Order Summary Report (OSR) for the month of April 2026, the OSR indicated an active medication order for:ˆ-Oxycodone Acetaminophen 5 mg/325 mg, give 1 tablet by mouth every 12 hours as needed for Breakthrough Pain with s/p (after care following) laminectomy L3-L5 (a surgery to remove bone from the lower back in order to take pressure off nerves). NTE (not to exceed) three (3) g (gram, unit of measurement) per 24 hours of Acetaminophen. HOLD for RR (respiration rate, the number of breaths taken per minute) less than 12, order dated 3/10/2026.Resident 30's CDR and MAR for the Month of April 2026 were reviewed and documentation indicated the following for Resident 30:-MAR dated 4/22/2026, timed at 9:40 AM, indicated a dose of Oxycodone 5 milligram (mg, unit of measurement mass) with Acetaminophen 325 mg (5 mg/325 mg) was administered. The CDR documentation indicated the last dose removed was on 4/22/2026, timed at 9:42 AM with a remaining quantity of 14 tablets Medication Card for of Oxycodone with Acetaminophen 5 mg/325 mg indicated a remaining quantity of 13 creating a controlled medication discrepancy.LVN 10 stated that he did not document on the CDR the removal of Oxycodone with Acetaminophen 5 mg/325 mg for Resident 30 on 4/22/2026. LVN 10 stated, he should have documented the removal on the CDR to show how much medication was actually remaining, if the CDR is not accurate the licensed nurses would not know what happened.B1. During a review of Resident 50's admission record, the admission record indicated Resident 50 was admitted to the facility 10/10/2024 and readmitted on [DATE] with diagnoses that included aftercare following joint (continued on next page)

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	04/23/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	replacement surgery, Osteomyelitis (a bone infection), Rheumatoid arthritis (a disease that causes the body to attack the joints and make them swollen and painful), and muscle spasm.During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's cognitive skills were intact. During a review of Resident 50's OSR for the month of April 2026, the OSR indicated an active medication order for:ˆ-Hysingla ER Oral Tablet ER 24 Hour Abuse-Deterrent 20 MG (Hydrocodone Bitartrate) Give 1 tablet by mouth two times a day for Dx: Chronic Pain (Hold if Resp Rate<12/Min) (Do Not Crush or Chew, Swallow Whole), order dated 2/5/2026-Hydrocodone-Acetaminophen 10 mg/ 325 mg, give 1 tablet by mouth as needed for BREAKTHROUGH PAIN (QID PRN) with multiple fractures, NTE 3G/24 HOURS OF Acetaminophen FROM ALL SOURCES. HOLD FOR RR < 12, order dated 3/30/2026 Resident 50's CDR and MAR for the Month of April 2026 were reviewed and documentation indicated the following for Resident 50:MAR dated 4/22/2026, timed at 12:00 PM, indicated a dose of Hysingla ER Tablet 20 mg was administered. The CDR documentation indicated that the last dose of Hysingla ER Tablet 20 mg removed was on 4/21/2026, timed at 2100 (9:00 PM) with a remaining quantity of five tablets. The Medication Card for Hysingla ER Tablet 20 mg indicated a remaining quantity of four tablets creating a controlled medication discrepancy.LVN 10 stated, I did not write it down. dose not recorded on controlled drug record for today, 4/22/2026.B2. Resident 50's CDR and MAR for the Month of April 2026 were reviewed and documentation indicated the following for Resident 50:MAR dated 4/22/2026, timed at 12:00 PM, indicated a dose of Hydrocodone with Acetaminophen 10 mg/325 mg CDR documentation indicated the last dose of Hydrocodone with Acetaminophen 10 mg/325 mg removed was on 4/22/2026, timed at 5:50 AM with a remaining quantity of 23 tablets Medication Card for of Hydrocodone with Acetaminophen 10 mg/325 mg indicated a remaining quantity of 22 tablets creating a controlled medication discrepancy.LVN 10 stated, not documenting on the CDR could lead to inaccurate documentation of controlled medications and miscommunication of what the facility has on hand, which could lead to drug diversion.C. During a review of Resident 58's admission record, the admission record indicated Resident 50 was admitted to the facility 4/11/2025 and readmitted on [DATE] with diagnoses that included Rheumatoid arthritis.During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 58's cognitive skills moderately impaired. During a review of Resident 58's OSR for the month of April 2026, the OSR indicated an active medication order for:ˆ-Modafinil Oral Tablet 100 MG (Modafinil) Give 1 tablet by mouth one time a day for Narcolepsy (a sleep disorder that causes sudden and uncontrollable episodes of sleepiness), order dated 12/24/2025, Resident 58's CDR and MAR for the Month of April 2026 were reviewed and documentation indicated the following for Resident 58:MAR dated 4/22/2026, timed at 8:20 AM, indicated a dose of Modafinil 100 mg was administered, the CDR documentation did not indicate when a dose of Modafinil 100 mg was for administration to Resident 58. The quantity available indicated 14 out of 14 tablets remaining.The Medication Card for Modafinil 100 mg indicated a remaining quantity of 13 tablets creating a controlled medication discrepancy. LVN 10 stated, for Resident 58 there was no last administered dose documented on the resident's CDR form.During a concurrent record review and interview on 4/22/2026 between 1:38 PM to 1:53 PM, with a Registered Nurse Supervisor (RNS) 1, RNS 1 reviewed physician orders, CDR, MAR, and medication cards for Residents 30, 50, and 58's controlled medications. RNS 1 confirmed the discrepancies identified on 4/22/2026 between the CDR, MAR and medication cards for Resident 30, Resident 50, and Resident 58. RNS 1 stated there could be a discrepancy in the narcotic count, communication issues, medication errors, residents are at risk for getting the medication twice by accident or not receiving the medication at all and a potential for drug abuse. RNS 1 stated the licensed nurses must count the medication to ensure what is on the medication card matches what is on the controlled medication sheet and document the time they are giving the controlled medication. RNS 1 stated the licensed nurse should document on the CDR sheet immediately when they remove the medication it is like an imaginary automated dispensing machine in which you are counting the controlled medication upon removal and verifying the count is accurate before you administer the (continued on next page)

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	04/23/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled medication to the resident. D. During a concurrent medication storage area inspection and interview on 4/22/2026 at 2:06 PM of Station 2 MedCart 3 with LVN 3, the Shift Change Narcotic Count Sheet for the month of 4/2026 was reviewed. The space for nurses' signature on the Narcotic Count Sheet oncoming On nurse from the 7 AM to 3 PM shift on 4/22/2026 was not initialed/signed. LVN 3 stated that she did not sign the Narcotic Count Sheet, because she thought the nurse (LVN 9) that was covering for her earlier had signed. LVN 3 stated that the incoming and outgoing nurses signing the Narcotic Count Sheet during shift change together means we counted the narcotic medications together and that there were no discrepancies. LVN 3 stated if the narcotic medications in the MedCart are not counted together the oncoming nurse should not take possession the MedCart in case something is missing and must ensure there are no narcotic medication discrepancies before taking over the medication cart.During an interview on 4/22/2026 at 2:15 PM with LVN 9, LVN 9 stated there was no licensed nurse present when he took possession of MedCart 3 on Station 2 and did not count with another nurse the narcotic medications and document on the Narcotic Count Sheet. During a review of the facility's policy and procedures (P&P) titled, Controlled Substances, dated 4/2019 indicated, Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift.Upon Administration: The nurse administering the medication is responsible for recording:(1) Name of the resident receiving the medication(2) Name, strength and dose of the medication(3) Time of administration(4) method of administration(5) quantity of the medication remaining; and(6) signature of nurse administering medicationAt the end of each shift:a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together b. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediatelyc. The director of nursing services investigates all discrepancies in controlled medication reconciliation to determine the cause and identify any responsible parties, and reports the findings to the administratord. The director of nursing services consults with the provider pharmacy and the administrator to determine whether further legal actions is indicated.Policies and procedures for monitoring controlled medications to prevent loss, diversion or accidental exposure are periodically reviewed and updated by the director of nursing services and the consultant pharmacist.

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	04/23/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that a licensed pharmacist performed a monthly medication regimen review (MRR, when a consultant pharmacist reviews and analyzes a resident's medication list, ensuring that the medications are appropriate, effective, and safe) to identify potential clinically significant medication issues, including drug interactions, for three of seven sampled residents (Residents 54, 97, and 76).This failure had the potential to result in unmonitored adverse drug reactions (undesired and harmful effects that occur because of medication, treatment, or procedure) and inappropriate medication usage for Residents 54, 97, and 76.Findings:1. During a review of Resident 54's admission record, the admission record indicated Resident 54 was admitted to the facility 7/12/2023 and readmitted on [DATE] with diagnoses that included seizures Idiopathic epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures, from unknown causes), epileptic syndromes with seizures of localized onset (seizures starting in one brain region), anemia (low red blood cells), Encounter for attention to gastrostomy, and dependence on respiratory (ventilator-a machine that helps a person breathe) status. During a review of Resident 54's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:^a. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 2/3/2026.b. Phenytoin Oral Suspension 100 milligram (mg, unit of measurement mass) per 4 milliliters (ml, unit of measurement volume), give 8 ml via g-tube two times a day for diagnosis of seizure (8ml = 200 mg), dated 2/3/2026c. Ferrous Sulfate Liquid 220 mg/ 5 ml, give 7.5 ml via g-tube one time a day for diagnosis of anemia (7.5 ml = 330 mg). Give with food, dated 2/3/2026.d. Minocycline Oral Tablet 100 mg, give one (1) tablet via g-tube two times a day for s/p (status post/ after) lesion removal ([MOHS surgery] [NAME] Micrographic Surgery, surgical technique used to treat skin cancer, thin layers of cancer-containing skin are progressively removed and examined until only cancer-free tissue remains) of the L-side (left side) of nose for 14 days, dated 4/16/2026.During a review of Resident 54's April 2026 Medication Administration Record (MAR) indicated by documentation and licensed nurses initials that Resident 54 was administered Ferrous Sulfate and Minocycline daily at the schedule 9 AM administration time for 18 days between 4/5/2026 through 4/18/2026.During a telephone interview on 4/22/2026 at 2:35 PM, with Pharm 1 in the presence of the DON, Pharm 1 stated Resident 54's minocycline and ferrous sulfate should be separated as the two medications affect the absorption of each other.During a telephone interview on 4/22/2026 at 2:56 PM with facility's dispensing pharmacist (Pharm 2) in the presence of the DON, Pharm 2 stated Resident 54's ferrous sulfate was not on the resident's profile. Pharm 2 stated Resident 54's minocycline 100 mg twice a day should not be given together with ferrous sulfate.During an interview on 4/23/2026 at 11:02 AM with the DON, the DON provided an Interim Medication Regiment Review for Resident 54. The DON stated was received from Pharm 1, the evening of 4/22/2026 with multiple recommendations, which included but was not limited to a recommendation to separate ferrous sulfate by two hours from minocycline. Pharm 1 documented a recommendation to give ferrous sulfate at 9 AM and minocycline at 11 AM. Pharm 1 indicated phenytoin may also affect the serum concentrations of acetaminophen, amlodipine, Keppra, lacosamide, or levothyroxine and dose adjustments may be necessary.During review on 4/23/2026 at 11:31 AM, Pharm 2 provided a documentation that indicated, I wanted to follow-up regarding the recent interaction identified between minocycline and ferrous sulfate. At the time of review, we were unable to detect this interaction because ferrous sulfate was not listed in the patient's profile.2. During a review of Resident 97's admission record, the admission record indicated Resident 97 was admitted to the facility 7/8/2023 and readmitted on [DATE] with diagnoses that included seizures, epilepsy, and (continued on next page)

