STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055457	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Healthcare & Rehabilitation Center	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 73) was informed of the dental treatment recommendation for tooth extraction (the process of removing a tooth from its socket in the jawbone).This deficient practice violated Resident 73's rights to be fully informed and had the potential to result in delay of care and services. Findings: During a review of Resident 73's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 73 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 73's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent unprovoked seizures), hypertension ([HTN] - high blood pressure), and congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 73's History and Physical (H&P), dated 5/29/2025, the H&P indicated, Resident 73 had the capacity to understand and make decisions.During a review of Resident 73's Minimum Data Set ([MDS] - a resident assessment tool), dated 7/3/2025, the MDS indicated, Resident 73 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 73 required moderate assistance (helper does less than half the effort) from staff with oral hygiene and upper body dressing. During a review of Resident 73's Dental Notes, dated 6/30/2025, the Dental Notes indicated, Resident 73 was evaluated because of molar (a large, flat tooth located at the back of the mouth, used for grinding and chewing food) pain. The Dental Notes indicated, treatment recommendation for X (extraction) B (buccal-outer surface of the tooth, facing the cheek). During a review of Resident 73's Interdisciplinary Note Team([IDT] - team members from different disciplines who come together to discuss resident care), dated 7/14/2025, the IDT Note did not indicate Resident 73 was notified of the dental treatment recommendation for tooth extraction. During an interview on 7/22/2025 at 10:53 a.m. with Resident 73, Resident 73 stated she was seen by the dentist one month ago because of her toothache. Resident 73 stated no facility staff have told her about the plan of the dentist. Resident 73 stated she wants the dentist to remove her tooth that causes discomfort. During a concurrent interview and record review on 7/23/2025 at 2:46 p.m., with the Social Service Director (SSD), Resident 73's clinical records were reviewed. The SSD stated she was aware of the dental treatment recommendation for tooth extraction for Resident 73. The SSD stated she informed Resident 73 about the dental treatment recommendation but did not document it. The SSD stated if it's not documented then it was not done. The SSD stated it is a violation of resident's rights by not informing the resident about the dental treatment recommendation. The SSD stated each resident has the right to be informed of any changes on their plan of care. During an interview on 7/25/2025 at 10:01 a.m., with the Director of Nursing (DON), the DON stated resident has the right to be involved in their plan of care. The DON stated any procedure or changes on resident's treatment plan should be discussed during the IDT meeting care conference. During a review of the facility's policy and procedure (P&P), titled Resident Rights, dated 2/2021, the P&P indicated, Federal and State laws guarantee certain basic rights to all residents of this facility that includes the right to be notified of his or her medical condition and be informed and participate in her care planning and treatment.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Complete and transmit the Minimum Data Set ([MDS]- a resident assessment tool) within the regulatory timeframe to the Center of Medicare and Medicaid Service (CMS) for two of two sampled residents (Resident 56 and 82). This deficient practice had the potential to result in a billing error and inaccurate data on resident care needs. Findings: A. During a review of Resident 56's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 56 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 56's diagnoses included squamous cell carcinoma (type of cancer), dysphagia (difficulty of swallowing), and malignant neoplasm of the glottis (a cancerous tumor that originates in the middle part of the voice box). During a review of Resident 56's MDS assessment, dated 3/11/2025, the MDS indicated, Resident 56's had modified independence (some difficulty in new situations only) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 56 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper and lower body dressing, and personal hygiene. During a review of the CMS MDS 3.0 Nursing Home (NH) Validation Report, the CMS MDS 3.0 NH Validation Report, indicated Resident 56's MDS assessment was submitted more than 13 days after the entry date. During a concurrent interview and record review on 7/24/2025 at 9:42 a.m., with the Minimum Data Set Nurse (MDSN), Resident 56's MDS 5-day assessment, dated 3/11/2025 was reviewed. The MDSN stated she put Resident 56's last entry to the facility as 2/27/2025 instead of 3/7/2025. The MDSN stated she completed Resident 56's MDS assessment late because of wrong entry date. The MDSN stated Resident 56's modified assessment was completed and transmitted to the CMS on 7/23/2025. B. During a review of Resident 82's admission Record, the admission Record indicated, Resident 82 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 82's diagnoses included metabolic encephalopathy (a disorder that affects brain function), respiratory failure (a serious condition that makes it difficult to breathe on your own), and sepsis (a life-threatening blood infection). During a review of Resident 82's discharge MDS assessment, dated 8/24/2023, the MDS indicated, Resident 82's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 82 required maximum assistance (helper does more than half the effort) from staff with shower, upper and lower body dressing. During a review of the CMS MDS 3.0 NH Validation Report, the CMS MDS 3.0 NH Validation Report, indicated Resident 82's MDS assessment was submitted more than 14 days after the Assessment Reference Date ([ARD] - the specific date used as the endpoint of the observation period when assessing resident's condition). During a concurrent interview and record review on 7/24/2025 at 9:22 a.m., with the MDSN, Resident 82's discharge MDS assessment, dated 8/24/2023 was reviewed. The MDSN stated Resident 82's ARD was 8/24/2023. The MDSN stated Resident 82's discharge MDS assessment was completed late on 9/18/2023 and transmitted late to the CMS on 9/25/2023. The MDSN stated Resident 82's discharge MDS assessment should have been completed within 14 days from the ARD. The MDSN stated it is important to notify the CMS of Resident 82's discharge from the facility in a timely manner for billing and tracking purposes of resident's location. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, dated 7/2017, the P&P indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for two of 18 sampled residents (Residents 54 and 49) by failing to: 1. Ensure Resident 54 who was receiving Restorative Nursing Assistant ([RNA], nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services seven times a week and receiving splint (knee braces that improve range of motion and assist with contracture management) placement had an accurate assessment.2. Ensure Resident 49 had accurate documentation in the MDS to reflect his current tobacco use. These deficient practices resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Residents 54 and 49. Findings: 1. During a review of Resident 54’s admission Record, the admission Record indicated Resident 54 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (a condition where the lungs are unable to adequately breath) anoxic brain damage (occurs when the brain is deprived of oxygen resulting in), tracheostomy (a surgical procedure to create an opening in the windpipe to help with breathing), and gastrotomy (plastic tube surgically placed in the stomach to provide nutrition and medication). During a review of Resident 54’s History and Physical (H&P), dated 4/8/2025, the H&P indicated Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54’s MDS dated [DATE], the MDS indicated Resident 54 was dependent (helper does all of the effort to complete the task) on self-care abilities such as oral hygiene, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 54 was dependent on mobility functions such as rolling left and right, sitting to lying position, lying on side of bed, bed to chair transfers, and shower transfers. The MDS indicated Resident 54 was receiving RNA services five times a week in the last seven calendar days for passive range of motion and no splint or brace assistance. During a review of Resident 54’s Order Summary Report, the Order Summary Report indicated RNA for passive range of motion exercises ([PROME], a type of range of motion exercises that involves a helper moving a person's joint through its range of motion) on bilateral upper extremity ([BUE], both arms)/ bilateral lower extremity ([BLE], both legs) on all joints, then apply left knee extension splint, bilateral hand wrist orthotics([BHWO], wrist brace used to treat injuries and strains to the wrist, hand), bilateral elbows orthotics (devices worn on both elbows to provide support, stability, and/or controlled movement) for four to six hours every day seven times a week or as tolerated ordered on 5/13/2025. During a review of Resident 54’s Documentation Survey Report for RNA Task dated May 2025, June 2025 and July 2025, the Documentation Survey Report for RNA Task indicated Resident 54 was receiving RNA services every day, seven days a week with no missing gaps in services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/22/2025 at 10:32 a.m., in Resident 54’s room, Resident 54 was receiving RNA services by RNA staff. RNA staff provided PROME on the left upper extremity ([LUE] left arm), then right upper extremity ([RUE, right arm) for 15 repetitions each. RNA staff applied splints on the right arm, and right hand, then on the left arm and then on left hand. RNA staff provided PROME on the right lower extremity ([RLE, right leg) then left lower extremity ([LLE], left leg) for 15 repetitions each, then applied a splint on the left leg. During a concurrent interview and record review on 7/25/2025 at 10:42 a.m. with MDS Nurse (MDSN), the MDS dated [DATE], the Order Summary Report and the Documentation Survey Report for RNA Task dated May 2025 were reviewed. MDSN stated the Order Summary Report and the Documentation Survey Report for RNA Task indicated Resident 54 was receiving RNA services seven times a week, but the MDS dated [DATE] indicated Resident 54 was receiving RNA services five times a week and no splint assistance was provided. MDSN stated if the MDS assessment was not coded correctly based on resident assessment, the plan of care for the residents was not accurate and care may be affected. MDSN stated the MDS assessment should be coded accurately so all facility staff are on the same page in terms of resident care and what the services resident was receiving. During an interview on 7/25/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated the MDS assessment was based on each individual resident. DON stated the MDS assessment was a document where staff should focus on the residents’ care, it was their baseline care and the MDS assessment should be accurate based on resident’s assessment. The DON stated if MDS was not accurate, it was not accurately displaying what the resident's needs are. During a review of the facility’s policy and procedure (P&P) titled Resident Assessments, dated 3/2022, indicated, a comprehensive assessment of every resident’s needs is made at intervals…. all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. During a review of the facility’s P&P titled Certifying Accuracy of the Resident Assessment, dated 11/2019, indicated any person completing a portion of the minimum data set/MDS (resident assessment instrument) must sign and certify the accuracy of that portion of the assessment….any person who completes any portion of the MDS assessment, tracking form, or corrective request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 2. During a review of Resident 49’s admission Record (front page of the chart that contains a summary basic information about the resident), the admission Record indicated, Resident 49 was admitted to the facility on [DATE]. Resident 49’s diagnoses included personal history of nicotine (a highly addictive stimulant found in tobacco and vaping devices), anemia (a condition where the body does not have enough healthy red blood cells), and abnormal posture. During a review of Resident 49’s History and Physical (H&P), dated 2/13/2025, the H&P indicated, Resident 49 could make decisions for activities of daily living. During a review of Resident 49’s Smoker Risk Assessment, dated 2/12/2025, the Smoker Risk Assessment indicated, Resident 49 required supervision from staff when smoking. (continued on next page)

