STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055408	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellflower Post Acute	9710 E. Artesia Ave Bellflower, CA 90706

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(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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure their ice machine - used to produce ice for resident distribution and consumption - was clean for safe and sanitary operation.This failure had the potential to result in at least 50 out of 56 residents in the facility suffering waterborne illness, increasing the risk for negative outcomes such as nausea, vomiting, diarrhea, and dehydration.Findings:During a concurrent observation and interview on April 15, 2026, at 1:55 PM with the Maintenance Director (MS) in the facility's kitchen, the facility's ice machine was observed for inspection. The following was observed during the facility ice machine's internal components inspection:- The ice cube product chute underneath the machine's ice cube forming plate, where the formed ice cube product deposited through to enter and rest in the machine's ice collection bin, contained white-colored matter that could be removed by hand with a folded paper towel.- Along the interior wall of the ice machine's housing, enclosing a section of the ice cube product chute's rim, black-colored matter was present on the surface.- Along the submerged surface of the feed water collection basin - positioned underneath the ice cube forming plate and collected the feed water that constantly circulated over the ice cube forming plate to form ice cube product - large surface areas of white-colored matter was present on the collection basin surface and was submerged in the feed water used to produce the machine's ice product.During a concurrent observation and interview on April 15, 2026, at 2:32 PM with the Dietary Supervisor (DS) in the facility's kitchen, the DS also observed the facility's ice machine during the inspection. The DS stated the ice machine was not clean, and residents can get sick and have diarrhea and other illnesses from dirty ice. The DS stated 55 residents out of the facility's 56 residents were subject to ingesting ice from the facility's ice machine.During a review of the facility's Diet Information [Name of Facility] as of 4/14/2026, dated April 14, 2026, the documentation indicated, 50 residents out of the facility's 55 residents listed were subject to receiving and consuming ice product from the facility's ice machine.During a review of the facility's policy and procedure (P&P) titled, Manual: Maintenance, Subject: Cleaning the Ice Machine, dated April 2017, the P&P indicated, Purpose: The ice machine shall be cleaned for maintenance of sanitary conditions in order to prevent food contamination and the growth of disease-producing organisms and toxins.During a review of the facility ice machine's user manual titled, [Name of Manufacturer] Ice Systems Installation and User's Manual for Air and Water Cooled Modular Cube [Name and Series of varying manufacturer models], dated June 2022, the document indicated, . This ice system requires three types of maintenance: . Sanitize the ice machine's water system and the ice storage bin or dispenser. It is the User's responsibility to keep the ice machine and ice storage bin in a sanitary condition. Without human intervention, sanitation will not be maintained.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews and record review, the facility failed to follow their Quality Assurance (QA) /Quality Assurance and Performance Improvement (QAPI]-a data driven proactive approach to improvement used to ensure services are meeting quality standards) to develop a corrective action plan or performance activities to address problems and opportunities for improvement.This had the potential to result in unsafe practices and harm to the residents.Findings:During a concurrent interview and record review on 4/16/2026 at 2:38 p.m. with the Administrator (ADM), the facility's QAPI binder was reviewed. The ADM stated the facility has identified falls, pressure injuries, and legionella water management as active QAPI topics. The ADM stated falls and pressure injury interventions and corrective actions are implemented on an individual level. The ADM did not provide documented plans or corrective actions that the facility has implemented to address falls, pressure injuries, and legionella water management.During a concurrent interview and record review on 4/16/2026 at 3:30 p.m. with the ADM, the facility's policy and procedure (P&P), titled Quality Assurance Performance Improvement Plan & Committee (QAPI), dated December 2026, was reviewed. The ADM stated the P&P indicated The QAPI plan will identify and use data to monitor its performance; establish goals and thresholds for performance measurement; utilize resident and staff input; identify and prioritize problems and opportunities for improvement; systemically analyze underlying causes of systemic problems and adverse events; and develop corrective action plans or performance improvement activities. The ADM stated not following the QAPI policy could result in unsafe practices.During a review of the facility's policy and procedure (P&P), titled Quality Assurance Performance Improvement Plan & Committee (QAPI), dated December 2026, the P&P indicated At the beginning of each performance improvement project goals, scope, timing, milestones, team roles and responsibilities will be developed and clearly established by the QAA committee and given to the team that will carry out the performance.