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	04/23/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	encounter for attention to gastrostomy. During a review of Resident 97's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:ˆa. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 4/16/2026.b. Phenytoin Oral Suspension 100 mg/4 ml, give 8 ml via g-tube three times a day related to epilepsy (8ml = 200 mg). Shake Suspension Well, dated 4/17/2026 During a review of Resident 97's Dilantin (phenytoin) laboratory results with a collection and report date of 2/24/2026, indicated Dilantin result as 7.0 micrograms (mcg, unit of measurement mass)/ml with reference range of 10.0 mcg/ml - 20.0 mcg/ml and was flagged as low (L).During a concurrent record review and interview on 4/22/2026 at 10:43 AM with the DON, Resident 97's current physician order for Dilantin was reviewed. The DON stated for Resident 97 there was no parameter on the order to hold enteral feeding before and after Dilantin administration. 3. During a review of Resident 76's admission record, the admission record indicated Resident 76 was admitted to the facility 3/13/2017 and readmitted on [DATE] with diagnoses that included seizures, coma (a state of deep unconsciousness in which a person cannot be awakened), and encounter for attention to gastrostomy During a review of Resident 76's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for Phenytoin Oral Suspension 125 mg/ 5 ml, give 4 ml via g-tube three times a day for seizures (4 ml = 100 mg), dated 1/27/2026During a concurrent record review and interview on 4/22/2026 at 11:09 AM with the DON, Resident 76's current physician order for Dilantin was reviewed. The DON stated for Resident 76 there was no order to hold enteral feeding before and after Dilantin administration. During a review of the facility binder for Consultant Pharmacist's Medication Regimen Review [MRR] for recommendations created between 1/2026 and 4/2026, the MRR indicated Resident 54, 97, and 76's names was listed among other residents as medications that were reviewed by the consultant pharmacist but did not show recommendations for enteral feeding and phenytoin medication instructions or identify drug interactions between Ferrous Sulfate and Minocycline for Resident 54 who was administered the medication 18 times between 4/5/2026 to 4/22/2026.During an interview and record review on 4/22/2026 at 10:27 AM with the DON, Resident 54, Resident 97, and Resident 76's Monthly Regimen Review, were reviewed for the months of January 2026, February 2026, and March 2026. The DON stated there was no documentation that the facility's pharmacist consultant made recommendations for the administration of phenytoin via g-tube.During a telephone interview on 4/22/2026 at 10:36 AM with the facility's Consultant Pharmacist (Pharm 1) in the presence of the DON. Pharm 1 stated enteral feeding should be held between one to two hours before and after phenytoin administration for better medication absorption and effectiveness. Pharm 1 stated enteral feeding may cause the phenytoin not to be absorbed well, may not be as effective, and the phenytoin level may not be therapeutic to be the most effective and the resident may need more phenytoin to reach an effective level for seizure control. Pharm 1 stated that no recommendations were made to the facility regarding holding the feeding before or after phenytoin administration. Pharm 1 stated should have documented the recommendation to hold enteral feeding before and after medication administration, especially for phenytoin. Pharm 1 stated the physician orders should have included to hold the enteral feeding before and after phenytoin administration for each resident receiving phenytoin. During a review of the facility's undated policy titled, Consultant Pharmacist Scope and Services, indicated, Their primary objective is to ensure medication safety, regulatory compliance, and optimal clinical outcomes through the following responsibilities:nCore Clinical Responsibilities: Medication Regimen Review (MRR): Conducts a comprehensive monthly review of every resident's medical chart and medication profile. They identify potential drug interactions, duplicate therapies, or improper dosing.During a review of the facility's policy titled, Medication Regimen Review, dated 12/2022, indicated, The consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents. The facility shall make available to the pharmacist all appropriate records. In addition to reviewing (continued on next page)

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	04/23/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacy and clinical records (such as medication administration records [MAR]); prescribers' orders, progress notes of prescribers, nurses.Resident-specific irregularities resulting from or associated with medications are documented in the resident's active record and reported to the Director of Nursing, Medical Director and Attending Physician.

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	04/23/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that the medication error rate was less than five percent (%, unit of measurement). The facility had four medication errors out of a total of twenty-five opportunities resulting in an overall medication error rate of 16 %, affecting one of six residents (resident 54) observed during medication administration (pass). The medication errors noted for Resident 54 were as follows:1. Facility failed to separate and check compatibility (the ability to combine two medicines without interfering with the action of either) between Minocycline (antibiotic) and Ferrous Sulfate (iron supplement) before administering the two medications together via gastrostomy tube (g-tube: a feeding tube that's surgically placed into the stomach).2. Facility failed to hold enteral feeding (giving food or medication directly into the stomach through a tube in the abdomen) before and after phenytoin administration 3. Facility failed to follow manufacturer instructions to shake well phenytoin oral suspension and Multivitamin and Minerals Liquid prior to pouring a dose of each into medication cups for administration.These failures to administer medications in accordance with manufacturer's specifications and standards of practice placed Residents 54 at risk to experience significant medical complications including reduced seizure (a sudden, uncontrolled electrical disturbance in the brain), control, drug (medication) interactions (when two or more drugs affect each other's action or cause unexpected side effects), administration of less than the full therapeutic dose of medication, adverse reactions (undesired or harmful effects caused by medication), and hospitalization. Findings:During a review of Resident 54's admission record, the admission record indicated Resident 54 was admitted to the facility 7/12/2023 and readmitted on [DATE] with diagnoses that included seizures Idiopathic epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures, from unknown causes), epileptic syndromes with seizures of localized onset (seizures starting in one brain region), anemia (low red blood cells), hemiplegia (severe or complete loss of strength or paralysis on one side of the body) affecting right dominant side, Encounter for attention to gastrostomy, and dependence on respiratory (ventilator-a machine that helps a person breathe) status. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 54's cognitive skills (thought process and ability to reason or make decisions) to make self-understood or to understand others that the resident was rarely or never understood or understandable.During a review of Resident 54's History and Physical (H&P), dated 2/4/2026, the H&P indicated Resident 54 does not have the capacity to understand and make decisions. During a review of Resident 54's Care Plans (CP), revised on 4/8/2026, indicated:1. The CP focus indicated Resident 54 was at risk for seizure activity. The CP indicated that Resident 54 will remain seizure free and will remain free from injury related to seizure. The CP interventions indicated to administer medications as ordered and monitor for any adverse effect: Dilantin.2. The CP focus indicated Resident 54 has infection related to diagnosis: Status post lesion removal. The CP indicated that Resident 54 will have infection resolved upon completion of anti-infective therapy as evidence by absence of signs and symptoms of infection. The CP interventions indicated to assess and document therapeutic effects of medication: Minocycline Oral Tablet 100 mg.During a review of Resident 54's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:ˆ1. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 2/3/2026.2. Phenytoin Oral Suspension 100 mg/4 ml, give 8 ml via g-tube two times a day for diagnosis of seizure (8ml = 200 mg), dated 2/3/2026.3. Ferrous Sulfate Liquid 220 milligrams (mg, unit of measurement mass) per 5 milliliters (ml, unit of measurement volume), give 7.5 ml via g-tube one time a day for diagnosis of anemia (7.5 ml = 330 mg). Give with food, dated 2/3/2026.4. Minocycline Oral Tablet 100 mg, give one (1) tablet via g-tube two times a day for s/p (status post/ after) lesion removal ([MOHS surgery] [NAME] (continued on next page)