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	055457	A. Building B. Wing	07/25/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49’s MDS assessment, dated 2/16/2025, the MDS indicated, Resident 49 had the ability to make self-understood and understand others. The MDS indicated, Resident 49 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene and upper and lower body dressing. During a concurrent interview and record review on 7/23/2025 at 9:40 a.m., with the Minimum Data Set Nurse (MDSN), Resident 49’s MDS assessment, dated 2/16/2025, was reviewed. The MDSN stated Resident 49’s MDS was completed inaccurately. The MDSN stated Resident 49’s MDS, Section J1300 (Current Tobacco Use) was coded 0 (No), however it should have been coded as 1 (Yes) because the resident still uses tobacco to smoke. The MDSN stated MDS assessment drives the plan of care for the resident. The MDSN stated inaccuracy of MDS assessment would lead to inefficient interventions that would be provided to the resident. During an interview on 7/25/2025 at 9:57 a.m., with the Director of Nursing (DON), the DON stated it is very important to complete MDS assessment accurately in order to meet the needs of the resident. During a review of the facility’s policy and procedure (P&P), titled “Certifying Accuracy of the Resident Assessment,” dated 11/2019, the P&P indicated, “Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment”.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a comprehensive care plan was developed and implemented for one of three sampled residents (Resident 66), when Resident 66 was non-compliant by refusing to open his mouth for dental assessments during multiple dental staff visits.This deficient practice had the potential to negatively affect the quality of life and wellbeing for Resident 66 to prevent him from achieving his highest practical well-being. Findings:During a review of Resident 66's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including tracheostomy tube (a surgical procedure that creates a small opening in the neck, inserts a tube into the windpipe to help with breathing), dependence of respirator ventilator status (a person relying on a mechanical ventilator to breathe due to impaired lung function or respiratory muscle weakness), and gastrostomy (surgically created opening into the stomach for the insertion of a feeding tube, known as a gastrostomy tube [G-tube]).During a review of Resident 66's History and Physical (H&P) dated 4/25/2025, the H&P indicated Resident 66 does not have the capacity to understand and make decisions.During a review of Resident 66's Minimum Data Set ([MDS], a resident assessment tool) dated 4/11/2025, the MDS indicated Resident 66 was dependent (helper does all the effort to complete the task) on self-care abilities such as oral hygiene, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 66 was dependent on mobility functions such as rolling left and right, sitting to lying position, lying on side of bed, bed to chair transfers, and shower transfers.During a review of Resident 66's Dental Consult Note dated 1/6/2025, the dental consult note indicated not able to do, resident could not follow instructions to open mouth.During a review of Resident 66's Dental Consult Note dated 4/7/2025, the dental consult note indicated Resident 66 was on a tracheotomy tube with very limited function and cooperation, very difficult to gain access to mouth due to resident clenches/shut the mouth tight.During a review of Resident 66's untitled care plan dated 1/16/2025, the untitled care plan did not indicate a refusal or noncompliance to the dental treatment and services from dental staff.During an interview on 7/25/2025 at 10:07 a.m., with the Director of Staff Development (DSD), the DSD stated care plan was how the facility staff provide the care needed for the residents. The DSD stated if residents refuse any type of care, or if residents were noncompliant with care, it should be added to their care plan. The DSD stated any noncompliance with care would alert staff of the refusal, and the care plan should be updated and revised. The DSD stated if a resident refused oral and/or dental care, it should be care planned.During an interview on 7/25/2025 at 2:23 p.m. with the Director of Nursing (DON), the DON stated the importance of a care plan was to meet the residents' needs. The DON stated the care plan should be individualized and personalized. The DON stated if residents were non-compliance with their care, there should be a care planned for the refusal of care so facility staff are aware, and the interventions can be revised.During a review of the facility's policy and procedures (P&P) titled Care Plan, Comprehensive Person-Centered, dated 3/2023, 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 interdisciplinary team ([IDT], a collaborative gathering of healthcare professionals from various disciplines to discuss and coordinate patient care, ensuring a holistic approach to treatment), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. when possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.assessments of residents are ongoing an care plans are revised as information about the residents and the residents' conditions change.