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(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 the call light device was within reach for one of eight sampled residents (Resident 53).This failure had the potential to prevent Resident 53 from receiving necessary care and services. Findings:During an observation on 4/13/2026, at 9:43 a.m., in Resident 53's room, Resident 53's call light was wrapped around the plug on the wall. Resident 53's right hand groped for something constantly.During a review of Resident 53's admission record, the admission record indicated Resident 53 was admitted to the facility on [DATE] with diagnosis including legal blindness (severe visual impairment or low vision), deafness (hearing loss that precludes a person from understanding spoken language), and congenital Rubella Syndrome (CRS- a condition occurring in newborns when a pregnant woman contracts the rubella virus, leading to severe, often permanent birth defects like heart issues, blindness, and deafness).During a review of Resident 53's History and Physical (H&P), dated 12/13/2025, the H&P indicated, Resident 53 had no capacity (ability) to understand and make decisions.During a review of Resident 53's Minimum Data Set (MDS-a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 53 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, transfer, bed mobility, dressing, hygiene, and maximal assistance (Helper does more than half the effort) from one staff for eating, oral hygiene.During a review of Resident 53's Care Plan (CP) titled, Resident 53 is at risk for fall and injury related poor safety awareness, revised 3/24/2026, the CP Goal indicated, Resident 53 will minimize risk for falls and recurrence daily until reevaluation date on 6/26/2026. The CP Approach Plan (Interventions) indicated, implementing fall precautions such as keeping call light withing reach and answer promptly. During an interview on 4/13/2026, at 9:46 a.m., with Licensed Vocational Nurse (LVN) 2 in Resident 53's room, LVN 2 stated, Resident 53 used the call light frequently and some staff got frustrated. LVN 2 stated that the call light should be placed within reach regardless of how frequently it was used. LVN 2 stated, if the call light was not within reach, Resident 53 would not be able to call for help during the emergency.During an interview on 4/14/2026, at 3:42 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated, the call light should always be accessible and within the resident's reach. RNS 1 stated that if the call light was not within the resident's reach, the resident would be unable to call for assistance to get his needs met. RNS 1 stated, the residents who were at risk of falling should be able to reach the call light to prevent fall related injuries.During a review of the facility's Policy and Procedure (P&P) titled, Call Lights revised 1/2017, the P&P indicated, Policy: It is the policy of the facility to respond to the resident's requests and needs. Procedure: When the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident. If a resident is unable to use the call light, staff should check on the resident frequently. Call lights should be answered promptly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents or responsible party ([RP] individual that exercises ultimate control, management, or decision-making authority over a business, asset, or legal obligation) had the opportunity to formulate an advance directive for three of four sampled residents (Resident 1, Resident 6, and Resident 25).This deficient practice had the potential to violate the resident's right to be fully informed of the option to formulate their advance directives and cause conflict with the residents' wishes regarding health care. Findings: A. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide) with hypoxia (when the body or a specific part does not receive enough oxygen to maintain normal function), and chronic kidney disease on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and dementia (a progressive state of decline in mental abilities). The admission Record indicated Resident 6 had a responsible party designated to make decisions.During a review of Resident 6's History and Physical (H&P), dated 2/24/2026, the H&P indicated Resident 6 did not have the capacity to understand and make decisions.During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 2/22/2026, the MDS indicated Resident 6 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision for eating and oral hygiene, required maximal assistance (helper does more than half of the effort) for toileting hygiene, and was dependent for bathing and lower body dressing. During a concurrent interview and record review on 4/15/2026 at 1:50 p.m. with the Social Services Director (SSD), Resident 6's Psycho-social assessment form dated 2/15/2026, Physician Orders for Life Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) dated 3/30/2026, and advance directive form was reviewed. The SSD stated Resident 6's Psycho-social assessment form indicated resident did not have an advance directive. The SSD stated Resident 6's POLST indicated Resident 6 did not have an advance directive. The SSD stated Resident 6's advance directive form was blank and did not indicate that Resident 6 or their Responsible Party was offered or educated about their rights to formulate an advance directive.B. During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, urinary tract infection (UTI - an infection in the bladder/urinary tract), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of right ankle and foot.During a review of Resident 25's H&P, dated 4/12/2026, the H&P indicated Resident 25 does not have the capacity to understand and make decisions. During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25's cognition was intact, required setup assistance when eating, required supervision for oral hygiene, required moderate assistance (helper does less than half the effort) for upper body dressing, and required maximal assistance (helper does more than half the effort) for toileting hygiene, bathing, and lower body dressing. During a concurrent interview and record review on 4/15/2026 at 1:58 p.m. with the SSD, Resident 25's Advance Directive form was reviewed. The SSD stated Resident 25's advance directive form is blank. The SSD stated Resident 25's advance directive acknowledgement should be completed on every readmission. C. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), pneumonia (an infection/inflammation in the lungs), and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	malignant neoplasm (cancer) of left breast and bone. The admission Record indicated Resident 1 had a responsible party designated to make decisions. During a review of Resident 1's H&P, dated 2/15/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had severe cognitive impairment, and was dependent for eating, oral hygiene, toileting hygiene, bathing, and upper and lower body dressing. During a concurrent interview and record review on 4/15/2026 at 2:01 p.m. with the SSD, Resident 1's POLST dated 3/24/2026 and advance directive form dated 2/6/2026 was reviewed. The SSD stated Resident 1's POLST indicated Resident 1 did not have an advance directive. The SSD stated Resident 1's advance directive form did not indicate that Resident 1 or their Responsible Party was offered or educated about their rights to formulate an advance directive. The SSD stated that when the resident or responsible party is not educated or offered to formulate an advance directive, there is a risk of violating the resident's right to autonomy (freedom to act on one's own will). During an interview on 4/16/2026 at 1:32 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the SSD should educate and offer the advance directive acknowledgement form to residents on admission. RNS 1 stated if residents are not offered or educated about formulating an advance directive, there is a risk of violating the residents' rights.During a review of the facility's policy and procedure (P&P), titled Advance Directives, dated April 2017, the P&P indicated prior to, or upon admission, resident's will be provided with written information concerning the resident's right under state law to accept or refuse medical or surgical treatment and the resident's right to prepare an advance directive. During a review of the facility's policy and procedure (P&P), titled POLST - Physician Orders for Life Sustaining Treatment, dated January 2017, the P&P indicated the POLST does not replace an advance directive.