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	04/23/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Micrographic Surgery, surgical technique used to treat skin cancer, thin layers of cancer-containing skin are progressively removed and examined until only cancer-free tissue remains) of the L-side (left side) of nose for 14 days, dated 4/16/2026. During a medication administration (pass) observation in Station 2, at Medication Cart (Med Cart) C on 4/22/2026 at 8:24 AM with a Licensed Vocational Nurse (LVN) 9, LVN 9 prepared a total of 13 medications that included the following four (4) medications for Resident 54: 1. 7.5 ml of Ferrous Sulfate Liquid 220 mg/5 ml (330 mg total) poured out into a medication cup2. 15 ml of Multivitamins with Minerals^Liquid was poured out into a medication cup without shaking the medication bottle prior to pouring3. Eight (8) ml of Phenytoin Oral Suspension 125 mg/ 5 ml (200 mg total) was poured into a medication cup without shaking the medication bottle prior to pouring4. Two tablets of Minocycline 50 mg (100 mg total) was crushed and placed into a medication cup During a medication administration (pass) observation on 4/22/2026 at 9:08 AM with LVN 9, LVN 9 put on personal protective equipment (PPE, gown and gloves), used alcohol based hand sanitizer (ABHS), and entered Resident 54's room, turned off the enteral feeding pump, after checking g-tube placement, providing initial water flush, administered each medication separately, and then turned back on the enteral feeding pump.During a concurrent observation, interview, and record review on 4/22/2026 at 9:43 AM with LVN 9, Resident 54's physician orders for phenytoin and enteral feed were reviewed. LVN 9 stated all done with medication pass and stated restarting Resident 54's enteral feeding. LVN 9 was observed pressing the restart button on the enteral feeding pump. LVN 9 stated that he was not sure if the g-tube feeding should be started immediately after administering phenytoin. LVN 9 reviewed Resident 54's phenytoin order and stated the order does not give instructions to hold feeding. LVN 9 reviewed Resident 54's enteral feed order and stated that the enteral feed order indicated to hold feeding, but the physician order and prescription label did not include the instructions to hold feeding before or after administering phenytoin. During a continued interview on 4/22/2026 at 9:48 AM with LVN 9, LVN 9 reviewed the manufacturer labels for phenytoin that indicated, Shake well before each use. LVN 9 reviewed the manufacturer's label for Multivitamin with Minerals Liquid that indicated, Shake well, LVN 9 stated that he forgot to shake well before pouring out of phenytoin oral suspension and Multivitamin with Minerals Liquid. During a concurrent interview and record review on 4/22/2026 at 9:56 AM with the Director of Nursing (DON) in the presence of LVN 9, the DON stated that enteral feeding must be held one hour before and one hour after administration of phenytoin. The DON stated the information to hold enteral feeding was not included on the physician order or on the prescription label to guide the nurse during medication administration. The DON stated the enteral feeding is held to improve the absorption of phenytoin and to prevent a drug/nutrient interaction with phenytoin. The DON stated if the phenytoin level is low, may trigger a seizure in Resident 54. The DON stated that a seizure could cause resident injury, a change of condition and hospitalization. The DON stated that Resident 54's physician Enteral Feeding order indicated to hold tube feeding for one hour before and after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin). During a telephone interview on 4/22/2026 at 10:36 AM with the facility's Consultant Pharmacist (Pharm 1) in the presence of the DON. Pharm 1 stated enteral feeding should be held between one to two hours before and after phenytoin administration for better medication absorption and effectiveness. Pharm 1 stated enteral feeding may cause the phenytoin not to be absorbed well, may not be as effective, and the phenytoin level may not be therapeutic to be the most effective and the resident may need more phenytoin to reach an effective level for seizure control.During a telephone interview on 4/22/2026 at 2:56 PM with facility's dispensing pharmacist (Pharm 2) in the presence of the DON, Pharm 2 stated Resident 54's ferrous sulfate was not on the resident's profile. Pharm 2 stated Resident 54's minocycline 100 mg twice a day should not be given together with ferrous sulfate.During a review of the facility's Policy and Procedures (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated to provide safe administration of medications for residents in the facility. The P&P indicated, Medications are administration times are determined by resident need and benefit, not staff (continued on next page)

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	04/23/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	convenience. Factors that are considered include:a. Enhancing optimal therapeutic effect of the medicationb. Preventing potential medication or food interactions.During a review of the facility's P&P titled, Administering Medication through an Enteral Tube, dated 11/2018, the P&P indicated, Check compatibility with feeding tube formula:a. If the resident is on continuous tube feedings and the medication(s) are to be given on an empty stomach and/or are associated with medication-feeding formula incompatibility, stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration.b. Recommended timeframes between medication and enteral formula administration should be determined by manufacturers of these products, or specified in the order.During a review of manufacturer labeling provided by the facility for Dilantin, dated 2/2021, indicated, Drug Enteral Feeding/ Nutritional Preparation Interaction - Literature reports suggest that patients who have received enteral feeding preparations and/or related nutritional supplements have lower than expected phenytoin levels. It is therefore suggested that phenytoin not be administered concomitantly with an enteral feeding preparation. More frequent serum phenytoin level monitoring may be necessary in these patients. Cross Referenced: F760 and F658

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	04/23/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of three residents (Resident 54, 97, and 76) were free of a significant medication error (any preventable error in medication administration that can result in resident discomfort, jeopardizing health and safety, or requiring medical intervention) by failing to:1. Ensure Resident 54 was not administered interacting medications, Ferrous Sulfate and Minocycline together for 18 days, between 4/5/2026 through 4/22/20262. Ensure Resident 54, Resident 97, and Resident 76 enteral feeding was turned off one hour before and after g-tube administration of Dilantin (phenytoin) to prevent the potential for feeding and phenytoin interaction in accordance with the physician's enteral feeding order and the facility's policy and procedures (P&P) titled, Administering Medication through an Enteral Tube and Administering Medicationsnot administered or had the potential to be administered via g-tube concomitantly Dilantin (phenytoin) with enteral feeding which increased the risk for interactions and uncontrolled seizure by lowering the effectiveness of phenytoin These deficient practices increased the risk that Residents 54, 97 and 76 experience adverse reactions (negative effects from medication), that include slow infection healing for Resident 54 and increased risk for uncontrolled seizures, that could lead to a decline in the residents' condition, harm, or hospitalization for Residents 54, 97, and 76. Findings:1. During a medication administration (pass) observation in Station 2, at Medication Cart (Med Cart) C on 4/22/2026 at 8:24 AM with a Licensed Vocational Nurse (LVN) 9, LVN 9 prepared a total of 13 medications that included the following four (4) medications for Resident 54: a. 7.5 ml of Ferrous Sulfate Liquid 220 mg/5 ml (330 mg total) poured out into a medication cupb. 15 ml of Multivitamins with Mineralsˆ Liquid was poured out into a medication cup without shaking the medication bottle prior to pouringc. Eight (8) ml of Phenytoin Oral Suspension 125 mg/ 5 ml (200 mg total) was poured into a medication cup without shaking the medication bottle prior to pouringd. Two tablets of Minocycline 50 mg (100 mg total) was crushed and placed into a medication cup During a medication administration (pass) observation on 4/22/2026 at 9:08 AM with LVN 9, LVN 9 put on personal protective equipment (PPE, gown and gloves), used alcohol based hand sanitizer (ABHS), and entered Resident 54's room, turned off the enteral feeding pump, after checking g-tube placement, providing initial water flush, administered each medication separately that included but was not limited to Ferrous Sulfate, Minocycline, and Phenytoin, and then LVN 9 turned back on the enteral feeding pump.During a review of Resident 54's admission record, the admission record indicated Resident 54 was admitted to the facility 7/12/2023 and readmitted on [DATE] with diagnoses that included seizures Idiopathic epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures, from unknown causes), epileptic syndromes with seizures of localized onset (seizures starting in one brain region), anemia (low red blood cells), hemiplegia (severe or complete loss of strength or paralysis on one side of the body) affecting right dominant side, Encounter for attention to gastrostomy, and dependence on respiratory (ventilator-a machine that helps a person breathe) status. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 54's cognitive skills (thought process and ability to reason or make decisions) to make self-understood or to understand others that the resident was rarely or never understood or understandable.During a review of Resident 54's History and Physical (H&P), dated 2/4/2026, the H&P indicated Resident 54 does not have the capacity to understand and make decisions. During a review of Resident 54's Care Plans (CP), revised on 4/8/2026, indicated: The CP focus indicated Resident 54 was at risk for seizure activity. The CP indicated that Resident 54 will remain seizure free and will remain free from injury related to seizure. The CP interventions indicated to administer medications as ordered and monitor for any adverse effect: Dilantin.The CP focus indicated Resident 54 has infection related to diagnosis: Status post lesion removal. The CP indicated that Resident 54 will have infection resolved upon completion of anti-infective therapy as evidence by (continued on next page)

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	04/23/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	absence of signs and symptoms of infection. The CP interventions indicated to assess and document therapeutic effects of medication: Minocycline Oral Tablet 100 mg.During a review of Resident 54's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:ˆa. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 2/3/2026.b. Phenytoin Oral Suspension 100 milligram (mg, unit of measurement mass) per 4 milliliters (ml, unit of measurement volume), give 8 ml via g-tube two times a day for diagnosis of seizure (8ml = 200 mg), dated 2/3/2026c. Ferrous Sulfate Liquid 220 mg/ 5 ml, give 7.5 ml via g-tube one time a day for diagnosis of anemia (7.5 ml = 330 mg). Give with food, dated 2/3/2026.d. Minocycline Oral Tablet 100 mg, give one (1) tablet via g-tube two times a day for s/p (status post/ after) lesion removal ([MOHS surgery] [NAME] Micrographic Surgery, surgical technique used to treat skin cancer, thin layers of cancer-containing skin are progressively removed and examined until only cancer-free tissue remains) of the L-side (left side) of nose for 14 days, dated 4/16/2026.During a review of Resident 54's April 2026 Medication Administration Record (MAR) indicated by documentation and licensed nurses initials that Resident 54 was administered Ferrous Sulfate and Minocycline daily at the schedule 9 AM administration time for 18 days between 4/5/2026 through 4/18/2026.During an interview with the Director of Nursing (DON) on 04/22/2026 at 12:05 PM, the DON stated there was a potential interactions between ferrous sulfate and Minocycline and should not be given together, because iron binds to minocycline. During a telephone interview on 4/22/2026 at 2:35 PM, with Pharm 1 in the presence of the DON, Pharm 1 stated Resident 54's medication was reviewed in the beginning, when medications are dispensed in the pharmacy will show interactions and the dispensing pharmacy will let the facility know regarding drug interactions. Pharm 1 stated minocycline and ferrous sulfate should be separated as the two medications affect the absorption of each other.During a telephone interview on 4/22/2026 at 2:56 PM with facility's dispensing pharmacist (Pharm 2) in the presence of the DON, Pharm 2 stated Resident 54's ferrous sulfate was not on the resident's profile. Pharm 2 stated Resident 54's minocycline 100 mg twice a day should not be given together with ferrous sulfate.2a. During a concurrent observation, interview, and record review on 4/22/2026 at 9:43 AM with LVN 9, Resident 54's physician orders for phenytoin and enteral feed were reviewed. LVN 9 stated all done with medication pass and stated restarting Resident 54's enteral feeding. LVN 9 was observed pressing the restart button on the enteral feeding pump. LVN 9 stated that he was not sure if the g-tube feeding should be started immediately after administering phenytoin. LVN 9 reviewed Resident 54's phenytoin order and stated the order does not give instructions to hold feeding. LVN 9 reviewed Resident 54's enteral feed order and stated that the enteral feed order indicated to hold feeding, but the physician order and prescription label did not include the instructions to hold feeding before or after administering phenytoin. During a concurrent interview and record review on 4/22/2026 at 9:56 AM with the Director of Nursing (DON) in the presence of LVN 9, the DON stated that enteral feeding must be held one hour before and one hour after administration of phenytoin. The DON stated the information to hold enteral feeding was not included on the physician order or on the prescription label to guide the nurse during medication administration. The DON stated the enteral feeding is held to improve the absorption of phenytoin and to prevent a drug/nutrient interaction with phenytoin. The DON stated if the phenytoin level is low, may trigger a seizure in Resident 54. The DON stated that a seizure could cause resident injury, a change of condition and hospitalization. The DON stated that Resident 54's physician Enteral Feeding order indicated to hold tube feeding for one hour before and after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin). During a telephone interview on 4/22/2026 at 10:36 AM with the facility's Consultant Pharmacist (Pharm 1) in the presence of the DON. Pharm 1 stated enteral feeding should be held between one to two hours before and after phenytoin administration for better medication absorption and effectiveness. Pharm 1 stated enteral feeding may cause the phenytoin not to be absorbed well, may not be as effective, and the phenytoin level may not be therapeutic to be the (continued on next page)