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	055457	A. Building B. Wing	07/25/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) received treatment and care in accordance with professional standards of practice by failing to ensure Resident 2 was not administered Carvedilol (used to treat high blood pressure) when Resident 2's systolic blood pressure (SBP) was less than 110 and when heart rate (HR) was lower than 60 beats per minute (BPM) as ordered by physician. This deficient practice had the potential to cause Resident 2 hypotension (blood pressure is too low) with dizziness and fainting which can lead to fall and injuries. Findings: During a review of Resident 2's admission Record dated 3/17/2025, the admission record indicated the resident was admitted to the facility on [DATE], and was readmitted on [DATE], to the facility with diagnoses of, but not limited to, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Atrial-Fibrillation (an irregular heartbeat, or arrhythmia that can lead to blood clots, stroke, heart failure and other heart-related complications). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 4/12/2025, the MDS indicated Resident 2's cognition (thought process) was moderately impaired. The MDS indicated Resident 2 required substantial/maximal assistance partial (helper does more than half the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a review of Resident 2's physician orders dated 7/1/2025, indicated to administer Carvedilol 25 milligrams (mg) by G-tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) two times a day for hypertension (HTN-high blood pressure) hold if systolic blood pressure is less than 110 or heart rate is less than 60 During a review of Resident 2's medication administration record (MAR) dated 7/17/2025 at 5:00 p.m., it indicated that the resident had a heart rate reading of 59 but Carvedilol was administered. On 7/18/2025 at 5 p.m., heart rate reading was 58 but carvedilol was administered. On 7/22/2025 at 5 p.m., SBP 102 but carvedilol was administered. During an interview with Licensed Vocational Nurse 5 (LVN 5) on 7/24/2025, at 2:10 p.m., LVN 5 stated the license nurse should have held the medication as ordered by physician. During a review of facility's policy and procedure (P&P) titled, Administering Medications dated 3/2023, indicated that vital signs if necessary are to be obtained prior to administration of medications.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents on tube feeding received treatment and care in accordance with professional standards of practice by failing to:1. Elevate the head of the bed while receiving formula through the gastrostomy tube ([GT] - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for one of three sampled residents (Resident 40). This deficient practice had the potential to cause aspiration (inhalation of foreign materials) that could lead to pneumonia (lung infection) for Resident 40. Findings:During an observation on 7/22/2025 at 10:13 a.m. in Resident 40's room, Resident 40's was in bed lying flat on her back while the TF was running.During a review of Resident 40's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included GT placement, chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures).During a review of Resident 40's History and Physical (H&P), dated 1/29/2025, the H&P indicated, Resident 40 did not have the capacity to understand and make decisions.During a review of Resident 40's Minimum Data Set ([MDS] - a resident assessment tool), dated 6/19/2025, the MDS indicated, Resident 40's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions).). The MDS indicated, Resident 40 was totally dependent (helper does all of the effort) from staff with oral hygiene, lower and upper body dressing, and personal hygiene. The MDS indicated, Resident 40 was on tube feeding. During a review of Resident 40's Order Summary Report (a document containing active orders), dated 7/24/2025, the Order Summary Report indicated Resident 40 had tube feeding order of Peptamen (type of tube feeding formula) 1.5 kilocalorie ([kcal] - unit of measurement) at 50 cubic centimeters ([cc] - unit of volume) per hour for 20 hours to provide 1000cc/1500 kcal per day. The Order Summary Report indicated to observe aspiration precaution and elevate head of bed at 30 to 45 degrees (a unit of measurement for angles) at all times during GT feeding. During a concurrent observation and interview on 7/22/2025 at 10:23 a.m., with Licensed Vocational Nurse 3 (LVN 3), in Resident 40's room, Resident 40 was observed receiving GT feeding of Peptamen 1.5 at 50 cc/hour. LVN 3 stated Resident 40's head of bed was only 10 degrees. LVN 3 stated as standard of practice the head of bed should be elevated at 30 to 45 degrees while tube feeding is running. LVN 3 stated by not elevating the head of bed at least 30 degrees, Resident 40 is at risk for aspiration pneumonia that would likely require hospitalization. During a review of the facility's policy and procedure (P&P), titled Enteral Feedings - Safety Precautions, dated 11/2018, the P&P indicated, The facility will remain current and follow accepted best practices in enteral nutrition. The P&P also indicated to prevent aspiration, elevate the head of bed at least 30 degrees during tube feeding and at least 1 hour after feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055457	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Healthcare & Rehabilitation Center	12627 Studebaker Road Norwalk, CA 90650

