

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Intercommunity Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12627 Studebaker 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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled residents (Resident 2), did not develop an avoidable unstageable (an injury where the true depth cannot be determined due to the injury being partially or fully covered with eschar (dead tissue brown, black or tan) and or slough (yellowish, soft, moist tissue indicating deeper tissue damage and advancement of the pressure injury) pressure injury (PI - injury to skin and underlying tissue resulting from prolonged, unrelieved pressure on bony areas of the skin) by failing to:1. Follow the physicians' orders dated 4/21/2026 and 4/28/2026 to change Resident 2's dressing once daily, and as needed when the dressing became soiled or dislodged. 2. Implement the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised March 2023, which indicated that a person-centered care plan must include measurable objectives and timetables to meet the resident's needs by updating and implementing Resident 2's care plan to address the significant change in Resident 2's pressure injury, when the pressure injury progressed from a Stage 2 (partial-thickness skin loss, with exposed dermis [the inner layer of the skin]) creating a visible, open wound) on 4/16/2026 to a Stage 4 (full-thickness skin and tissue loss with exposed or directly palpable muscle, tendon, cartilage or bone) on 4/28/2026.3. Implement the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised March 2023, which indicated that during skin assessments, staff were to inspect pressure points, including the sacrum (triangle-shaped bone at the base of the spine), buttocks, coccyx (tailbone), elbows, and other areas at risk of pressure injury and reposition residents as indicated on the care plan to prevent the development and progression of pressure injuries. These failures resulted in Resident 2 developing a Stage 4 pressure injury to the sacrococcygeal (the area where the lower spine and the tailbone meet) area on 4/28/2026. Subsequently, Resident 2 was transferred to a general acute care hospital (GACH) on 5/7/2026, where the resident remained hospitalized for 10 days until 5/17/2026, for treatment and management of the Stage 4 pressure injury. Resident 2 was admitted to the GACH on 5/7/2026, for treatment of an infected Stage 4 sacrococcygeal pressure injury, sacral osteomyelitis (infection of the underlying bone tissue) and sepsis (the body's life-threatening response to infection in the blood stream).Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses including nontraumatic (Spontaneous, not caused by an external physical force) subarachnoid hemorrhage (bleeding in the space between your brain and the membrane that covers it), tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure).During a review of Resident 2's Braden Scale (a standardized tool used by healthcare professionals to assess an individual's risk of developing pressure injuries, or (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055457	Facility ID: 055457 If continuation sheet Page 1 of 10

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F 0686 Level of Harm - Actual harm Residents Affected - Few	bedsores) assessment dated [DATE], the Braden scale assessment identified Resident 2 as being at high risk for developing pressure injuries. During a review of Resident 2's care plan, dated 3/13/2026, regarding Resident 2's alteration in skin integrity (MASD) related to bowel and bladder incontinence (loss of voluntary control of bowel and bladder), the interventions included to assist with turning and repositioning as needed, keep the skin clean and dry, provide incontinent care as needed and provide treatment as ordered. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/19/2026, the MDS indicated Resident 2 was dependent (helper does all the effort while the resident does none of the effort to complete the activity) on staff for self-care activities such as eating, hygiene, bathing, and getting dressed. The MDS indicated Resident 2 was dependent on facility staff for mobility such as rolling from left to right. The MDS indicated Resident 2 was always incontinent of bladder and bowel and did not have pressure injuries upon admission and was at risk of developing pressure injuries. During a review of Resident 2's Braden Scale assessment dated [DATE], the Braden scale assessment identified Resident 2 as continuing to be at very high risk for developing pressure injuries. During a review of Resident 2's Change of Condition Evaluation (COC), dated 4/16/2026 at 9:00 a.m., the COC indicated Resident 2 had reddish moist tissue presenting as a shallow opening, (Stage 2- Pressure Injury- a break in the skin where the outer layer and part of the inner layer are damaged, leaving a visible, open wound without exposing fat, muscle, or bone) to the coccyx area. There were no measurements of the area documented. The COC indicated Resident 2 was not admitted with any wounds. During a review of Resident 2's Care Plans for the month of April 2026, there were no care plans in place for Resident 2's Stage 2 Pressure Injury (PI) to the sacrococcyx area documented on 4/16/2026. During a review of Resident 2's physician's orders dated 4/16/2026, the physician's orders indicated cleanse the Stage 2 PI on the sacrococcyx with normal saline (medical grade mix of water and salt used for cleaning wounds), cover with dry dressing daily and as needed when dressing becomes soiled or dislodged for 21 days every day. During a review of Resident 2's Certified Nursing Assistant (CNA) daily task documentation for toileting hygiene for April 2026, the documentation indicated toileting hygiene was completed during each of the three shifts (7 a.m. to 3 p.m., 3 p.m. - 11 p.m., and 11 p.m. to 7 a.m.) on 4/16/2026 through 4/25/2026 and on 4/27/2026, for a total of 33 documented episodes of toileting hygiene. During a review of Resident 2's Treatment Administration Record (TAR) for April 2026, the TAR indicated the dressing change for Resident 2's Stage 2 coccyx pressure injury was documented as completed once daily during the 7 a.m. to 3 p.m. shift on 4/2/2026 through 4/16/2026 and 4/27/2026, for a total of 11 documented dressing changes. The TAR contained no documentation that additional dressing changes were performed during the 3 p.m. to 11 pm or 11 p.m. to 7 a.m. shifts when the dressing became soiled or dislodged, as ordered. During a review of Resident 2's COC, dated 4/28/2026 at 9:00 am, the COC indicated Resident 2's pressure injury had slough to the wound bed of the sacrococcyx area indicating the wound had deteriorated. No measurements were documented. During a review of Resident 2's Skin Issues Note, dated 4/28/2026 at 11:44 am, the Skin Issues Note indicated Resident 2's sacrococcyx pressure injury had deteriorated, and the pressure injury was now an unstageable pressure injury due to slough 60% and eschar, the wound measured Length 5.1 cm X width 5.1 cm. No depth was documented. During a review of Resident 2's physician's order dated 4/28/2026, the physician's orders indicated treatment for the sacrococcyx pressure injury; cleanse with normal saline, pat dry, apply skin barrier to peri-wound (a product applied to skin to protect from moisture) area of the skin that surrounds the outer edges of a wound) and Santyl ointment (a prescription medicine used to remove dead tissue from wounds) to the wound bed, cover with dry dressing daily and as needed when dressing becomes soiled or dislodged for 30 days. During a review of Resident 2's daily CNA (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	daily tasks for toileting hygiene dated April 2026, and May 2026 the CNA daily task list indicated Resident 2's toileting hygiene was completed three times a day (during the 7 a.m. to 3 p.m. shift, during the 3 p.m. to 11 p.m. shift and during the 11p.m. - 7 a.m. shift) on 4/28/2026, 4/29/2026, 4/30/2026, 5/1/2026, 5/2/2026,5/3/2026, 5/4/2026, 5/5/2026, 5/6/2026, and 5/7/2026. (30 times).During a review of Resident 2's TAR for April 2026 and May 2026, the TAR indicated the dressing change for Resident 2's (Stage 2) coccyx pressure injury was documented as completed once daily during the 7 a.m. to 3 p.m. shift, on 4/16/2026, 4/17/2026, 4/18/2026, 4/19/2026 and 4/20/2026, 4/21/2026, 4/22/2026, 4/23/2026, 4/24/2026, 4/25/2026 and 4/27/2026, for a total of 11 times. The TAR contained no documentation that additional dressing changes were performed during the 3 p.m. to 11p.m. shift and the 11 p.m. to 7 a.m. shifts, as needed, when the dressing became soiled or dislodged.During a