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 3 sampled residents (Resident 8 and Resident 42) were provided the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN - written notice issued by the facility to inform the resident of the cost of services that Medicare [federally funded health insurance for individuals aged 65 or older] may not cover and the reason why) in a manner the resident's understood. This deficient practice had the potential to result in violating the residents' rights to appeal the Medicare decision and cause financial burden on Resident 8 and Resident 42.Findings:A. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain), cellulitis (infection of the skin) of right lower limb, and chronic obstructive pulmonary disease (COPD - lung disease that causes obstruction of airflow and can limit normal breathing).During a review of Resident 8's History and Physical (H&P), dated 11/23/2025, the H&P indicated Resident 8 had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2026, the MDS indicated Resident 8's cognition (ability to learn, reason, remember, understand, and make decisions) was intact, required setup assistance when eating and oral hygiene, and required maximal assistance (helper does more than half the effort) for toileting, lower body dressing, and personal hygiene.During an interview on 4/13/2026 at 10:41 a.m. with Resident 8, Resident 8 stated they did not understand the share of cost that the facility is charging monthly. During a concurrent interview and record review on 4/15/2026 at 2:32 p.m. with the Business Office Manager (BOM), Resident 8's Notice of Medicare Non-Coverage (NOMNC-a standardized and required (Center for Medicare & Medicaid Services (CMS - federal agency that manages Medicare, Medicaid, and other federally funded health programs) form informing residents when Medicare-covered services are ending and the resident's right to appeal the decision), signed 1/23/2026, and SNF ABN, signed 1/23/2026, were reviewed. The BOM stated Resident 8's last covered date (LCD - last day of final day Medicare pays for skilled services) was 1/27/2026. The SNF ABN did not indicate which option Resident 8 chose regarding whether to continue to receive the skilled services of Physical therapy, Occupational therapy, and/or Daily Skilled Nursing Care and who Resident 8 designated to pay the bill. The BOM stated Resident 8 did not select an option listed on the SNF ABN.B. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy, heart failure, and COPD. During a review of Resident 42's History and Physical (H&P), dated 3/9/2026, the H&P indicated Resident 42 had the capacity to understand and make decisions.During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42's cognition (ability to learn, reason, remember, understand, and make decisions) was intact, required setup assistance when eating, required supervision for oral hygiene, required moderate assistance (helper does less than half the effort) for upper body dressing, and required maximal assistance for toileting hygiene, bathing, and lower body dressing. During a concurrent interview and record review on 4/15/2026 at 2:32 p.m. with the BOM, Resident 42's NOMNC, signed 9/15/2025, and SNF ABN, signed 9/15/2025, were reviewed. The BOM stated Resident 42's LCD was 9/18/2025. The BOM stated the SNF ABN did not indicate which option Resident 42 chose regarding whether continue to receive the skilled services of Physical therapy, Occupational therapy, and/or Daily Skilled Nursing Care and who Resident 42 designated to pay for the bill. The BOM stated Resident 42 did not select an option listed on the SNF ABN. The BOM stated it was the BOM's responsibility to explain the SNF ABN to Resident 42, ensure the resident understood the form, and ensure the SNF ABN option was selected by the resident.During an interview on 4/16/2026 at 8:40 a.m. with Resident 42, Resident 42 stated they (Resident 42) (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remembered receiving the SNF ABN, but did not understand why the facility is taking so much money.During an interview on 4/16/2026 at 1:39 p.m. with Registered Nurse Supervisor (RNS) 1, it was important for residents to receive and understand NOMNC and the SNF ABN because it notifies the resident of the LCD, informs the resident of their right to appeal the decision, and indicates the resident decision of continuing to receive the skilled services and who the resident designated to pay for the bill. The RNS stated for SNF ABN forms are incomplete without the options checked off. During a review of the facility's policy and procedure (P&P), titled Medicare Beneficiary Notice, dated August 2018, the P&P indicated it is the facility's responsibility to ensure forms are completed as per Medicare guideline and given to the resident and or representative timely.

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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 identify, assess, monitor, and document the use of abdominal binder (a wide, elastic compression belt worn around the abdomen is used with patients who have removed essential lines or tubes on more than one occasion) to prevent the resident from pulling out the gastrostomy tube ([G-tube]- a tube inserted through the belly that brings nutrition directly to the stomach) for one of eight sampled residents (Resident 7).These failures had the potential to result in entrapment, skin injury/breakdown, and compromised circulation.Findings:During an observation on 4/13/2026, at 11:26 a.m., in Resident 7's room, there was splint (a medical device that stabilizes a part of your body and holds it in place) for Resident 7's right hand and right arm and abdominal binder on Resident 7 was noted. Resident 7 had difficulty moving the right arm and both legs. Resident 7 was able to move left arm but noted weakness.During a review of Resident 7's admission Record, the admission Record indicated, Resident 7 was initially admitted to the facility on [DATE] and last readmission was on 10/2/2025 with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), cerebral infarction (loss of blood flow to a part of the brain), pathological fracture (broken bone caused by disease), and dementia (a progressive state of decline in mental abilities).During a review of Resident 7's History and Physical (H&P), dated 10/4/2025, the H&P indicated, Resident 7 had no capacity (ability) to understand and make decision.During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/26/2026, the MDS indicated Resident 7 required dependent assistance (Helper does all of the effort) from two or more staff for dressing, hygiene, bed mobility, and transfer. The MDS indicated, Resident 7 had impairment (A loss of part or all of a physical or mental ability) on one side of upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) for both sides.During a concurrent interview and