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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	055457	A. Building B. Wing	07/25/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label and properly disposed discontinued medications per the facility's policy.This deficient practice had the potential to result in the residents accidentally ingesting unknown medications and increased the risk of diversion (any use other than that intended by the prescriber) of unknown medications.Findings:During a concurrent observation and interview on [DATE], with Licensed Vocational Nurse (LVN) 4, in medication storage room for station 1 and 2, there was an unlocked discontinued medication storage cabinet observed with 24 opened and unlabeled medications in a plastic cup inside of the cabinet. There was no pharmaceutical waste bin (a container, often color-coded, designed for the safe disposal of unused, expired, or contaminated medications) observed nearby. LVN 4 stated that all discontinued medications should be labeled and disposed of in blue pharmaceutical waste bins for safety to prevent accidental ingestion. LVN 4 stated, the license staff only document when the discontinued medications were disposed of with two witnesses, but the staff would not know what medications were in the discontinued medication cabinet. LVN 4 stated that the medications were disposed twice a week by night shift nurses.During an interview on [DATE], at 12:39 p.m., with the Director of Staff Development (DSD), the DSD stated, all medications should be labeled. The DSD stated that discontinued and unused medications should be discarded with proper pharmaceutical waste bins as soon as possible to prevent accidental ingestion or misuse. The DSD stated, if the medications cannot be discarded immediately, the staff should document and place them in a locked place for safety.During an interview on [DATE], at 2:53 p.m., with the Director of Nursing (DON), the DON stated that all discontinued medications should be documented when they are brought into discontinued medication cabinet, so the licensed staff knows which medications to discard. The DON stated, all medications should be labeled and not placed in a plastic cup. The DON stated that the staff should have disposed of discontinued medications in pharmaceutical waste bins to prevent accidental ingestion. The DON stated the discontinued medication cabinet should be locked in a safe place. During a review of the facility's Medication Disposition Record Log (MDRL), dated 7/2025, the MDRL indicated, there was no record of the 24 opened and unlabeled medications in a plastic cup.During a review of the facility's Policy and Procedure (P&P) titled, Storage of Medications, revised 3/2023, the P&P indicated, Policy Heading: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destructed as indicated.6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. During a review of the facility's Policy and Procedure (P&P) titled, Discarding and Destroying Medications, revised 4/2019, the P&P indicated, Policy Interpretation and Implementation: 6. For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste fol1owing the steps below: a. Take the medication out of the original containers. b. Mix medication, either liquid or solid, with an undesirable substance.d. Document the disposal on the medication disposition record. e. Include the signature(s) of at least two witnesses. 10. The medication disposition record will contain the following information: a. The resident's name: b. Date medication disposed; c. The name and strength of the medication; d. The name of the dispensing pharmacy; e. The quantity disposed; f. Method of disposition; g. Reason for disposition; and h. Signature of witnesses.During a review of the facility's Policy and Procedure (P&P) titled, Labeling of Medication Containers, revised 3/2023, the P&P indicated, Policy Interpretation and Implementation: 1. Medication labels must be legible at all times. 2. Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy.

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	055457	A. Building B. Wing	07/25/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 2), had monitoring for complications related to Xarelto (an anticoagulant medication used to treat and prevent harmful blood clots) a medication that may increase the risk of bleeding. This deficient practice placed Resident 2 at risk of bleeding a possible side effect of anticoagulant medication. Findings: During a review of Resident 2's admission Record dated 3/17/2025, the admission record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] to the facility with diagnoses of, but not limited to, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Atrial-Fibrillation (an irregular heartbeat, or arrhythmia that can lead to blood clots, stroke, heart failure and other heart-related complications). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 4/12/2025, the MDS indicated Resident 2's cognition (thought process) was moderately impaired. The MDS indicated Resident 2 required substantial/maximal assistance partial (helper does more than half the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a review of Resident 2's medication administration record (MAR) for the month of 7/1/2025, the MAR indicated Resident 2 has been receiving Xarelto 20 milligrams since 6/25/2025. During a concurrent record review and interview on 7/24/2025, 11:10 a.m. with Licensed Vocational Nurse 5 (LVN 5), stated Resident 2 did not have monitoring for adverse consequences and potential risk associated with medication and LVN 5 stated should have been started when medication was initiated because Xarelto can cause bruising and bleeding. During a review of the facility's policy and procedure (P&P) title, Anticoagulant/Antiplatelet with administration of Xarelto Resident 2 should have been monitored daily for signs and symptoms of bleeding.