review of a Nursing Progress Note dated 5/7/2026 at 9:00 am, the Nursing Progress Note indicated the Treatment Nurse (TN) noted Resident 2's sacrococcyx pressure injury had a foul odor, and the tissue surrounding the pressure injury was warm to the touch (indicating the wound was infected).During a review of Resident 2's physician's orders dated 5/7/2026 at 9:10 a.m., the physician's orders indicated to transfer Resident 2 to the GACH for Sacrococcyx pressure injury management.During a concurrent interview and record review on 7/30/2026 at 11:51 a.m., with the TN, Resident 2's admission skin assessment dated [DATE], the Braden scale dated 3/13/2026, Resident 2's COCs dated 4/2/2026, 4/16/2026 and 4/28/2026, the TAR's for 4/2026 and 5/2026, the nurses progress notes dated 5/7/2026 and Resident 2's care plans for the months of 4/2026 and 5/2026 were reviewed. The TN stated Resident 2's sacrococcyx PI would get worse if the wound care treatments were not being completed when the wound dressing got soiled or dislodged in addition to the once daily wound dressing. The TN stated all licensed staff are trained to perform wound care and if Resident 2 was soiled at any time, the licensed staff could provide treatments as ordered. The TN stated CNAs cleaned Resident 2 and reported any abnormal skin changes, soiled or dislodged wound dressing to the Licensed Vocational Nurse (LVN) and the LVN then reported the findings to the Registered Nurse (RN).During an interview on 7/30/2026 at 1:24 p.m., with CNA 5, CNA 5 stated that she changed Resident 2's adult briefs due to soilage, she (CNA 5) did not notify the charge nurse she just changed Resident 2, and the wound dressing may need to be changed.During an interview on 7/30/2026 at 4:26 p.m., with LVN 5, LVN 5 stated she had performed the dressing change once or twice for Resident 2 when it was soiled on her shift (did not recall exact dates), but it was not done consistently when it was soiled.During an interview on 7/30/2026 at 5:12 p.m., with the Director of Nursing (DON), the DON stated if staff observed that a resident was soiled, the licensed nursing staff should assist the Certified Nursing Assistants (CNAs) with providing hygiene and perform wound treatments as indicated. The DON stated Resident 2's wound treatment should have been provided as needed, including during shifts when the Treatment Nurse was not working, because the physician's order indicated the treatment was to be provided daily and as needed. The DON stated wounds could worsen, become larger, and deepen if wound care was not provided in a timely manner. The DON further stated Resident 2's pressure injury was avoidable if appropriate interventions had been provided timely and as needed when the wound dressing became dislodged or soiled, especially because Resident 2 was at very high risk for skin breakdown.During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, revised March 2023, the P&P indicated a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and must be developed and implemented for each resident.During a review of the facility's P&P titled Prevention of Pressure Injuries, revised March 2023, indicated assess the resident on admission for existing pressure injury (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	risk factors. Repeat the risk assessment weekly and upon any changes in condition. inspect the skin daily when performing or assisting with personal care or activities of daily living.inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, etc.wash the skin after any episodes of incontinence, skin cleanser. reposition resident as indicated on the care plan.clean promptly after episodes of incontinence.use a barrier product to protect skin from moisture.use incontinence products with high absorbency.do not rub or otherwise cause friction on skin that is at risk of pressure injuries.use facility-approved protective dressings for at risk individuals.reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. evaluate, report and document potential changes in the skin .review the interventions and strategies for effectiveness on an ongoing basis		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing progress notes were accurately and individually documented by two Licensed Vocational Nurses (LVN 3 and LVN 4). LVN 3 and LVN 4 entered identical progress notes for one of 1 sampled