record review on 4/14/2026, at 3:09 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 7's Order Summary Report (OSR), dated 4/15/2026 was reviewed. The OSR indicated to place an abdominal binder at all times to prevent pulling out of G-tube with a start date of 10/30/2025. RNS 1 stated there was no order to monitor and assess skin under abdominal binder every two hours. RNS 1 stated, there was no documentation regarding monitoring and assessment of skin integrity and abdominal binder use. RNS 1 stated, Resident 7 was at risk for skin breakdown and compromised circulation due to prolonged abdominal binder use. RNS 7 stated, without assessment, monitoring, and documentation, it would be hard to prevent skin breakdown and compromised circulation.During a concurrent interview and record review on 4/15/2026, at 9:40 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 7's MDS section P ([Restraint -any manual method, physical/mechanical device, or medication used to intentionally limit a patient's movement, freedom, or normal access to their body] and alarm), dated 1/26/2026 was reviewed. The MDS Section P indicated Resident 7 did not have any trunk or limb restraints in use. The MDSC stated, she did not realize that Resident 7's abdominal binder could be considered as restraints because it prevented her from access to her body and she could not remove it by herself. The MDSC stated nursing staff should re-evaluate and assess the needs of the restraints and use less restrictive measures. The MDSC stated that nursing staff should monitor every two hours for pain, circulation, and skin breakdown to prevent unintentional injuries related to the restraint use.During a concurrent interview and record review on 4/15/2026, at 3:02 p.m., with the Director of Staff Development (DSD), Resident 7's Informed Consent for Abdominal Binder, undated was reviewed. The Informed Consent for Abdominal Binder indicated, Resident's Responsible Party (RP- an individual, including the patient's relative or health care surrogate decisionmaker, who assists the resident in placement or assumes varying degrees of responsibility for the well-being of the resident) gave a verbal consent via (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	telephone, but there was no date of the consent given documented. The DSD stated the informed consent for abdominal binder was incomplete and invalid. The DSD stated, the informed consent should be completed prior to applying restraints after less restricted measures were tried. The DSD stated, restraint should be monitored every two hours and documented to prevent unintended injury. The DSD stated that the staff failed to identify as a restraint. The DSD stated that the staff failed to assess, monitor and document use of the restraint (abdominal binder) to prevent injury.During a review of the facility's Policy and Procedure (P&P) titled, Physical Restraints, reviewed 9/2017, the P&P indicated, Policy: It is the policy of the facility that restraints will only be used after other alternatives have been tried unsuccessfully and only with a thorough assessment, informed consent from the resident or their responsible party, a physician's order and a plan of care to address the use of the restraint. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The resident must be physically and cognitively able to self-release devices such as Velcro lap trays or tables, seat belts with Velcro, or easy snap seat belts) If a resident cannot mentally or physically self-release, then the device is considered a restraint. Procedure: Upon admission, quarterly and with a change of condition, residents shall be assessed for the need or lack of physical restraints. Least restrictive measures shall be assessed prior to the use of an actual restraint. Approaches may include the use of transfer poles, trapeze bars, self-release seat belt . If restraints are utilized, the opportunity for motion and exercise should be provided for a period of not less than ten (10) minutes during each two (2) hour period in which the restraints are utilized. Restrained residents should be repositioned at least every two (2) hours on all shifts.During a review of the facility's Policy and Procedure (P&P) titled, Informed Consent Policy, reviewed 4/2024, the P&P indicated, Policy: It is the policy of the facility that if the attending physician, physician assistant (PA) or nurse practitioner (NP) for a resident the use of siderails for the resident as a restraint, enabler, or assistive device, the physician, PA or NP or facility shall do the following: There is a requirement for the facility to renew informed consent every six months . The facility shall verify that informed consent has been obtained prior to use of a restraint . The information material to a decision concerning the use of a restraint, enable for assistive device shall include: 1. That less restrictive alternative approaches have proven ineffective, and the less restrictive approaches should be listed on the consent form. 2. The potential benefits include prevention of falls, which might result in injury and an increased feeling of safety and security. 3. The potential risks, which shall include accidental injury, increased incidence of falls and other accidents, such as strangulation and entrapment.

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Bellflower Post Acute	9710 E. Artesia Ave Bellflower, CA 90706

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure accurate resident assessments and the status were reflected on medical records for one of three sampled residents (Resident 7) by failing to ensure the assessment entries on the Minimum Data Set (MDS-a resident assessment tool) for abdominal binder (a wide, elastic compression belt worn around the abdomen is used with patients who have removed essential lines or tubes on more than one occasion) that was a physical restraint (any manual method, physical/mechanical device, or medication used to intentionally limit a patient's movement, freedom, or normal access to their body) was accurately reflected and documented.This failure had the potential to result in a negative effect on Resident 7's plan of care and delivery of necessary services, care, and treatment.Findings:During an observation on 4/13/2026, at 11:26 a.m., in Resident 7's room, there was an abdominal binder on Resident 7. Resident 7 had difficulty moving right arm and both legs. Resident 7 was able to move left arm but noted weakness.During a review of Resident 7's admission Record, the admission Record indicated, Resident 7 was initially admitted to the facility on [DATE] and last readmission was on 10/2/2025 with diagnoses including Quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), cerebral infarction (loss of blood flow to a part of the brain), pathological fracture (broken bone caused by disease), and dementia (a progressive state of decline in mental abilities).During a review of Resident 7's History and Physical (H&P), dated 10/4/2025, the H&P indicated, Resident 7 had no capacity (ability) to understand and make decision.During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 required dependent assistance (Helper does all of the effort) from two or more staff for dressing, hygiene, bed mobility, and transfer. The MDS indicated, Resident 7 had impairment (A loss of part or all of a physical or mental ability) on one side of upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) for both sides.During a review of Resident 7's Order Summary Report (OSR), dated 4/15/2026, the OSR indicated to place an abdominal binder at all times to prevent pulling out of gastrostomy tube ([G-tube]- a tube inserted through the belly that brings nutrition directly to the