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	055457	A. Building B. Wing	07/25/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications, syringes, hand sanitizers and wound cleanser were not stored beyond their expiration dates in one of one disaster boxes (a container filled with emergency supplies e.g., medications, flashlights, extension cords, items for use in case of an emergency) stored in the Station 1 medication room.This deficient practice had the potential to result in the administration or use of expired medications and products, which had reduced effectiveness and the protentional to cause adverse effects to residents. Findings: During an observation on 7/23/2025 at 2:45 p.m. , in the Station 1 medication room a disaster box the following expired items were found: 1 . Medline Acetaminophen bottle 100 tablets - expiration date 20022. Walgreens Ibuprofen bottle 100 tablets - expiration date 20213. [NAME] wound cleanser - expiration date 20224. 25 Medline Insulin syringes - expiration date 20245. 25 Medline spectrum 4oz hand sanitizers - expiration date 2019During an interview on 7/23/2025 at 2:45 p.m., with Licensed Vocational Nurse (LVN), LVN 1 stated, the expired items should not be in our disaster box, they could be given to a resident by mistake. During an interview on 7/25/2025 at 9:49 a.m., with the Director of Nursing (DON), the DON stated, expired medications are not given to residents. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated March 2023, the P&P indicated, outdated or deteriorated drugs or biologicals are to be returned to the dispensing pharmacy and destructed as indicated.

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	055457	A. Building B. Wing	07/25/2025

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview, and record review the facility failed to follow up on dental services for one of six sampled residents (Resident 32).This deficient practice had the potential to place Resident 32 at risk for poor self-esteem and weight loss.Findings:During a review of Resident 32's admission Record (Face Sheet), the admission Record indicated Resident 32 was admitted to the facility 6/6/2024 with diagnoses of moderate protein-calorie malnutrition (inadequate intake of food) and dysphagia (difficulty swallowing).During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool) dated 6/3/2025, the MDS indicated Resident 32 was cognitively (mental processes that relate to acquiring knowledge and understanding through thought, experience, and the senses) intact.During a review of Resident 32's Dental Notes dated 6/21/2024, the Dental Notes indicated Resident 32 was evaluated by the dentist and was noted to be edentulous (no teeth) and had old dentures with an inadequate fit. The Dental Note indicated Resident 32 requested new dentures with smaller teeth.During a review of Resident 32's Order Summary Report, the Order Summary Report indicated Resident 32 had an order placed on 5/20/2025 for a dental consultation and treatment as needed for dental problems.During a concurrent observation and interview on 7/23/2025 at 12:15 p.m., Resident 32, Resident 32 was observed without any teeth and Resident 32 stated he wanted new dentures and hasn't seen the dentist since 6/21/2025.During a concurrent interview and record review of Resident 32's Dental Notes on 7/25/2025 at 10:06 a.m., with the Social Services Director (SSD), the SSD stated Resident 32 was only seen by the dentist on 6/21/2024 while in the facility. The SSD stated the Dental Note dated 6/21/2024 indicated Resident 32 was requesting new dentures due to improper fit. The SSD stated she was not aware of the Dental Note recommendations from 6/21/2025 and there was no Dental Note in Resident 32's indicating the facility followed up on the request for new dentures. The SSD stated she is usually in charge of following up on dental recommendations and ensuring the resident has a follow up visit, but it was not done and there were no additional follow up consultations by the dentist. The SSD stated it was important that the facility followed up on dental recommendations to ensure the residents' needs were met.During an interview on 7/25/2025 at 2:45 p.m. with the Director of Nursing (DON), the DON stated it was important to follow up on dental recommendations to meet resident needs and poor dental status could affect the way residents eat.During a review of the facility's policy and procedure (P/P) titled Routine Dental Care dated 2001, the P/P indicated each resident would receive routine dental care and consultation with the dental consultant as needed.