resident (Resident 97). This failure had the potential to create an inaccurate legal medical record by failing to accurately identify which licensed nurse provided care and communicated with the Physician and Resident 97's Responsible Party. Findings: During a record review of Resident 97's admission record, the admission record indicated Resident 97 was admitted to the facility on [DATE] with diagnoses including end-stage renal disease (ESRD, permanent kidney failure requiring dialysis), dependence on renal dialysis (ongoing dialysis treatment), heart failure (impaired ability of the heart to pump blood effectively), atrial fibrillation (irregular heart rhythm), chronic kidney disease-related anemia (low red blood cell count associated with kidney disease), hypertension (high blood pressure), dysphagia (difficulty swallowing), dementia (progressive cognitive impairment). During a record review of the Minimum Data Set (MDS - a resident assessment tool) dated [DATE], Resident 97 was assessed as cognitively intact with a Brief Interview for Mental Status (BIMS - a short, standardized Resident 97st used by healthcare providers in nursing homes and rehabilitation centers to evaluate a person's memory, thinking, and orientation) score of 15, indicating intact cognition. Required assistance with dressing, bathing, toileting, transfers, walking, and wheelchair mobility, was dependent bed mobility. During a review of Resident 97's nursing progress notes dated [DATE], two LVN (LVN 3 and LVN 4) documented separate progress notes for the same event. The progress note indicated created and entered by LVN 4 at 11:07:51 p.m., and another progress note, created and entered by LVN 3 at 7:05:25 p.m., contained identical documentation stating that Resident 97 was found unresponsive at approximately 6:07 p.m., a code blue (an emergency alert meaning a patient has experienced cardiac arrest (heart has stopped) or respiratory arrest (breathing has stopped)). was initiated, cardiopulmonary resuscitation (CPR - a life-saving emergency procedure used when someone's breathing or heartbeat stops, combining chest compressions and rescue breaths to keep blood flowing to vital organs) was performed, paramedics arrived at 6:10 p.m. and assumed care at 6:12 p.m., and Resident 97's RP was notified at 6:15 p.m. During a concurrent interview on [DATE] at 1:26 p.m. with LVN 3, LVN 3 stated that Licensed Nurses are not permitted to copy another LVN's documentation and that each licensed nurse is responsible for documenting their own individual assessment or any communication transcribed. LVN 3 stated that she was the one who called the Physician and LVN 3 was the one who informed the RP because she had a good relationship with the RP. LVN 3 stated that she does not know why LVN 4 has the same identical progress notes, but it should not be like that. LVN 3 stated whoever created the progress note is authorized to edit or amend their documentation with and all changes tracked by an electronic time stamp. During a concurrent interview with the Director of Nursing (DON) on [DATE] at 5:50 p.m., the DON stated that licensed nurses are expected to document accurately, and resident-specific documentation based on their own assessment and must not be copied by another nurse. The DON stated the nurse who created a progress note may amend or correct the documentation and that all edits are electronically tracked by date and time stamps. The DON stated that duplicate documentation does not accurately identify which licensed nurse provided care or communicated with the physician and the resident's family and is not consistent with the facility's documentation standards. The DON stated that when duplicate, altered, or inaccurate documentation (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is identified, the facility investigates the incident, provides staff education, and implements corrective action, including adding an addendum to the medical record when appropriate. During a record review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, revised [DATE], the policy stated that all services provided to the resident, progress toward care plan goals, and any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The policy stated that documentation in the medical record must be objective (not opinionated or speculative), complete, and accurate.		