stomach) with a start date of 10/30/2026.During a concurrent interview and record review on 4/15/2026, at 9:40 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 7's MDS section P (Restraint and alarm), dated 1/26/2026 was reviewed. The MDS Section P indicated Resident 7 did not have any trunk or limb restraints in use. The MDSC stated, she did not realize that Resident 7's abdominal binder could be considered as restraints because it prevented her from access to her body and she could not remove it by herself. The MDSC stated that MDS coding should be done accurately because it affects the residents' plan of care and treatment.During an interview on 4/15/2026, at 3:02 p.m., with the Director of Staff Development (DSD), the DSD stated, all assessments in MDS should be coded correctly because this would affect resident's overall care and treatment negatively. The DSD stated, assessments should be accurate to get a clear representation of the residents.During a review of the facility's Policy and Procedure (P&P) titled, Resident Assessment Instrument (RAI) Process, revised 4/2017, the P&P indicated, Policy: The facility will utilize the Resident Assessment Instrument (RAI) process for the accurate assessment of each resident's functional capacity and health status. Procedure: The facility must maintain all resident assessments completed within the previous 15 months in an easily accessible location and retrievable and use the results of the assessments to develop, review and revise the resident's comprehensive care plan . The last comprehensive assessment with the most recent assessment completed must be maintained in the active clinical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of eight sampled residents (Resident 5 and Resident 7) by failing to:A. Develop a comprehensive care plan for Gentamicin (medication to treat severe bacterial infections) for Resident 5.B. Implement a comprehensive person-centered care plan for abdominal binder (a wide, elastic compression belt worn around the abdomen is used with patients who have removed essential lines or tubes on more than one occasion) use for Resident 7.These failures had the potential to result in Resident 5 and Resident 7's needs not being met, affecting the residents' well-being, and poor patient outcomes.Findings: A. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (ESRD - chronic kidney disease that causes gradual loss of kidney function), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and cellulitis (infection of the skin). During a review of Resident 5's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS – a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 5 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required supervision for oral hygiene and upper body dressing, and required maximal assistance (helper does more than half the effort) for toileting hygiene, bathing, and lower body dressing. During a review of Resident 5's Order Summary Report dated 4/23/2026, the Order Summary Report indicated Resident 5 had an order for gentamicin sulfate ophthalmic (eye) solution in the left ear two times a day for an ear infection for 7 days starting 4/9/2026. During a review of Resident 5's Medication April 2026 Medication Administration Record (MAR), the April 2026 MAR indicated Resident 5 received the gentamicin sulfate drops from 4/9/2026 – 4/16/2026 as scheduled. During a concurrent interview and record review on 4/15/2026 at 9:33 a.m. with the infection Prevention Nurse (IPN), the Resident 5's Physician Orders and Care Plans were reviewed. The IPN stated Resident 5's Physician Orders indicated that resident was prescribed gentamicin sulfate starting 4/9/2026. The IPN stated Resident 5 did not have a care plan for antibiotic therapy related to the use of gentamicin. The IPN stated a care plan for gentamicin should be initiated so the facility would know what to monitor and the plan of care. The IPN stated if a care plan for antibiotics is not initiated, the resident may be at risk for not receiving appropriate care or may not meet their goals. During an interview on 4/16/2026 at 1:44 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated care plans are initiated on admission, quarterly, annually, and as needed for significant changes or changes of conditions. RNS 1 stated if a care plan is not initiated for gentamicin, the staff may not know what to monitor, the type of antibiotic, the plan, or know when to evaluate if or when it is effective. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. During an observation on 4/13/2026, at 11:26 a.m., in Resident 7's room, there was an observation of an abdominal binder on Resident 7. During a review of Resident 7's admission Record, the admission Record indicated, Resident 7 was initially admitted to the facility on [DATE] and last readmission was on 10/2/2025 with diagnoses including Quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), cerebral infarction (loss of blood flow to a part of the brain), pathological fracture (broken bone caused by disease), and dementia (a progressive state of decline in mental abilities). During a review of Resident 7's H&P, dated 10/4/2025, the H&P indicated Resident 7 had no capacity (ability) to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 required dependent assistance (helper does all of the effort) from two or more staff for dressing, hygiene, bed mobility, and transfer. The MDS indicated Resident 7 had impairment (a loss of part or all of a physical or mental ability) on one side of upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) for both sides. During a concurrent interview and record review on 4/14/2026, at 3:09 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 7's Order Summary Report (OSR), dated 4/15/2026 was reviewed. The OSR indicated, place abdominal binder at all times to prevent pulling out of gastrostomy tube ([G-tube]- a tube inserted through the belly that brings nutrition directly to the stomach) was ordered on 10/30/2025. RNS 1 stated there was no order to monitor and assess skin under abdominal binder every two hours. RNS 1 stated, there was no documentation regarding monitoring and assessment of skin integrity and abdominal binder use. RNS 1 stated, Resident 7 was at risk for skin breakdown and compromised circulation due to prolonged abdominal binder use. RNS 7 stated, without assessment, monitoring, and documentation, it would be hard to prevent skin breakdown and compromised circulation. During a concurrent interview and record review on 4/15/2026, at 9:40 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 7's Care Plan (CP) titled, Resident 7 requires the use of abdominal binder secondary to pulling out feeding tube, initiated on 10/28/2025 was reviewed. The CP goal indicated that Resident 7 would have no skin impairments and minimize the risks for complications related to abdominal binder by 4/26/2026. The CP interventions indicated, assess resident for use of abdominal binder, assess skin underneath abdominal binder for impairments routinely, and assess for possible discontinuance of abdominal binder. The MDSC stated, all care plan interventions were reflecting Interdisciplinary team (IDT-a group of different experts who work together to help the residents with complex needs) meeting recommendations and should be implemented to prevent unintended skin breakdown and injury. During an interview on 4/15/2026, at 3:02 p.m., with the Director of Staff Development (DSD), the DSD stated, the Resident 7's care plan is a specific plan of care, and it should be implemented as it stated. The DSD stated, care plan interventions should be implemented and reevaluated. The DSD stated care plan interventions were from the IDT meeting