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	04/23/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	most effective and the resident may need more phenytoin to reach an effective level for seizure control.During a concurrent interview and record review on 4/22/2026 at 10:43 AM with the DON, the DON reviewed residents on Dilantin via g-tube and stated the facility have three residents on Dilantin, Resident 54, Resident 97, and Resident 76. The DON stated he will have to communicate to the medication nurses to hold the g-tube feeding before and after Dilantin administration by at least an hour.2b. During a review of Resident 97's admission record, the admission record indicated Resident 97 was admitted to the facility 7/8/2023 and readmitted on [DATE] with diagnoses that included seizures, epilepsy, and encounter for attention to gastrostomy. During a review of Resident 97's MDS, dated [DATE], the MDS indicated Resident 97's cognitive skills to make self-understood or to understand others that the resident was rarely or never understood or understandable.During a review of Resident 97's H&P, dated 4/17/2026, the H&P indicated Resident 97 has the capacity to understand and make decisions. During a review of Resident 97's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for:ˆa. Enteral Feed Order every shift Enteral: Hold feeding one (1) hour before and one (1) hour after administration of medication that has a drug/nutrient interaction such as Dilantin (phenytoin), dated 4/16/2026.b. Phenytoin Oral Suspension 100 mg/4 ml, give 8 ml via g-tube three times a day related to epilepsy (8ml = 200 mg). Shake Suspension Well, dated 4/17/2026During a review of Resident 97's Care Plans (CP), initiated on 4/18/2026, the CP focus indicated Resident 97 has a seizure disorder related to epilepsy. The CP indicated that Resident 97 will remain seizure free and will remain free from injury related to seizure activity. The CP interventions indicated to give medications as ordered. Monitor/document for effectiveness and side effects. Phenytoin Oral Suspension.During a review of Resident 97's Dilantin (phenytoin) laboratory results with a collection and report date of 2/24/2026, indicated Dilantin result as 7.0 micrograms (mcg, unit of measurement mass)/ml with reference range of 10.0 mcg/ml - 20.0 mcg/ml and was flagged as low (L).During a concurrent record review and interview on 4/22/2026 at 10:43 AM with the DON, Resident 97's current physician order for Dilantin was reviewed. The DON stated for Resident 97 there was no parameter on the order to hold enteral feeding before and after Dilantin administration. 2c. During a review of Resident 76's admission record, the admission record indicated Resident 76 was admitted to the facility 3/13/2017 and readmitted on [DATE] with diagnoses that included seizures, coma (a state of deep unconsciousness in which a person cannot be awakened), and encounter for attention to gastrostomy During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76's was in a comatose state.During a review of Resident 76's H&P, dated 5/15/2025, the H&P indicated Resident 76 does not have the capacity to understand and make decisions. During a review of Resident 76's Order Summary Report (OSR) for the month of April 2026, the OSR indicated active medication orders for Phenytoin Oral Suspension 125 mg/ 5 ml, give 4 ml via g-tube three times a day for seizures (4 ml = 100 mg), dated 1/27/2026During a review of Resident 76's Care Plans (CP), revised on 3/24/2026, the CP focus indicated Resident 76 is at risk for seizure activity. The CP indicated that Resident 76 will remain seizure free and will remain free from injury related to seizure. The CP interventions indicated to administer medications as ordered and monitor for any adverse effects. phenytoinDuring a concurrent record review and interview on 4/22/2026 at 11:09 AM with the DON, Resident 76's current physician order for Dilantin was reviewed. The DON stated for Resident 76 there was no order to hold enteral feeding before and after Dilantin administration. During an interview on 4/22/2026 at 11:11 AM, with the DON, the DON reviewed and provided a drug reference titled, Management of phenytoin with enteral tube feeding, dated 11/2012, published by Mental Health Clinician, that indicated phenytoin absorption is reduced when given concomitantly with tube feeding to such an extent that phenytoin serum levels may be reduced as much as 50 % to 75 %, leaving the patient at risk for seizures.Ideally, the feeds should be held one to two hours before or after each phenytoin dose with adequate tube flushes before and after phenytoin administration.During a review of the facility's Policy and Procedures (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated to provide safe administration of (continued on next page)

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	04/23/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications for residents in the facility. The P&P indicated, Medications are administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:a. Enhancing optimal therapeutic effect of the medicationb. Preventing potential medication or food interactions. During a review of the facility's P&P titled, Administering Medication through an Enteral Tube, dated 11/2018, the P&P indicated, Check compatibility with feeding tube formula:a. If the resident is on continuous tube feedings and the medication(s) are to be given on an empty stomach and/or are associated with medication-feeding formula incompatibility, stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administrationb. Recommended timeframes between medication and enteral formula administration should be determined by manufacturers of these products, or specified in the order.

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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 establish and maintain an implementation for prevention and control program (IPCP) to maintain safety and sanitary for two out of two sampled residents by failing to: Report an outbreak of scabies (a contagious skin condition caused by tiny insects called mites that infest and irritate your skin by intense itching, inflammation, and red patches) to the local health Department after 2 residents (Residents 66 and Resident 87) had rashes with severe itching and tested positive for skin scraping (a quick, minimally invasive diagnostic procedure used to sample the outer layer of skin, usually with a scalpel blade, to detect fungal infections (using [NAME]) or parasites like scabies/mites (using mineral oil) under a microscope. for scabies, which affected their quality of life, while being treated for suspected scabies. Perform disinfection of the mattress, pillows, bedside equipment, and floors after permethrin cream used for scabies prevention treatment for Residents 66 and 87. Ensure Resident 36 and Resident 39 who are exhibiting symptoms of suspected scabies were placed on contact isolation (used to prevent disease from spreading) and ensure the facility protocol for scabies was followed. These deficient practices placed all residents, staff, vendors, and visitors at risk to acquire and be exposed to the scabies infection. Findings: a. During a review of Resident 87's admission Record, admission Record indicated Resident 66 was admitted on [DATE] with diagnoses including hypertension (high blood pressure) diabetes mellitus (DM- high blood glucose), acute respiratory failure with hypoxia . During a review of Resident 87's Minimum Data Set (MDS- a resident assessment) dated 2/8/26, MDS indicated, Resident 66 has no speech, and with short term and long-term memory problem. The MDS indicated Resident 87 is dependent on all activities of daily living (ADL's). During a review of Resident 87's Skin Scraping for scabies dated 1/20/26, it indicated positive for sarcoptes scabiei (microscopic, parasitic mite that burrows into the upper layer of human skin to live and lay eggs, causing a contagious skin infestation known as scabies). During a review of Resident 66's admission Record, the admission Record indicated, Resident 66 was admitted on [DATE] with diagnoses including hemiplegia (complete paralysis) and hemiparesis (weakness) following unspecified cerebrovascular disease affecting right dominant side, acute respiratory failure with hypoxia (dangerous condition where body tissues do not receive enough oxygen), cardiac arrest (life-threatening emergency where the heart abruptly stops beating and pumping blood), pneumothorax (collapsed lung), acute embolism (thrombus or foreign substance that breaks off and travels through the bloodstream, getting lodged in a smaller vessel) and thrombosis (stationary clot formed in a vein or artery) of unspecified deep veins of right lower extremity. During a review of Resident 66's MDS dated [DATE], MDS indicated Resident 66 has no speech, with short term memory problem and long-term memory problem. The MDS indicated Resident 66 is dependent with staff on all ADL's. During a review of Resident 66's Skin Scraping for scabies dated 2/28/26, it indicated positive for sarcoptes scabiei (microscopic, parasitic mite that burrows into the upper layer of human skin to live and lay eggs, causing a contagious skin infestation known as scabies). During a review of a Resident 66's Dermatologist (a medical practitioner specializing in the diagnosis and treatment of skin disorders) Visit Note dated 3/3/26, Resident 66 was seen for a chief complaint of a rash located throughout the body, rash is itchy, red, scaly and moderate in severity, has had this rash for weeks, pertinent history includes difficulty sleeping at night due to itch, it indicated Dermatologist prescribed ivermectin (prescription medication used to treat human infections caused by parasitic worms (strongyloidiasis, onchocerciasis) and external parasites like head lice and scabies)and permethrin cream (prescription topical medication used primarily to treat scabies by killing Sarcoptes scabiei mites and their egg), apply from neck down to the toes, leave for 12 hours then rinse, repeat once a week x 4 weeks, and perform skin scraping. During a record review of the undated line listing (a table that contains key information about each case in an outbreak), the line list indicated on 1/16/2026 (continued on next page)