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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 interview and record review, the facility failed to address the following for one of 10 sampled residents (Resident 2) by failing to initiate and implement a care plan for Resident 2, who developed a stage 2 pressure ulcer (a partial-thickness skin loss where the outer layer epidermis and part of the second layer dermis are damaged) that progressed to a unstageable pressure ulcer (a severe full-thickness tissue loss where the true depth and exact stage cannot be seen) and ultimately becoming a stage 4 pressure ulcer (a severe, deep wound with full-thickness tissue loss). This deficient practice resulted in Resident 2's wound becoming a stage 4 pressure injury. Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included nontraumatic subarachnoid hemorrhage (a type of bleeding in the space around the brain, caused by a burst brain or high blood pressure), acute embolism (a sudden blockage in a blood vessel by a stray clot, fat, or air), tracheostomy (a tube placed into a surgically created hole through the front of the neck and into the windpipe-trachea), and nontraumatic intracranial hemorrhage (a sudden bleed inside the brain tissue caused by damaged blood vessels).During a review of Resident 2's History and Physical (H&P), dated 5/18/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 3/19/2026, the MDS indicated Resident 2 could not complete the brief interview for mental status. The MDS indicated Resident 2 was dependent (helper does all the effort while resident does none of the effort to complete the activity) for self-care activities such as eating, hygiene, bathing, and dressing. The MDS indicated Resident 2 was dependent on mobility such as rolling from left to right. The MDS indicated Resident 2 was always incontinent with bladder (urination) and bowel (bowel movement).During a review of Resident 2's Change of Condition Evaluation ([COC], a sudden clinical deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition), dated 4/16/2026, timed at 9:00 a.m., the COC indicated Resident 2 had reddish moist tissue presenting as a shallow open area (a minor break in the skin where the outer layer and part of the inner layer are damaged, leaving a visible, superficial open sore without exposing fat, muscle, or bone) to the coccyx (tailbone) area.During a review of Resident 2's Care Plans, there was no care plan to address the newly identified shallow open area located on the coccyx area.During a concurrent interview and record review on 7/30/2026 at 1:35 p.m., with the Treatment Nurse (TN), the Care Plan and the COC were reviewed. The TN stated that a care plan should have been initiated for the newly identified shallow wound located in the coccyx area. The TN stated a care plan serves as a structured approach for resident care, outlining specific goals and interventions to address the needs of residents within the facility. The TN stated that upon identification of a stage 2 pressure ulcer, it was essential to promptly initiate a care plan and implement appropriate interventions to prevent further deterioration of the wound.During an interview on 7/30/2026 at 5:12 p.m., with the Director of Nursing (DON), the DON stated that a care plan should have been initiated immediately upon identification of the stage 2 pressure ulcer. The DON stated that appropriate interventions for managing the pressure ulcer include repositioning residents every two hours as needed, maintaining residents' skin cleanliness and dryness, conducting weekly and as-needed skin assessments, and considering recommendations such as the use of a low air loss mattress (a therapeutic medical bed system that uses a continuous stream of air escaping through tiny laser holes in the fabric) to support wound (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing and prevention. The DON stated the wound could have been avoidable if proper interventions were provided in timely manner, that if staff were aware of the wound, they should follow the interventions right away. During a review of the facility's policy and procedures titled Care Plans, Comprehensive Person-Centered, revised March 2023, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. the comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. the interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address the following for one of 10 sampled residents (Resident 78) by failing to: Failing to initiate a care plan for Resident 78's abuse allegation, monitor Resident 78 for 72 hours when there was a chance of condition (COC), and conduct an Interdisciplinary Team (IDT Resident healthcare team consisting of various specialties) meeting post abuse allegation. This deficient practice increased the risk for Resident 78 to continue feeling unsafe and subjected to continued neglect, verbal, mental, and physical abuse. Findings: During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted on [DATE] and with diagnoses including encephalopathy (any damage or disease that affects the brain), dysphagia (difficulty swallowing), and urinary tract infection (UTI, an infection in any part of the urinary system). During a review of Resident 78's history and physical (H&P) dated 6/18/2026, the H&P indicated Resident 78 had the capacity to understand and make decisions. During a review of Resident 78's Minimum Data Set (MDS, a resident assessment tool), dated 6/19/2026, the MDS indicated Resident 78 had mild cognitive (ability to think and make decisions) impairment. The MDS indicated Resident 78 was dependent on staff for toileting hygiene, required