and should be implemented to prevent recurrent problems and unintended injuries. The DSD stated, the staff should have followed care plan interventions to assess, monitor, and document regarding the use of abdominal binder to prevent skin injuries and complications such as compromised circulation and entrapment. The DSD stated, she reviewed Resident 7's chart and realized interventions were not followed by the staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Planning, revised 3/2019, the P&P indicated, Policy: It is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment . Procedure: A comprehensive care plan is completed by the Interdisciplinary Team (IDT) within seven days of the completion of the residents Minimum Data Set (MDS) . The care plan must be reviewed and revised periodically, at least quarterly, and on an ongoing basis to reflect changes in the resident and the services provided or arranged must be consistent with each resident's written plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was provided with a communication board (a device that displays photos, symbols, or illustrations to help people with limited language skills express themselves) and language translating service with the language that the resident was able to understand for one of eight sample residents (Resident 58).These failures had the potential to result in preventing Resident 58 from communicating with the staff and had the potential to delay receiving appropriate care/treatment and safety for Resident 58.Findings:During a record review of Resident 58's admission Record, the admission record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of breast (cancerous, abnormal cell growth arising from breast tissue), chronic pain, and history of falling.During a review of Resident 58's History and Physical (H&P), dated 4/13/2026, the H&P indicated, Resident 58 had no capacity to make decisions.During a record review of Resident 58's Minimum Data Set (MDS- a resident assessment tool), dated 4/13/2026, the MDS indicated, Resident 58 required maximal assistance (Helper does more than half the effort) from one staff for bed mobility, moderate assistance (Helper does less than half the effort) from one staff for shower, dressing, toileting hygiene, supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for personal hygiene, oral hygiene, and setup or clean-up assistance (Helper sets up or cleans up; resident completes activity) from one staff for eating.During a review of Resident 58's Care Plan (CP) titled, Resident 58 was at risk for impaired communication skills initiated on 4/7/2026, the CP goal indicated, Resident 58's needs would be met daily until reevaluation date on 7/2026. The CP indicated the use of a communication device to anticipate needs and meet them.During a concurrent observation and interview on 4/13/2026, at 9:50 a.m., with Certified Nurse Assistant (CNA) 2 in Resident 58's room, Resident 58 tried to explain something in Spanish, but CNA 2 told Resident 58 that she could not understand. Resident 58 frowned with frustration and there was no communication board at the bedside. CNA 2 stated, she did not speak Spanish, and she could not find anyone on the floor who could speak Spanish. CNA 2 stated that the communication board should have been provided for Resident 58 to communicate her needs, especially during the emergency. CNA 2 stated, she had never used language translating service and did not know how to use it.During a concurrent observation and interview on 4/13/2026, at 10:10 a.m., with Payroll Staff (PS) 1, CNA 2 brought PS 1 for translation. PS 1 started speaking Spanish and Resident 58 was smiling and thanking her. PS 1 stated, Resident 58 told her that sometimes it was hard to get what she needed when there was no Spanish speaking staff available. PS 1 stated, she did not have any medical related background, and she might not help Resident 58 if Resident 58 needs medical related help. PS 1 stated, she understood Resident 58's frustration and the staff should have provided communication board.During an interview on 4/15/2026, at 9:15 a.m., with the Social Service Director (SSD), the SSD stated, the facility had a contract with language translating service company via I-Pad (a small portable tablet computer activated by touching a screen), but she had never used it and there was no instruction available. The SSD stated, there should be the password and username to access service, but she thought that only medical records staff have them. The SSD stated that the staff might not be able to access it if it were off hours or holidays due to availability of medical record staff. The SSD stated, she provided language board to staff for residents, and she did not know how she missed providing it to Resident 58. The SSD stated it was important to have the way of communication with non-English speaking resident.During an interview on 4/15/2026, at 3:02 p.m., with the Director of Staff Development (DSD), the DSD stated, it was important to provide a way of communication for Resident 58 to accommodate their needs and to provide proper treatment, especially for emergencies. The DSD (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the communication board should always be available to the residents and the instruction including the password and username for language translating services should be available for the staff to accommodate the residents' needs.During a review of the facility's policy and procedure (P&P) titled, Residents Who Present with Communication Barriers, undated, the P&P indicated, it is the policy of this facility to meet the needs of residents who present with communication barriers. RATIONALE: Communication supports psychosocial well-being by enabling residents to participate in their care. Procedure: Communication boards will be provided at no charge to the resident so that non-English speakers, or aphasic residents can use pictograms to communicate needs and desires.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to properly store medications safely in a locked crash cart (a supply cart stocked with equipment and medications used for emergency situations) located by Nursing station 1.This had the potential to result in adverse medication effects, medication tampering and medication theft.Findings: During an observation on 4/13/2026 at 10:22 a.m., the crash cart located across from nursing station 1 was observed unattended with a key inserted in the lock of the cart. During a concurrent observation and interview on 4/13/2026 at 10:28 a.m. with Licensed Vocational Nurse (LVN) 1, the crash cart was observed with the key inserted in the lock of the cart. LVN 1 stated the crash cart had a box of glucose gels (medication used to treat rapid-onset low blood sugar in residents with diabetes) and normal saline syringes (pre-filled syringe, used to clear, maintain, or assess the patency of intravenous (IV) catheter) located in the top drawer. LVN 1 stated the key are always left in the lock of the crash cart so that it is available for emergencies.During an interview on 4/16/2026 at 10:45 a.