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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 87 has positive skin scraping. The line list indicated that on 2/25/2026 Resident 66 tested positive for skin scraping of scabies which is within the 4-8 weeks of incubation period. During a concurrent interview and record review conducted on 4/23/2026 at 9:00 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated that a report was not made to the agency because there were not yet two positive residents to qualify as an outbreak. The IPN stated they had been waiting for a response from the Local Public Health Department, but no response was received until March 2026. The IPN stated that the report should have been submitted when two residents tested positive on 2/25/2026. The IPN stated that the agency must be notified so it can visit the facility and ensure appropriate measures are being taken to contain the spread of infection. The IPN stated that the report should have been made sooner. The IPN stated that the process for the application of the permethrin cream is that applied at nighttime then showered in the morning to remove the cream. The housekeeping will clean the room including bagging the belongings while providing showers to the residents. During a concurrent record review and interview conducted on 4/23/2026 at 9:50 a.m. with the Housekeeping Supervisor (HS), the HS stated that a complete log of deep cleaning for rooms occupied by affected residents, as well as for shower rooms, was not maintained. The HS stated that the regular deep-cleaning schedule was followed and no additional deep-cleaning procedures were performed. The HS also stated that there was no documentation indicating that the linens or personal belongings of Resident 66 or Resident 87 had been bagged or deep cleaned. During an interview conducted on 4/23/2026 at 11:00 a.m. with the Director of Nursing (DON), the DON stated that the first positive case occurred on 1/20/2026 and the second positive case on 2/25/2026. The DON explained that two positive cases within this timeframe constitute an outbreak. The DON stated that the facility failed to report the positive case identified in 02/2026 and stated that it is essential to report when two positive cases occur within a 4-6-week incubation period. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted on [DATE] with diagnoses including acute respiratory failure (a life-threatening, sudden inability of the lungs to oxygenate the blood or remove carbon dioxide), malignant neoplasm of endometrium (cancer of the uterine lining), dependence on ventilator (machine that helps residents breathe), congestive heart failure (the heart cannot pump blood efficiently), chronic kidney failure, anemia (blood disorder where the body lacks sufficient healthy red blood cells). During a review of Resident 36's MDS dated [DATE], MDS indicated, Resident 36 has no speech, moderate hearing difficulty, The MDS indicated that Resident 36 dependent on ADLs with staff. During a review of Resident 36's Situation, Background, Assessment, and Recommendation (SBAR-a communication framework) or Change of Condition (COC) dated 3/16/26, SBAR indicated, rash on left shoulder: during morning care, noted rash like eruptions on left shoulder, dry and scaly, with redness and scant serous exudate, complaining of itchiness SBAR also indicated to perform skin scraping. During a review of Resident 36's Dermatology Progress Notes dated 4/13/26, Derma Notes indicated, diagnosis of dermatitis unspecified gen body, treatment: permethrin and ivermectin, topical steroids, and skin scraping. There is no documented contact precaution while there is a suspicious rash on 3/16/26. During a review of Resident 36's Physician Orders dated 4/14/26, Physician Orders indicated, rash: dermatitis unspecified on generalized body; monitor and assess once a day for any changes in appearance, there is no documented contact isolation. During a review of Resident 39's admission Record on 4/20/26, admission Record indicated, Resident 39 was admitted on [DATE] with diagnoses including acute and chronic respiratory failure, epilepsy (recurrent, unprovoked seizures), DM. During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39 has no speech, cognitive skills for daily decision making is severely impaired and dependent with ADL's. During a review of Resident 39's SBAR or COC dated 3/27/26, SBAR indicated, rash like eruption on left side trunk during morning care noted rash like eruption on left side trunk, raised red and dark brown patches and scattered red spots with no drainage, some are raised and pimple like. During a review of Resident 39's Dermatology Notes dated 4/13/26, Derma Notes indicated, diagnosis of dermatitis unspecified gen body, treatment (continued on next page)

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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	includes permethrin, ivermectin, oral steroids, topical steroids, and skin scraping, no contact precaution order for a generalized body rash. During a concurrent record review and interview on 4/23/26 at 9:00 a.m. of Resident 39 and 36's Physician's order and SBAR with IPN, IPN stated, Resident 39 was not placed on contact precaution when rash was identified on 3/27/26. The IPN stated it should have been on contact isolation to prevent the spread of infection to other residents or staff. During an interview on 4/23/2026 at 11:20 a.m. with the DON, the DON stated that contact precautions are implemented when a contagious disease is suspected in order to prevent transmission. The DON stated that they remain actively involved and proactive in monitoring infections reported within the facility to prevent the spread of disease. The DON stated that he was not aware that there was no physician order in place for the initiation of contact precautions when there is a suspected rash.During a review of the facility's Policy and Procedure (P&P), titled Infection Prevention Quality Control Plan, reviewed October 2022, Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease . Transmission-based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. During a review of facility's P&P on Scabies Identification, Treatment and Environmental Cleaning, reviewed August 2022, P&P indicated, incubation period can be 2-6 weeks before onset of itching for persons with no previous exposure. Affected residents should remain on Contact Precautions. Treatment with Permethrin leave cream on for at least 8 hours but no more than 12 hours and then shower or bathe the resident in warm water, soaping the body completely, rinsing and drying well. Environmental Control: Typical Scabies 1. Place residents with typical scabies on contact precautions during the treatment period, Environmental Control: Crusted/Atypical Scabies: Maintain contact precautions until treatment is complete and/or resident is determined (by dermatologist or primary care provider) to be scabies-free.

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	04/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure reasonable accommodation of resident needs when staff did not respond in a timely manner to gastrostomy tube (GT-a tube surgically inserted into the stomach to allow access for nutrition, fluids, and medications) alarms for 2 of 8 sampled residents (Residents 56 and 74).This deficient practice resulted in the potential for the GT pump to become dislodged or for the tube to slip out of proper position, causing incorrect or delayed delivery of the required volume (Resident 74). Findings: During a review of Resident 74's admission Record on 4/20/26, the admission Record indicated, Resident 74 was admitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia (dangerous condition where body tissues do not receive enough oxygen), gastrointestinal hemorrhage (uncontrollable escape of blood from damaged blood vessels of the stomach and intestines, dysphasia (language disorder caused by brain damage) following cerebral infarction (or ischemic stroke, occurs when blood flow to part of the brain is blocked by a clot/thrombus, causing tissue death), hypertension , anemia (blood disorder where low red blood cell or hemoglobin levels reduce oxygen delivery), diabetes mellitus, and BPH. During a review of Resident 74's Minimum Data Set (MDS-a resident assessment tool) dated 4/7/26, Resident has no speech, rarely/never understood, sometimes understands, highly impaired vision, cognitive skills for daily decision making severely impaired, impaired ROM on both sides, dependent with ADLs, always bladder/bowel incontinent, on oxygen therapy (treatment providing extra concentrated oxygen), tracheostomy care (routine cleaning and maintenance of a surgically created hole and tube in the neck), and suctioning. During a review of Resident 74's Physician Orders dated 4/3/26, Physician Orders indicated, Resident 74 enteral feed order every shift enteral feed order every shift tube feeding - Glucerna 1.5 (high-calorie, nutrient-dense beverage designed for people with diabetes or high blood sugar) via GT @65 ml/hr x 18 hours via pump to provide 1170ml/1755kcal per day, to start from 2pm till 8am and or until dose is completed dx: dysphagia (swallowing difficulty). Physician Orders indicated, enteral feed order every shift enteral: monitor GT patency every shift, start date 4/3/26. During an observation on 4/20/26 at 9:16 a.m., Resident 74's GT feeding pump was audibly alarming, and the pump screen displayed the message, found tube slip detected, remove and reload cassette. During an observation on 4/20/26 at 9:30 a.m., Licensed Vocational Nurse (LVN) and Registered Nurse (RN) walked past Resident 74's room without entering to check on or respond to the beeping GT pump. During a follow-up observation on 4/20/26 at 9:38 a.m., more than 20 minutes after the GT pump was first noted to be alarming, no staff had entered the room to address the beeping. During a concurrent observation and interview on 4/20/26 at 9:40 a.m. with LVN 1, LVN 1 entered the room and stated, I can't tell you if it is loose. LVN 1 stated, it doesn't say whether the tubing is dislodged or if clogging is detected. If the feeding is complete, the screen will show a check mark, but this machine didn't indicate anything. During a review of Resident 74's Care Plan dated 4/21/26, the CP indicated Resident 74 is at risk for alteration in nutritional status due to use of: GT feeding related to dysphagia. The CP indicated, administer feeding and flush as ordered at proper rate and volume.During an interview on 4/23/26 at 12:13 p.m. with the DON, DON stated, Resident 74's GT pump needs to be attended right away. DON stated, if GT pump keeps beeping and no one attends to it, Resident doesn't receive the correct order of feeding; there is delayed total volume delivery. DON stated, if there is a machine beeping, we shouldn't ignore it. We cannot just keep educating the staff, if not following, it's the behavior of staff that should be dealt with.

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	04/23/2026

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 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 facility failed to ensure one of five sampled residents (Resident 67) was assessed and monitored properly for the use of hand mittens (padded, mitt-shaped devices designed to prevent patients from pulling at tubes or self-injury). This deficient practice had the potential to place Resident 67 in unnecessary restraints.Findings:During an observation on 4/20/2026 at 10:12 a.m., Resident 67 was observed in bed with a hand mitten (soft, padded gloves worn over a patient's hands to prevent them from pulling out tubes or causing self-harm). on his left hand.During a review of Resident 67's admission Record, the admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses including gastrostomy tube (G-tube, a tube placed directly into the stomach for long-term feeding), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) affecting right dominant hand, and anxiety disorder.During a review of Resident 67's history and physical (H&P) dated 2/17/2026, the H&P indicated Resident 67 does not have the capacity to understand and make decisions.During a review of Resident 67's Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2026, the MDS indicated Resident 67 had severe cognitive impairment. The MDS indicated Resident 67 was dependent on all aspects of activities of daily living (ADL, basic activities such as eating, dressing, toileting). The MDS indicated Resident 67 had impairments on both sides of the upper (arms/shoulders) and lower (hips/legs) extremities.During a review of Resident 67's Restraint-Physical Initial Evaluation on 1/19/2026 at 10:34 a.m., the Restraint-Physical Initial Evaluation indicated hand mittens were implemented for Resident 67 as they are least restrictive and would be used as a trial period instead of Ativan (medication used for anxiety or agitation)During a review of Resident 67's Quarterly Restraint-Physical Assessment on 4/9/2026 at 6:05 p.m., the Quarterly Restraint-Physical Assessment indicated Resident 67 had cognitive impairment and continued to try to pull out the g-tube. There were no attempts documented to reduce the hand mitten restraint over the past quarter and Resident 67 continued the use of hand mitten restraints.During a concurrent interview and record review on 4/22/2026 at 9:48 a.m. with Licensed Vocational Nurse 8 (LVN) 8, LVN 8 stated hand mittens were considered restraints as it did not allow Resident 67 to move. LVN 8 stated Resident 67 had not had any episodes of pulling out his g-tube or dislodgements and indicated there is no documentation of monitoring episodes of him pulling out his g-tube. LVN 8 stated they have not tried other methods to see if Resident 67 needs to continue wearing the hand mittens. LVN 8 stated if Resident 67 did not need hand mittens and have them, that it is considered abuse as it could restrain Resident 67 and jeopardize the residents' skin integrity and mobility.During a concurrent interview and record review on 4/22/2026 at 12:12 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated she, the admissions nurse, or the Quality Assurance (QA) nurse does the restraint assessment. The MDSN stated a restraint reassessment for Resident 67 occurred on 4/9/2026 and only visual monitoring was being done with no documentation. The MDSN stated if Resident 67 had restraints when it is not indicated it would affect them.During an interview on 4/23/2026 at 3:04 p.m. with the Director of Nursing (DON), the DON stated restraints restrict the mobility of residents and hand mittens are utilized because Resident 67 pulled on the g-tube. The DON stated prior to applying restraints, the licensed staff would try the least restrictive interventions before moving to a more invasive approach. The DON stated the licensed nurses did visual checks and based on the assessment, the continuation of hand mittens was determined. The DON stated there was no documentation and tally marks of Resident 67 trying to pull out his g-tube. The DON stated having documentation would allow licensed nurses to assess if the intervention is effective and not monitoring the residents would unnecessarily have them continue an intervention that is not needed. The DON stated leaving restraints on when not indicated could restrict Resident 67 movement and (continued on next page)