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	055457	A. Building B. Wing	07/25/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide foods that aligned with one of six sampled residents (Resident 51's) ethnic (of or relating to large groups of people classed according to common racial, national, tribal, religious, linguistic [language], or cultural origin or background) preferences. This deficient practice resulted in Resident 51 disliking the food provided and at times refused to eat meals provided by the facility. Findings:During a review of Resident 51's admission Record (face sheet), the admission Record indicated Resident 51 was admitted to the facility 11/2/2025 with diagnosis including major depressive disorder (persistent feelings of sadness or loss of interest) and anxiety disorder (mental disorder characterized by significant and uncontrollable feelings of worry and fear). The admission Record indicated Resident 51's primary language was Spanish.During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool) dated 4/30/2025, the MDS indicated Resident 51 was cognitively (mental processes that relate to acquiring knowledge and understanding through thought, experience, and the senses) intact.During a review of Resident 51's Nutritional assessment dated [DATE], the Nutritional Assessment indicated Resident 51's meal intake ranged from 25-100% and it was noted Resident 51 refused 3 meals. The Nutritional Assessment indicated the refusals were likely due to Resident 51 disliking the food from the facility.During a review of the facility's Alternative Food Choices, undated, a cheese quesadilla was the only substitute considered to be a Latino food option.During a review of the facility's Week 4, July 21-27, 2025 Menu, out of 21 meals (breakfast, lunch, and dinner for the week), one meal out of the 21 was a Latino food option. On 7/22/2025, the lunch meal was cheese enchiladas with fiesta rice.During an interview on 7/22/2025 at 9:56 a.m., with Resident 51, Resident 51 stated the facility hardly ever offers Latino food. Resident 51 stated she sometimes refuses to eat the food because every day they get American food. Resident 51 stated she would want rice and beans and other Latino food options that she is accustomed to. During an interview on 7/23/2025 at 12:47 p.m. with Resident 51, Resident 51 stated it made her upset the facility did not provide Latino food options.During an interview on 7/25/2025 at 2:17 p.m., with the Dietary Services Supervisor (DSS) , the DSS stated the facility had a large population of Latino residents. The DSS stated he had been working at the facility for less than two weeks (unknown hire date), but it had come to his attention that the residents were requesting more Latino food options. The DSS stated it was important to honor residents' ethnic food preferences because that is what they are used to and the residents would be happier, eat more, and the facility could prevent unwanted weight loss.During a review of the facility's policy and procedure (P/P) dated 2001, the P/P indicated the facility was to offer a variety of foods at each scheduled mealtime.

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	055457	A. Building B. Wing	07/25/2025

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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 safe and sanitary food storage and food preparation practices in the kitchen when:1. five boxes of tea bags were stored in the dry storage area with no date and label.2. An opened Clorox disinfecting wipes stored in the dry storage area.3. Three gallons of rainbow sherbet were stored in freezer #2 with no date and label.4. Dietary Aide 1 (DA 1) did not wear hair covering in the food preparation area.These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 45 out of 80 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on 7/22/2025 at 8:22 a.m., with the Dietary Service Supervisor (DSS) in the dry storage area, there were five boxes of tea bags with no date and label. The DSS stated all food items stored in the dry storage area should be labeled with received date and use by date. The DSS stated giving expired food items to resident would affect their health and safety and possible food poisoning. 2. During a concurrent observation and interview on 7/22/2025 at 8:27 a.m., with the DSS in the dry storage area, one bottle of opened Clorox disinfecting wipes was observed. The DSS stated he had no idea who placed the disinfecting wipes in the dry storage area. The DSS stated all disinfecting wipes, and chemical solution should be placed in the designated chemical room due to possible cross contamination with the food items in the dry storage area. 3. During a concurrent observation and interview on 7/22/2025 at 8:30 a.m., with the DSS in the freezer #2, found 3 gallons of rainbow sherbet was observed with no label with an open date. The DSS stated it was important to label frozen food items to know when it will be expired and to ensure the likelihood of cross contamination is reduced. 4. During a concurrent observation and interview on 7/23/2025 at 11:55 a.m., in the food preparation area with DA 1, the DA 1 was observed getting hot water in the dispenser machine with no hair covering. The DA 1 stated all staff that works in the kitchen should use a hair net in that way the hair does not go into the food and to prevent cross contamination. During a review of the facility's undated Policy and Procedure (P&P), titled Dating and Labeling, the P&P indicated, To ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/freezer areas. During a review of the facility's undated P&P titled, Storage of Canned and Dry Goods, the P&P indicated, No chemicals or cleaning products will be stored with food items. Separate storage area should be available for chemical and cleaning products. During a review of the facility's undated P&P titled, Sanitation and Infection Control, the P&P indicated, A hair net or head covering which completely covers all hair should be worn at all times.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement an individualized person-centered care plan to meet the residents' needs for one of three sampled residents (Resident 5) by failing to develop an individualized/person-centered care plan to address Resident 5's preferred activities. This deficient practice had the potential to negatively affect the delivery of necessary care and services.Findings:During a review of Resident 5's admission Record dated 5/19/2016, the admission record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] to the facility with diagnoses of, but not limited to, chronic respiratory failure (lungs gradually lose their ability to effectively exchange gases oxygen and carbon dioxide). Dependent on ventilator (a medical device to help support or replace breathing) status. During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 4/18/2025, section C indicated Resident 3's cognition level is severely impaired. The MDS indicated Resident 3 required dependent assistance (helper does all the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a review of Resident 5's Activity assessment dated [DATE] indicated Resident 5's activity preferences such as soft music, western, and reading tapes. During a concurrent interview and record review on 7/25/2025 at 10:16 a.m., with Activity Director (AD) stated Resident 5 ‘s activities involved room visits, soft music, movies and reading tapes. A review of the care plan dated 1/18/2023 did not mention Resident 5's preferences of soft music, movies and reading tapes. During the interview with the AD, she stated that Resident 5's care plan should have been updated to reflect the resident's activity preferences. During a review of the facility's policy and procedure, titled Care Plans, Comprehensive Person-Centered, revised March 2023 indicated each resident will have a comprehensive care plan developed that include goals, measurable objectives to meet their medical, nursing, mental, and psychosocial need identified during the comprehensive assessment. The care plan must describe services that are provided to the residents to attain or maintain the residents' highest practicable, mental and psychosocial well-being.