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated glucose gels are medications that are given for emergencies such as hypoglycemia (excessively low blood sugar). RNS 1 stated normal saline syringes are medications and require an order for use. RNS 1 stated only licensed staff should have keys to access medications. During a concurrent observation and interview on 4/16/2026 at 11:05 a.m. with RNS 1, the crash cart was observed with the key inserted in the lock of the cart. RNS 1 stated the key is always here for emergencies. RNS 1 stated glucose gels and normal saline syringes should not be freely accessible. RNS 1 stated it is important that only licensed nursing staff have access to medications to prevent adverse medication effects. RNS 1 stated if residents access the unattended cart with glucose gels and normal saline syringes, the resident could be at risk for high blood sugar levels.During a review of the facility's policy and procedure (P&P), titled Medication Storage in the Facility, dated April 2008, the P&P indicated only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food served was palatable (food or drink that is pleasant, savory, or agreeable to the taste) and/or at the preferred temperature for three of 54 sampled residents (Resident 19, Resident 60, and Resident 53).This failure had the potential for residents' poor meal intake and which could lead to weight loss. Findings:A. During a review of Resident 19's admission record, the admission record indicated Resident 19 was admitted to the facility on [DATE] with diagnosis including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), and essential hypertension (high blood pressure that is not due to another medical condition).During a review of Resident 19's History and Physical (H&P), dated 1/1/2026, the H&P indicated, Resident 19 had the capacity (ability) to understand and make decisions.During a review of Resident 19's Minimum Data Set (MDS-a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 19 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, transfer, bed mobility, dressing, hygiene, and dependent assistance (Helper does ALL of the effort) from one staff for transfer, dressing, maximal assistance (Helper does more than half the effort) from one staff for shower, toilet hygiene, and moderate assistance (Helper does less than half the effort) from one staff for eating, oral hygiene, bed mobility.During a review of Resident 19's Order Summary Report (OSR), dated 4/15/2026, the OSR indicated, Regular texture, consistent carbohydrate (eating the same amount of carbohydrates every day), no added salt, and thin liquid diet was ordered on 1/30/2026. During an interview on 4/13/2026, at 10:53 a.m., with Resident 19 in his room, Resident 19 stated, he was upset about the food he was getting. Resident 19 stated, food was served cold with no seasoning. Resident 19 stated, breakfast meals were usually the worst. Resident 19 stated, vegetables were so bland and flavorless. Resident 19 stated, he asked his nephew to bring meal from home twice a week. Resident 19 stated, he understood if they used less salt because of high blood pressure, but there was no seasoning on vegetables.During a concurrent observation and interview on 4/14/2026, at 7:45 a.m., in Resident 19's room, Resident 19 received breakfast tray and was frowning. There was Southwestern casserole, wheat toast, oatmeal, a cup of fruit punch juice, and a cup of milk on the tray. Resident 19 stated, he wanted his oatmeal to be served hot, but it was lukewarm and tasteless. Resident 19 stated, the casserole was bland. Resident 19 refused to eat and asked for ham and cheese sandwich.B. During a review of Resident 60's admission record, the admission record indicated Resident 60 was admitted to the facility on [DATE] with diagnosis including cellulitis (a skin infection that causes swelling and redness) of right arm, essential hypertension, and acute kidney failure (a sudden, often reversible, loss of kidney function occurring within hours or days).During a review of Resident 60's H&P, dated 4/7/2026, the H&P indicated, Resident 60 had the capacity (ability) to understand and make decisions.During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60 required moderate assistance from one staff for dressing, supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for hygiene, shower, transfer, bed mobility, and setup or clean-up assistance (Helper sets up or cleans up; resident completes activity) from one staff for eating.During a review of Resident 60's Order Summary Report (OSR), dated 4/15/2026, the OSR indicated, Regular texture with thin liquid diet was ordered on 4/5/2026. During an interview on 4/13/2026, at 11:06 a.m., with Resident 60 in his room, Resident 60 stated, hot food has been served lukewarm or cold frequently. Resident 60 stated, steamed vegetables looked unappetizing and bland. Resident 60 stated he had to ask the staff to reheat, but microwaving altered the texture of food in a very unpleasant way. Resident 60 stated, he skipped the meals sometimes.During an interview on 4/14/2026, at 11:40 a.m., with Resident 60 in a hallway, Resident 60 stated, he was upset about lunch tray. Resident 60 stated, he did not want to eat lunch because (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	steamed carrots were not seasoned at all and looked mushy. Resident 60 stated, he lost his appetite.C. During a review of Resident 53's admission record, the admission record indicated Resident 53 was admitted to the facility on [DATE] with diagnosis including legal blindness (severe visual impairment or low vision), deafness (hearing loss that precludes a person from understanding spoken language), Congenital Rubella Syndrome (CRS- a condition occurring in newborns when a pregnant woman contracts the rubella virus, leading to severe, often permanent birth defects like heart issues, blindness, and deafness), and dysphagia (difficulty swallow).During a review of Resident 53's H&P, dated 12/13/2025, the H&P indicated, Resident 53 had no capacity to understand and make decisions.During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 required dependent assistance from two or more staff for shower/bath, transfer, bed mobility, dressing, hygiene, and maximal assistance (Helper does more than half the effort) from one staff for eating.During a review of Resident 53's Order Summary Report (OSR), dated 4/15/2026, the OSR indicated, pureed texture, consistent carbohydrate, honey thick liquid consistency double portion diet was ordered on 1/22/2026. During a concurrent observation and interview on 4/14/2026, at 11:50 a.m., with Certified Nurse Assistant (CNA) 2 in Resident 53's room, CNA 2 was assisting with feeding for Resident 53. Resident 53 received pureed (cooked, blended, or strained into a thick, smooth, and lump-free paste with a pudding-like consistency) barbeque chicken, pureed carrots, pureed wheat roll, pureed potato salad. Resident 53 tasted pureed carrots and pureed wheat roll. CNA 2 tried to give him more, but Resident 53 shut his mouth tightly. CNA 2 stated, Resident 53 shut his mouth tightly when he did not want to eat. Resident 53 ate pureed barbeque chicken. CNA 2 stated, she could tell that Resident 53 did not like the pureed carrots and pureed wheat roll.During a concurrent observation and interview on 4/14/2026, at 11:57 a.m., with the Dietary Supervisor (DS), the DS brought the test trays for regular lunch tray and pureed lunch tray. There was wheat roll with butter packet, steamed carrots, barbeque chicken, and macaroni salad in a disposable plastic container for regular diet tray. There was pureed wheat roll, pureed carrots, and pureed barbeque chicken on a disposable plastic container with plastic spoons and knives for pureed diet tray. The DS tried the regular carrots and stated he agreed that it was bland. The DS tried pureed carrots and pureed wheat roll. The DS agreed they are little bland. The DS stated they were bland, but they are probably better for the residents who had restriction on salt intake. The DS stated, he should have used salt substitute [alternatives to salt (sodium chloride) that contain varying amounts of potassium chloride] to enhance the flavor. The DS stated, he should have brought test trays in proper plates with silverware for better presentation. The DS