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	04/23/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause skin issues.During a review of the facility's policy and procedures (P&P) titled, Use of Restraints, revised 4/2017, the P&P indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. When the use of restraints is indicated, the lease restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. The following safety guidelines shall be implemented and documented while a resident is in restraints: a resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. Documentation regarding the use of restraints shall include full documentation of the episode leading to the use of the physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode, the length of effectiveness of the restraint time, and observation, range of motion and repositioning flow sheets.

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	04/23/2026

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 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 one of five sampled residents (Resident 8) received nonˆpharmacological interventions (evidence-based, non-invasive, non-drug treatments aimed at improving, maintaining, or modifying health conditions) prior to the administration of PRN (given as needed or requested) Ativan (a medication used to treat anxiety-feelings of fear, dread, or uneasiness).This deficient practice had the potential to result in resident's unnecessary consumption of medications and cause untoward adverse reactions for taking psychotropic (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications.Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral (brain) hemorrhage (bleeding), acute and chronic respiratory failure (body can't get enough oxygen into the blood), dependent on ventilator (a medical device to help support or replace breathing), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental health condition characterized by excessive persistent worry).During a review of Resident 8's Minimum Data Set ([MDS] resident assessment tool), dated 3/23/2026, the MDS indicated Resident 8's cognition was moderately impaired. The MDS indicated Resident 8 was dependent (helper does all the effort) on staff for activities of daily living (activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 8's Order Listing Report, from 1/1/2026 to 4/31/2026, the report indicated Ativan 0.5 mg via gastrostomy ([G-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach) was ordered every 6 hours PRN for anxiety manifested by restlessness leading to shortness of breath/hyperventilation (rapid deep breathing).During a review of Resident 8's Medication Administration Record (MAR) for the period of 4/1/2026 through 4/22/2026, the MAR showed that Resident 8 received Ativan 0.5 mg PRN for six days. The MAR also indicated that nonˆpharmacological interventions were not attempted prior to administering Ativan.During a concurrent interview and record review on 4/23/2026 at 8:34 a.m., with Registered Nurse Supervisor (RN) 2, Resident 8's MAR was reviewed, and RN 2 stated nonpharmacological measures were not attempted prior to the administration of Ativan. RNS 2 stated nonpharmacological measures should be attempted before administering Ativan to prevent unnecessary use of Ativan.During an interview on 4/23/2026 at 8:44 a.m. with the Director of Nursing (DON), the DON stated non-pharmacological interventions for behavior prior to medication use were to prevent use of Ativan because the medication has undesirable side effects.During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised 7/2022, the P&P indicated: non-pharmacological interventions are used (unless contraindicated) to minimize the need for medications when possible.

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	04/23/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one resident (Resident 88) received daily activities appropriate to the resident's needs. The deficient practice had the potential to negatively affect the residents' physical and mental well-being. Findings:During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of permanent movement and posture disorders caused by abnormal brain development or damage before, during, or shortly after birth), muscle weakness, and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right knee.During a review of Resident 88's Minimum Data Set ([MDS] a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 88's cognition (ability to think) was severely impaired. The MDS indicated Resident 10 was dependent on staff for all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily)During a concurrent interview and record review on 4/21/2026 at 3:24 p.m. with the Activities Director (AD), Resident 88's Activities Point of Care Report, for March and April 2026 was reviewed. The AD stated Resident 88 did not have daily activities. The AD acknowledged that residents should receive daily activities to support brain stimulation and promote quality of life.During an interview on 4/23/2026 at 8:44 a.m. with the Director of Nursing (DON), the DON stated activities are a part of residents' daily living that can stimulate cognition.During a review of the facility's policy and procedure (P&P) titled, Activity Program, revised 6/2018, the P&P indicated activities are provided to support the well-being of residents.

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	04/23/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 41) who was assessed as being at very high risk for pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) development was provided a pressure relieving barrier to be placed between Resident 41's overlapping, contracted (loss of motion of a joint associated with stiffness and joint deformity) toes of the left foot as indicated per facility policy.This deficient practice had the potential to result in Resident 41 developing pressure ulcers on the left foot. Findings: During a review of Resident 41's admission Record, the admission Record indicated the facility initially admitted Resident 41 on 9/6/2024 with diagnoses including anoxic brain damage (injury to the brain caused by lack of oxygen), acute respiratory failure (condition that occurs when the lungs cannot get enough oxygen into the blood) with hypoxia (medical condition where the body's tissues and organs do not receive adequate oxygen to maintain normal function), and a persistent vegetative state (chronic condition of wakefulness without awareness following severe brain damage). During a review of Resident 41's Minimum Data Set (MDS, resident assessment tool), dated 3/5/2026, the MDS indicated Resident 41 was dependent (helper does all the effort) in oral hygiene, toileting, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 41 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. The MDS indicated Resident 41 was at risk for pressure ulcer development. During a review of Resident 41's Braden Scale (pressure ulcer risk assessment tool), dated 3/5/2026, the Braden Scale indicated Resident 41 was at very high risk for pressure ulcer development due to completely limited sensory perception (unresponsive to painful stimuli due to diminished level of consciousness or sedation or limited ability to feel pain over most of the body), very moist skin, complete immobility (inability to move), and concerns for friction (force that resists or slows down movement when two surfaces rub against each other) and shearing (tissue damage that occurs when skin stays in one place while the underlying bone or tissues shift causing tissues to stretch, tear or slide in opposite directions). During a concurrent observation and interview on 4/20/2026 at 11:34 am with Registered Nurse 1 (RN 1), in Resident 41's room, Resident 41 was lying in bed. Resident 41's both legs were fully straight with both legs curved inwards and hyperextended (the extension of a body part beyond its normal limits) at the knees and both feet pointing downwards. Resident 41's second toe was positioned on top of the big toe on the left foot, causing an overlap. RN 1 assessed Resident 41's left foot and confirmed Resident 41's second toe overlapped the big toe. RN 1 physically separated both toes and confirmed there was a visible indentation of Resident 41's second toe on Resident 41's big toe caused by direct pressure from the overlapping toes. RN 1 stated Resident 41's toes on the left foot were overlapping and required staff to physically separate and consistently reposition the toes to prevent areas of pressure. RN 1 stated Resident 41 should have a barrier or ointment in between Resident 41's overlapping toes to prevent pressure ulcers but did not. During a concurrent observation and interview on 4/20/2026 at 11:57 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 assessed Resident 41's left foot and confirmed Resident 41 had contractures of the left foot causing the second toe and big toe to overlap. LVN 2 physically separated Resident 41's second toe and big toe on the left foot and confirmed there was a visible indentation of Resident 41's second toe on the top, left side of Resident 41's big toe caused by areas of pressure from the overlap. LVN 2 stated the area of pressure caused by the overlapping of Resident 41's second toe and big toe of the left foot should be off loaded with a barrier device in between both toes to prevent pressure ulcers and skin breakdown. LVN 2 stated Resident 41 was at high risk for skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) and pressure ulcers due to immobility, contractures, and overlapping toes causing prolonged area of pressure. During an interview on 4/23/2026 at 1:53 pm with the (continued on next page)

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	04/23/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON), the DON stated the lack of repositioning, prolonged areas of pressure, poor nutrition, and immobility put residents at risk for skin breakdown and pressure ulcers. The DON stated Resident 41 was at high risk for developing skin breakdown and pressure ulcers due to immobility, contractures, and multiple co-morbidities (presence of two of more distinct medical or mental health conditions occurring simultaneously in the same individual). The DON stated contracted, overlapping toes placed residents at high risk for pressure ulcer development due to areas of prolonged pressure and should be assessed by the Rehabilitation Department (Rehab), nursing, and/or the physician to ensure the pressure between the toes was off-loaded, monitored, and treated appropriately to prevent skin breakdown and pressure ulcers. During a review of the facility's Policy and Procedure (P/P) titled, Prevention of Pressure Injuries, revised 4/2020, the P/P indicated staff were to review the care plan and identify the risk factors as well as the interventions designed to reduce or eliminate pressure injuries. The P/P indicated staff inspected skin daily when performing or assisting with personal care or activities of daily living (ADLs) which included the inspection of pressure points, repositioning the resident, and providing support devices and assistance as needed. The P/P indicated skin care and prevention of pressure injuries included the use of facility-approved protective dressings for at risk individuals. The P/P indicated staff were to review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device, monitor regularly for comfort and signs of pressure-related injury, and to consult with current clinical practice guidelines for prevention measures associated with specific devices.