substantial assistance (helper does more than half for bathing, upper (above waist) and lower (below waist) dressing, required partial assistance (helper does less than half the effort) for personal hygiene, rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, required supervision with oral hygiene, and required set up for eating. During a review of Resident 78's Change of Condition (COC) dated 7/21/2026 at 8:00 p.m., the COC indicated Resident 78 stated Certified Nursing Assistant (CNA) 4 took her to shower and were putting water in her face and was not able to breathe. During a review of Resident 78's care plan, titled, Resident making false accusations, dated 7/21/2026, the care plan interventions indicated acknowledge resident's concerns without confirming or denying the allegation, ensure resident safety and provide reassurance, assess the resident for pain, unmet needs, emotional distress, communicate findings and interventions as appropriate, and communicate patterns of behavior during shift report to ensure consistent responses. During a review of Resident 78's Licensed Nurses Note dated the following, there was no documentation of staff addressing Resident 78's allegations of abuse. 7/21/2026 at 12:47 a.m. 7/21/2026 at 1:43 p.m. 7/22/2026 at 12:51 a.m. 7/22/2026 at 3:48 p.m. 7/23/2026 at 2:55 p.m. 7/23/2026 at 11:56 p.m. During an interview on 7/28/2026 at 4:35 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated when she was informed of the incident by Resident 78's family member, she notified the Director of Nursing (DON) and completed an incident report. LVN 2 stated when there was an allegation of abuse made by a resident, a COC was created, the doctor was informed, and staff would monitor the resident for three days. LVN 2 stated an IDT meeting would also be conducted. LVN 2 stated they initiated care plans to address the allegations of abuse reported by the resident. LVN 2 stated a care plan should be initiated when there was a COC for Resident 78. LVN 2 stated care plans were initiated to monitor how the resident was improving and indicated that with no care plans, they would not be able to monitor progress to ensure improvement. During a concurrent interview and record review on 7/30/2026 at 12:08 p.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated the care plan titled Resident making false accusations, did not address the main allegation and indicated there should be a care plan for the actual incident that occurred. RNS 2 stated the care plan should be related to the COC so the staff could develop a plan and understand how to care for the resident, otherwise staff would not know how to take care of the resident. RNS 2 stated IDT meetings were done as soon as (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Intercommunity Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12627 Studebaker 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible when there was an incident to ensure the resident was safe and the allegation was addressed accordingly. During a concurrent interview and record review on 7/30/2026 at 12:25 p.m. with RNS 2, Resident 2's Progress notes were reviewed. RNS 2 stated the follow up documents dated the following: 7/22/2026 at 12:51 a.m. 7/22/2026 at 3:48 p.m. 7/23/2026 at 2:55 p.m. did not address how the resident was feeling or doing since the COC. RNS 2 stated after a COC, the Resident 78 should be monitored for 72 hours to identify if there were any changes in behavior or if new physical injury arose. During an interview on 7/30/2026 at 4:49 p.m. with the Director of Nursing (DON), the DON stated when there was an allegation that CNA 4 had sprayed water in Resident 78's face making it difficult for Resident 78 to breath, during a shower, staff should monitor Resident 78's behavior and condition of the resident for 72 hours. The DON stated monitoring the Resident 78 for 72 hours benefited the resident, because the staff could track Resident 78's progress and be sure they were provided with the care needed. The DON stated without proper monitoring, it was difficult to assess the residents condition and staff could miss the signs of decline or improvement. The DON stated Resident 78 did not have a care plan for the residents specific abuse allegation that CNA 4 sprayed water in her face during a shower, making it hard for her to breath. The DON stated a specific care plan would be created to address the issue and indicated with no care plans, they would not be able to monitor and see the outcome. The DON stated an IDT would be held within the next day or when the resident/family representative was available. The DON stated IDT's were conducted in order to discuss interventions, care plans, and corrective actions to prevent the incident from happening again. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised date 2/2021, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be free from abuse and be informed of, and participate in, his or her care planning and treatment. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised date 9/2022, the P&P indicated the resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, revised date 11/28/2022, the P&P indicated the facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse. Resident assessments and Care Planning are performed to monitor resident needs and address behaviors that may lead to conflict. The facility will reassess the resident following the abuse incident to determine if the resident's medical, nursing, physical, mental or psychosocial needs or preferences have changed as a result of the incident of abuse and initiate or update the care plan as indicated.		