state, pureed food items were blended only with flavorless thickener [a substance added to liquids to increase viscosity (stiffness) without changing other properties].During a concurrent interview and record review on 4/14/2026, at 12:17 p.m., with the DS, the facility's Recipe for Pureed Breads and Pureed Vegetables, dated 2025 was reviewed. The Recipe for Pureed Breads indicated, put blender on low speed and add milk gradually and add food thickener if needed. The Recipe for Pureed vegetables indicated, place a blender on low speed and add warm liquid such as low sodium broth or milk gradually. The Recipe for Pureed vegetables indicated, add food thickener if needed and adjust seasoning as needed after tasting it. The DS stated, he should have ensured that the cook followed the recipes to enhance the flavors to prevent unintended weight loss. During an interview on 4/15/2026, at 4 p.m., with the Registered Dietitian (RD), the RD stated, food should be presented palatable and appetizing for all residents regardless of types of diets. The RD stated, the cook should have followed the recipes, and the DS should have ensured recipes were followed during the preparation. The RD stated, if the residents were on a sodium restricted diet, salt substitute should be used to enhance the flavor without adding salt. The RD stated that preferred food temperature should be honored as well, and the DS should have assessed for preference. The RD stated, the dietary staff had responsibility for food to be served with palatable, appetizing, and proper/ preferred temperature to prevent poor intake and unintended weight loss.During a review of the facility's Policy and Procedure (P&P) titled, Meal Service, dated 5/2019, the P&P indicated, Policy: It is the policy of 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
	055408	A. Building B. Wing	04/16/2026

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Bellflower Post Acute	9710 E. Artesia Ave Bellflower, CA 90706

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility to provide meals that meet the nutritional needs of the residents and they will be served in an accurate and efficient manner and served at the appropriate temperatures. Procedure: Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot.During a review of the facility's Policy and Procedure (P&P) titled, Dietary-Food and Nutrition Preparation and Service, dated 1/2017, the P&P indicated, Policy: It is the policy of the facility to provide each resident with a nourishing, palatable, well balanced diet that meets the daily nutritional and dietary needs. Procedure: Each resident will be provided a nourishing, palatable, well-balanced diet that meets their daily nutritional and dietary needs while taking into account the preferences of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 follow their antibiotic stewardship policy for one of three sampled residents (Resident 5) when the facility did not inform the physician when Resident 5, who was prescribed gentamicin (antibiotic to treat bacterial infections) eye drops did not meet McGeer's criteria (criteria used to detect infections based on symptoms and laboratory values).This resulted in Resident 5 receiving inappropriate antibiotic eye drops and the potential to develop antibiotic resistance.Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (ESRD - chronic kidney disease that causes gradual loss of kidney function), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine), and cellulitis (infection of the skin).During a review of Resident 5's History and Physical (H&P), dated 3/19/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 5 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required supervision for oral hygiene and upper body dressing, and required maximal assistance (helper does more than half the effort) for toileting hygiene, bathing, and lower body dressing. During a review of Resident 5's Order Summary Report dated 4/23/2026, the Order Summary Report indicated Resident 5 had an order dated 4/9/20206 for gentamicin sulfate ophthalmic (eye) solution 0.3% two drops in left ear two times a day for ear infection for 7 days.During a review of Resident 5's Medication April 2026 Medication Administration Record (MAR), the April 2026 MAR indicated Resident 5 received the gentamicin sulfate drops from 4/9/2026 - 4/16/2026 as scheduled.During a concurrent interview and record review on 4/15/2026 at 9:33 a.m. with the infection Prevention Nurse (IPN), the April 2026 Infection Prevention and Control Surveillance Log, Resident 5's Surveillance Data Collection Form, dated 4/9/2026, and Resident 5 Nursing notes were reviewed. The April 2026 Infection Prevention and Control Surveillance Log indicated Resident 5's did not meet McGeer's criteria. The IPN stated the Surveillance Data Collection Form indicated Resident 5 had a left earache that was red and tender. The IPN stated Resident 5 was oriented and stated having the symptoms of an ear infection before. The IPN stated they (IPN) did not inform the physician that Resident 5 did not meet McGeer's criteria for an infection, because they (IPN) did not find it right to stop something if you know the resident needed it.During a concurrent interview and record review on 4/16/2026 at 1:48 p.m. with Registered Nurse Supervisor (RNS) 1, the April 2026 Infection Prevention and Control Surveillance Log and Resident 5's Surveillance Data Collection Form, dated 4/9/2026, were reviewed. RNS 1 stated it was the licensed nurse's responsibility to inform the physician when residents were prescribed an antibiotic and do not meet criteria for an infection to prevent the use of unnecessary antibiotics and developing antibiotic resistance.During a review of the facility's policy and procedure (P&P), titled Infection Control - Antibiotic Stewardship, dated January 2018, the P&P indicated feedback will be given to physicians on their individual prescribing patterns of cultures ordered and antibiotics prescribed, on a regular basis.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to educate and offer the COVID-19 vaccination for the 2025-2026 respiratory season for two of five sampled staff (Physician 1 and Physician 2).These failures had the potential to result in spreading the COVID-19 virus throughout the facility. Findings:During a concurrent interview and record review on 4/15/2026 at 10:26 a.m. with the Infection Prevention Nurse (IPN), the staff vaccination records were reviewed. The IPN stated there was no documentation that Physician 1 and Physician 2 were offered the COVID-19 vaccination for the 2025-2026 respiratory season and educated on the risks and benefits of receiving the vaccination. The IPN stated both Physician 1 and Physician 2 actively cared for current residents.During an interview on 4/16/2026 at 1:52 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated it was important to offer the COVID-19 vaccine and educate all staff to prevent the spread of the COVID-19 virus to residents. RNS 1 state the COVID-19 consent form is proof that the facility encouraged and educated the staff about the COVID-19 vaccine.During a review of the facility's policy and procedure (P&P), titled Coronavirus Vaccine Policy (COVID-19 Vaccine Policy), dated February 2025, the P&P indicated COVID-19 vaccinations will be offered to all staff and residents per Centers of Disease Control (CDC) and/or Food and Drug Administration (FDA) guidelines.All staff and residents/representatives will be educated on the COVID-19 vaccine they are offered in a manner they can understand.The facility will maintain documentation for all resident and staff on COVID-19 vaccination status. For staff, the information will be documented in their personnel file.