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	04/23/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with a physician order for a foley catheter (also called indwelling catheter, a thin, flexible tube that drains urine from the bladder into a bag outside the body) and had monitoring and care provided to prevent recurrent urinary tract infection ([UTI], a bacterial infection that affects the urinary tract, which includes the bladder, ureters, and kidneys) for one of two sampled residents (Resident 94).This deficient practice had the potential to result in Resident 94 acquiring recurrent UTIs when foley catheter was not monitored and care was not provided according to the physician's order.Findings:During a review of Resident 94's admission Records, the admission Records indicated Resident 94 was originally admitted to the facility on [DATE] with a readmission date on 12/30/2025 with diagnoses of chronic obstructive pulmonary disease ([COPD], lung disease that causes obstruction of airflow and can limit normal breathing), diabetes mellitus ([DM], a chronic disease that affects how the body processes sugar), and vesicoureteral reflux ([VUR], the backward flow of urine from the bladder up the ureters into the kidneys).During a review of Resident 94's history and physical (H&P), dated 12/31/2025, the H&P indicated Resident 94 had the capacity to understand and make decisions.During a record review of Resident 94's Minimum Data Set ([MDS], a resident assessment tool) dated 2/26/2026, the MDS indicated Resident 94 had intact cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 94 required moderate assistance (helper does less than half the effort) for self-care abilities such as eating, hygiene and dressing. The MDS indicated Resident 94 was maximal assistance (helper does more than half the effort) for mobility such as sit to stand and transfers. The MDS indicated Resident 94 had a neurogenic bladder (a dysfunction of the bladder caused by nerve damage leading to an inability to empty the bladder) and an indwelling catheter was in place.During a record review of Resident 94's Order Summary Report dated 7/6/2025, the Order Summary Report indicated cleanse indwelling catheter site with water and soap, rinse then dry pat every shift. The Order Summary Report indicated to monitor catheter urinary drainage bag and document the following every shift for color, consistency, odor, hematuria, bladder distention, burning, sensation, document (+) if there is presence of signs and symptoms of UTI, document (0) if there is absence of signs and symptoms of UTI.During a review of Resident 94's Treatment Administration Record (TAR) dated 2/1/2026 to 2/28/2026, the TAR indicated to cleanse the indwelling catheter site with water and soap, rinse then pat dry every shift, it was not done the night shift on 2/19/2026. The TAR indicated the treatment of monitoring catheter urinary drainage bag and document the following every shift for color, consistency, odor, hematuria, bladder distention, burning, sensation, document (+) if there is presence of signs and symptoms of UTI, document (0) if there is absence of signs and symptoms of UTI was done every shift except 11:00 p.m. shift on 2/19/2026.During a review of Resident 94's TAR dated 3/1/2026 to 3/31/2026, the treatment of cleansing indwelling catheter site with water and soap, rinse then pat dry every shift was done every shift except evening shift on 3/8/2026, night shift on 3/8/2026, and night shift on 3/26/2026. The TAR indicated the treatment of monitoring catheter urinary drainage bag and document the following every shift for color, consistency, odor, hematuria, bladder distention, burning, sensation, document (+) if there is presence of signs and symptoms of UTI, document (0) if there is absence of signs and symptoms of UTI was done every shift except 3:00 p.m. shift on 3/8/2026, 11:00 p.m. shift on 3/8/2026, and 3:00 p.m. shift on 3/26/2026.During a review of Resident 94's TAR dated 4/1/2026 to 4/30/2026, the treatment of cleansing indwelling catheter site with water and soap, rinse then pat dry every shift was done every shift except night shift on 4/5/2026. The TAR indicated the treatment of monitoring catheter urinary drainage bag and document the following every shift for color, consistency, odor, hematuria, bladder distention, burning, sensation, document (+) if there is presence of signs and symptoms of UTI, (continued on next page)

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	04/23/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document (0) if there is absence of signs and symptoms of UTI was done every shift 11:00 p.m. shift on 4/5/2026.During a concurrent observation and interview on 4/20/2026 at 11:37 a.m. in Resident 94's room, Resident 94 was laying in bed watching television. Resident 94 stated she was hospitalized in December, and had a catheter placed. Resident 94 stated she could not walk to the restroom, and the catheter was placed to help her empty her bladder. During a concurrent interview and record review on 4/9/2026 at 10:14 a.m. with Registered Nurse Supervisor (RNS) 3, the TAR for dated 2/1/2026 to 2/28/2026, TAR dated 3/1/2026 to 3/31/2026 and TAR dated 4/1/2026 to 4/30/2026 was reviewed. RNS 3 stated there was missing documentation for cleansing and monitoring the urinary catheter drainage bag on some dates for February, March and April 2026. RNS 3 stated he cannot say the nurses are doing the monitoring and following the physician's order for cleansing, but if it was not documented in the TAR, it was not done. RNS 3 stated if staff are not following physicians' orders, it increases the risk of infections. RNS 3 stated Resident 94 had her share of UTI and was getting antibiotics (medications that treat bacterial infections by killing bacteria or stopping their growth) for UTI in the past. RNS 3 stated if the nurses are not following the physician's order to monitor and cleansing the indwelling catheter as ordered, the resident may get recurrent infections. During an interview on 4/9/2026 at 1:03 p.m. with the Director of Nursing (DON), the DON stated the importance of monitoring and providing indwelling catheter care was to prevent infection. The DON stated Resident 94 had recurrent UTI in the past and staff should be following physician's orders to monitor and provide catheter care to prevent UTI.During a review of the facility's policy and procedures (P&P) titled Catheter Care, Urinary, revised September 2014, indicated, purpose of this procedure is to prevent catheter-associated urinary tract infections.maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.do not clean the periurethral area with antiseptics to prevent catheter-associated UTI's while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate.be sure the catheter tubing and drainage bag are kept off the floor.empty the drainage bag regularly using a separate, clean collection container for each resident and avoid splashing and prevent contact of the drainage spigot with the nonsterile container.the following information should be recorded in the resident's medical record such as the date and time that catheter care was given, the name and title of the individual(s) giving the catheter care, character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor, any problems noted at the catheter-urethral junction during perinea] care such as drainage, redness, bleeding, irritation, crusting, or pain, any problems or complaints made by the resident related to the procedure.

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	04/23/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents (Resident 10) received HD on 1/27/2026.This deficient practice had the potential to result in fluid overload (a condition where excessive water and sodium accumulate in the body) weight gain, edema (swelling in legs/arms), and shortness of breath.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was recently re-admitted to the facility on [DATE] with diagnoses including chronic kidney disease (a serious, long-term condition where kidneys are damaged and cannot effectively filter blood, often leading to waste buildup) and dependence on renal dialysis.During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2026, the MDS indicated Resident 10's cognition (ability to think) was severely impaired. The MDS indicated Resident 10 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 10's Order's, dated 1/13/2026, the order indicated to start hemodialysis to an outpatient dialysis center on Tuesday, Thursday, and Saturday. During a concurrent interview and record review on 4/22/2026 at 2:24 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 10's SBAR & Initial COC/Alert Charting & Skilled Documentation, dated 1/27/2026, was reviewed. RNS 1 stated Resident 10 missed dialysis on 1/27/2026 because there was an issue with transportation. RNS 1 stated the HD residents should not miss dialysis because it could cause fluid overload. During an interview on 4/23/2026 at 8:44 a.m. with the Director of Nursing (DON), the DON stated missing dialysis could cause fluid overload.During a review of the facility's policy and procedure (P&P) titled, End Stage Renal Disease, ([ESRD]irreversible kidney failure) Care of Resident with revised 9/2010, the P&P indicated residents with ESRD will be cared for according to currently recognized standards of care.

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	04/23/2026

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 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 and interview, the facility failed to ensure a thermometer was placed in the dry storage food area. This deficient practice had the potential to result in food-borne illnesses (food poisoning) of the residents with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization.During a concurrent observation and interview on 4/20/2025 at 9:08 a.m. with the Dietary Manager (DM), the DM verbalized the current storage room temperature is 72 degrees Fahrenheit (F, temperature scale). The DM stated the facility did not need to have a thermometer in the dry storage room and indicated that when the room gets too hot, they will put the thermometer in the dry storage room and take the temperature. The DM stated nothing in the storage room would be affected by not having a thermometer since there is no produce. During an interview on 4/23/2025 at 3:03 p.m. with the Director of Nursing (DON), the DON stated a thermometer should be in the dry storage room so they can monitor the temperature as certain foods have temperature requirements and would not want the items to spoil. The DON stated if there were no thermometers in the dry storage room, they would not be able to monitor the temperature, and they may hand out spoiled goods to the residents since they did not maintain the room temperature. During a review of the facility's policy and procedures (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated thermometers should be placed in all storage areas and checked frequently. Recommended temperature is 50 degrees Fahrenheit (F, temperature scale) - 85 F- if dry food storage goes over 85 F take corrective action.

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	04/23/2026

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 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 exterior waste disposal containers were fully closed and trash collection area was cleaned and free of black sticky residue.This failure had the potential to result in the attraction of pests and spread of pathogens due to unsanitary environment.Findings:During an observation on 4/20/2026 at 8:34 a.m. of the designated trash collection area located on the left side of the facility, two of three gray waste disposal containers and one blue waste container were not fully closed. The floor of the designated trash collection area had used pair of gloves and black sticky residue.During a concurrent observation and interview on 4/20/2026 at 9:10 a.m. with the Dietary Supervisor (DS), the DS stated the waste disposal containers were full and were not fully closed, a used pair of gloves was on the floor, and the floor had black sticky residue. The DS stated the importance of keeping the waste disposal containers fully closed and the designated waste disposal area clean was to ensure trash was contained and to prevent rodents or pests from digging through the trash. The DS stated if the designated waste disposal area was not clean, there would be potential for flies, rodents, or any pests to dig through the trash and potential find a way to enter the facility.During a review of the facility's policy and procedure (P&P) titled. Garbage and Trash dated, 2023, the P&P indicated, The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. 1. The area must be swept and washed down by maintenance with a detergent on a regular basis. If a commercial rubbish service is used, arrangements must be made for periodic exchange of trash bins.