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	055457	A. Building B. Wing	07/25/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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	055457	A. Building B. Wing	07/25/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement infection control measures by failing to follow its policy regarding monitoring and documenting the temperature of laundry equipment (water temperature for washers and temperature for dryers) and logs daily.This failure had the potential to result in compromised infection control measures of the facility laundry and the spread of infection from bacteria (microorganisms that can cause infectious disease) throughout the facility.Findings:During a concurrent interview and record review on 7/25/2025, at 10:55 a.m., with Laundry Aid (LA) 1, the facility's Water Temperature Log (WTL), dated 7/2025 was reviewed. The WTL indicated, water temperature for washers 1 and 2 were 140 Fahrenheit (F-a temperature scale) from 7/1/2025 to 7/25/2025. LA 1 stated, she was not sure where 140 F was referring from. LA 1 stated, the thermometer (an instrument for measuring and indicating temperature) above the washers indicated 120 F. LA 1 stated, she did not know what type of laundry machines were in the laundry room. LA 1 stated, she did not know what water temperature range was acceptable per policy. LA 1 stated, she did not document temperature for dryers and did not know the proper temperature range for dryers.During an interview on 7/25/2025, at 11:19 a.m., with Laundry Supervisor (LS), LS stated, he was not sure, but he thought the washers were low temperature water with bleach. LS stated he did not know the proper water temperature range for washers. LS stated, he believed the temperature requirement for dryers was 180 F. LS stated, staff should have known type of equipment, proper water temperature range for washer, and proper temperature range for dryer. LS stated monitoring and documentation of the temperature was important to ensure that it was on right range to effectively kill bacteria. During a concurrent observation and interview on 7/25/2025, at 11:40 a.m., with the Maintenance Supervisor (MS), the temperature for dryers 1 and 2 were measured by MS. The temperature of dryer 1 was 120 F and the temperature of dryer 2 was 122 F with multiple tries. MS stated, he believed they are lower than requirement. MS stated, if the temperature did not reach the proper level, it would not effectively remove germs that could cause illness.During an interview on 7/25/2025, at 12:49 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated, she realized there are three different policies for laundry washer water temperature. The IPN stated that the facility should have provided the uniform and clear policy and procedure to staff. The IPN stated, washer and dryer temperature should be monitored for certain temperatures to effectively kill bacteria and germs because laundry was part of infection prevention. During a telephone interview on 7/25/2025, at 1:10 p.m. with Contracted Laundry Machine Service Company Representative (CLMSCR) 1, CLMSCR 1 stated, the facility's washers are low temperature (71F-77F) machine with chlorine. CLMSCR 1 stated that the company's washers work best when the water temperature is lower than 120 F, but the facility should develop and follow their own policy.During an interview on 7//25/2025, at 2:23 p.m., with the Director of Nursing (DON), the DON stated, monitoring the temperature was important to ensure infection prevention effectively. The DON stated, the facility should have clear policy regarding laundry policy and procedures especially monitoring water temp for washer and temp for dryer to kill microbes effectively without any confusion. The DON stated, if the temperature was out of range, the staff should reach out to contracted maintenance company to fix.During a review of the facility's Policy and Procedure (P&P) titled, Laundry Dryer Temperature, undated, the P&P indicated, Procedure: 3. C Proper drying and cool down temperature must be maintained.[NAME]: 180-190 F, Sheets and Pillowcases:160-170 F, Table Napery: 140-160 F, Blankets: 150-170 F, Diapers: 140-150 F.During a review of the facility's Policy and Procedure (P&P) titled, Laundry Water Temperature, undated, the P&P indicated, Procedure: 1. The maintenance Supervisor will maintain laundry temperature of the water within a range of 70 F to 135 F. 2. The Laundry personnel will maintain a log of daily laundry water temperatures to ensure that water is maintained at the appropriate temperature to provide proper disinfection of soiled linen.During a review of the facility's Policy and Procedure (P&P) titled, Manufacturer Suggested Operating Procedures, dated 3/2019, the P&P indicated, Verifying Bacteria Reduction (Disinfection): Water temperatures between 60 F to 130 F are used with the system, disinfection is achieved anywhere in this temperature range.During a review of the facility's Policy and Procedure (P&P) titled, Laundry System Agreement, dated 11/3/ 2023, the P&P indicated, There are three acceptable methods for processing laundry.2. Low temperature washing, in the range of 71 F-77F, with high levels of chlorine at 125 ppm.