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	04/23/2026

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 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. Based on interview and record review, the facility failed to ensure the General Acute Care Hospital (GACH) Discharge Summary for one of six sampled residents (Resident 3) was in the medical record and readily accessible.This deficient practice had the potential to delay and negatively affect the delivery of necessary care and services.Findings:During a review of Resident 3's admission Record, the admission Record indicated the facility initially admitted Resident 3 on 12/26/2022 and re-admitted Resident 3 on 2/13/2025 with diagnoses including a left ulna (longer of the two bones in the forearm which stretches from the elbow to the wrist) fracture (broken bone), anoxic brain damage (injury to the brain caused by lack of oxygen), and osteoporosis (condition in which the bones become brittle) with pathological fracture (broken bone caused by an underlying disease or condition that weakens the bone structure). During a review of Resident 3's Minimum Data Set (MDS, resident assessment tool), dated 2/17/2026, the MDS indicated Resident 3 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 was dependent (helper does all the effort) in oral hygiene, toileting, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 3 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During a review of Resident 3's GACH Emergency Department (ED) Note (GACH ED Note), dated 2/8/2025, the GACH ED Note indicated Resident 3 was transferred to the hospital from the facility for an evaluation of Resident 3's left forearm fracture sustained on 2/8/2025 while staff tried to move Resident 3 in bed. The GACH ED Note indicated Resident 3 could return to the facility after a splint was placed on Resident 3's left arm. The GACH ED Note indicated for Resident 3 to follow up with her primary care physician/Orthopedics in the next seven to 10 days after discharge where Resident 3 would be given aftercare instructions for her left arm fracture.During a concurrent interview and record review on 4/23/2026 at 12:22 pm with Registered Nurse Supervisor 3 (RNS 3), RNS 3 stated a licensed nurse was responsible for accepting a resident's paperwork, implementing new physician orders and scheduling follow up appointments as needed when a resident was re-admitted to the facility after discharge from the hospital. RNS 3 reviewed Resident 3's clinical record and confirmed Resident 3 sustained a left ulna fracture on 2/8/2025, went to the hospital for evaluation and treatment of the fracture, and returned to the facility on 2/10/2026. RNS 3 reviewed Resident 3's GACH ED Note, dated 2/8/2025, and confirmed Resident 3 was placed in a left arm splint and discharged back to the facility with the recommendation to follow up with orthopedics in seven to 10 days. RNS 3 reviewed Resident 3's clinical record and stated Resident 3's GACH Discharge Summary for 2/10/2025 when Resident 3 was re-admitted back to the facility from the hospital for evaluation of the left ulna fracture was missing. RNS 3 stated the licensed nurse needed a resident's Discharge Summary from the hospital to know what type of care to provide to the resident, including medications and follow up care or appointments. RNS 3 stated if the Discharge Summary was missing from the medical record, the facility would not know how to provide the appropriate care for the resident. RNS 3 stated Resident 3's GACH Discharge Summary was supposed to be in the resident's electronic medical record (EMR) but was not. RNS 3 stated it was important that GACH Discharge Summaries were readily accessible and scanned into the EMR to ensure staff were aware of any recommendations, instructions, follow-up appointments, and changes to the plan of care. During a concurrent interview and record review on 4/23/2026 at 12:35 pm with the Medical Record Director (MR), the MR confirmed Resident 3's GACH Discharge Summary for 2/10/2025 was missing and not in Resident 3's clinical record. The MR stated the GACH Discharge Summary should be uploaded into Resident 3's EHR but was not and had to contact the GACH to obtain the GACH Discharge Summary. During an interview on 4/23/2026 at 1:23 pm with the Director of Nursing (DON), the DON stated a (continued on next page)

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	04/23/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed nurse was responsible for accepting a resident's paperwork, implementing new physician orders and scheduling follow up appointments as needed when a resident was re-admitted to the facility after discharge from the hospital. The DON stated the licensed nurse needed the resident's GACH Discharge Summary to know what type of care to provide the resident upon re-admission to the facility. The DON stated it was a common occurrence for residents to return from the hospital without a Discharge Summary. The DON stated if a resident's GACH Discharge Summary was missing and inaccessible to staff, it could negatively impact a resident's care and result in missed appointments and a lack of or delay in necessary care and services. During a review of the facility's Policy and Procedure (P/P) titled Location and Storage of Medical Records, 12/2006, the P/P indicated all current medical records were filed in the medical records department and were maintained by the medical records clerk. The P/P indicated archived medical records would be clearly identified as archived records and stored appropriately. During a review of the facility's P/P titled, Charting and Documentation, 7/2017, the P/P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The P/P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P/P indicated documented in the medical record would be objective, complete, and accurate.

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	04/23/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two hospice (compassionate care for people who are near the end of life) residents (Resident 13) home health aide ([HHA] trained professional who provides in-home personal care, basic health monitoring, and companionship to elderly, disabled, or chronically ill individuals) visits were made twice a week.The deficient practice had the potential to result in negative health outcomes. Findings:During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was recently re-admitted to the facility on [DATE] with diagnoses including Severe Protein Calorie Malnutrition (life-threatening condition resulting from inadequate intake of protein and calories, causing significant muscle wasting, fat loss, and organ dysfunction.), dementia (a progressive state of decline in mental abilities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements)During a review of Resident 13's Minimum Data Set ([MDS] a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 13's cognition (ability to think) was severely impaired. The MDS indicated Resident 13 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 13's hospice admission Agreement, 2/18/2026, the agreement indicated hospice aide will make visit twice a week. During a review of Resident 10's Order Summary Report, active orders as of 4/22/2026, the report indicated Resident 13 was admitted under hospice care.During a concurrent interview and record review on 4/22/2026 at 10:28 a.m. with Registered Nurse Supervisor (RNS) 3, Resident 13s hospice records were reviewed. RNS 3 stated the HHA was supposed to visit twice a week and documented evidence indicated the HHA did not visit twice a week. During an interview on 4/23/2026 at 8:44 a.m. with the Director of Nursing (DON), the DON stated that hospice care was essential to ensuring residents' comfort goals were met.During a review of the facility's policy and procedure (P&P) titled, Hospice Program, revised 7/2017, the P&P indicated hospice providers who contract with facility are held responsible for meeting professional standards.

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	04/23/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one out of four sampled residents (Resident 31) was screened appropriately prior to initiating antibiotic treatment. This deficient practice had the potential to increase antibiotic resistance and provide antibiotics without justification.During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses including tracheostomy (a tube placed into a surgically created hole through the front of the neck and into the windpipe-trachea), gastrostomy (G-tube, a tube placed directly into the stomach for long-term feeding), and acute and chronic respiratory failure. During a review of Resident 31's history and physical (H&P) dated 6/13/2025, the H&P indicated Resident 31 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 31 had severe cognitive impairment. The MDS indicated Resident 31 was dependent on all aspects of activities of daily living (ADL, basic activities such as eating, dressing, toileting). The MDS indicated Resident 31 had impairments on both sides of the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 31's Intravenous (IV, administering medications or nutrients directly into a vein) Medication Administration Record (MAR, document used to track all medications administered) dated 4/1/2026 -4/30/2026, the MAR indicated Resident 31 had received Zosyn (generic name: Piperacillin Sodium Tazobactam Sodium in Dextrose, powerful intravenous antibiotic used to treat moderate-to-severe bacterial infections, including pneumonia) Intravenous Solution (liquid containing water, electrolytes injected directly into a vein to deliver medications) 3.375 gram (gm, unit of mass) / 50 milliliter (mL, unit of volume) one dose intravenously every six (6) hours for pulmonary infiltrate (substance such as fluid that accumulates in spaces of lungs) in left middle and lower long field for seven (7) days with start dated 4/4/2026 end date 4/10/2026. During a review of Resident 31's Infection Screening Evaluation dated 4/3/2026 at 9:13 p.m., the Infection Screening Evaluation indicated Resident 31 has a current, active diagnosis of infection, chest x-ray (image of the internal body, produced by X-rays being passed through it and being absorbed to different degrees by different materials) showing new infiltrates consistent with pneumonia (an infection/inflammation in the lungs). The Infection Screening Evaluation did not indicate any signs and symptoms to meet the McGeer's (evidence-based definitions used for detecting infections in facilities) or Loeb's (a minimum set of signs and symptoms which may indicate that the use of antibiotic [medication used to treat infection] might be indicated) Criteria. During a review of Resident 31's Infection Screening Evaluation dated 4/16/2026 at 1:31 p.m., the Infection Screening Evaluation indicated Resident 31 has a current, active diagnosis of infection, respiratory rate greater than 25 breaths/minute(min), new or increased cough with productive purulent sputum (thick, yellow-green phlegm signaling underlying respiratory infection or inflammation). The Infection Screening Evaluation did not indicate any signs and symptoms to meet the McGeer's or Loeb's Criteria. During a review of Resident 31's order summary report, dated 4/23/2026, the order summary report indicated Resident 31's medications included Cefepime (antibiotic) Hydrochloride (HCl, used to enhance absorption, effectiveness, and stability for active pharmaceutical ingredients) Intravenous Solution two (2) grams every eight (8) hours for gram negative bacilli (type of bacteria characterized by their rod shape associated with infections) sputum results until 4/26/2026 active 4/19/2026. During a concurrent interview and record review on 4/23/2026 at 11:51 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated antibiotic stewardship is a way of monitoring residents with antibiotics, ensure they are taking the right antibiotic for the indication, and advocate for the resident to discontinue or change the antibiotic when it is not needed. The IPN stated they will inform the doctor whether the resident still needs antibiotics or not and indicated they follow the McGeer's Criteria to determine the need for antibiotics. During a concurrent interview and record review on 4/23/2026 2:30 p.m. with the IPN, the IPN stated (continued on next page)

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	04/23/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she does not know what the No Infection prevention and control (IPC) Case Triggered on the Infection Screening Evaluation dated 4/3/2026 means and indicated based on her interpretation, this infection screening did not meet the McGeer's or Loebs criteria. The IPN stated she did not see the Infection Analysis section that indicates whether the infection screening evaluation med McGeer's or Loeb's criteria when initiating this form. The IPN stated the Infection Screening Evaluation dated 4/16/2026 did not also meet the McGeer's or Loebs criteria. The IPN stated if the screening did not meet the criteria, she would notify the doctor and ask if they would like to discontinue the medication. The IPN stated if the residents continue to get antibiotics when not indicated, they can become resistant to it, and it will be harder to treat the residents when they get sick. During an interview on 4/23/2026 at 3:27 p.m. with the Director of Nursing (DON), the DON stated the antibiotic stewardship is done to ensure the residents meet the criteria to receive the appropriate treatment and ensure the residents will not unnecessarily receive antibiotics to prevent developing resistance. The DON stated if they do not do the infection screening properly, they will not be able to provide the resident with the appropriate treatment and can affect their care. During a review of the facility's policy and procedures (P&P) titled, Antibiotic Stewardship, dated 12/2022, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. The P&P did not indicate procedures for identifying appropriateness for the use of antibiotics.