STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER Cottage Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 12350 Rosecrans 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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) care plan was revised after Resident 2 fell on [DATE].This deficient practice had the potential for the nursing staff to be unaware of Resident 2's current fall-risk precautions and interventions, which could delay or negatively impact the delivery of her care and potentially lead to further falls.Findings:During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (temporary or permanent damage to the brain due to lack of glucose, oxygen or other metabolic agent, or organ dysfunction), dementia (a progressive state of decline in mental abilities), and difficulty walking.During a review of Resident s's Minimum Data Set ([MDS] a resident assessment tool) dated 7/8/2025, the MDS indicated Resident 2 was not able to make decisions that were reasonable and consistent and required partial/moderate assistance (helper does more than half the effort) from staff to complete her activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily), such as toilet transfer, repositioning from sitting to standing, position and transferring from the bed/chair-to-chair. The MDS indicated Resident 2 was incontinent of bowel and bladder (involuntary voiding of urine and stool). During a review of Resident 2's Care Plan, dated 8/10/2025, the Care Plan indicated Resident 2 was at risk for falls due to incontinence, psychoactive drug (medications that affect mood, thinking, behavior, or perception), and unawareness of safety needs. The Care Plan's goal was for Resident 2 to be free from falls and minor injuries and will not sustain serious injuries. The Care Plan's interventions included anticipating and meeting Resident 2's needs, ensuring staff respond promptly to Resident 2's calls and requests for assistance, and providing a safe environment by keeping pathways free of spills or clutter, providing adequate lighting, and ensuring personal items including the call light were within reach. During a review of Resident 2's Change of Condition Evaluation (COC) dated 12/25/2025 and timed 12:58 a.m., the COC indicated Resident 2 had a fall and was found sitting on the lobby floor with blood on her face. During a review of Resident 2's Change in Condition Progress Notes dated 12/26/2025 and timed at 1:59 a.m., the Change in Condition Progress Notes indicated Resident 2 was found on the floor by the nursing station with a quarter sized cut on the forehead actively that was actively bleeding. The Change in Condition Progress Notes indicated the paramedics (a group of individuals trained to provide emergency medical care to people who are injured or ill outside the GACH) were called and Resident 2 was transferred to a general acute care hospital (GACH) via 911 for further treatment.During a review of Resident 2's Clinical Records, there was no documentation indicating an Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) of the facility implemented a care conference with Resident 2's emergency contact to discuss recommendations, changes and/or update (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's fall risk Care Plan interventions.During a review of Resident 2's Risk for Fall Care Plan, the Care Plan did not indicate revisions and/or updates of Resident 2's Care Plan to include interventions after she fell on [DATE].During an interview on 2/23/2026 at 12:20 p.m., Resident 2's Emergency Contact (EC) 1 stated the facility staff informed her when Resident 2 had a fall incident few months ago but was not called to attend a meeting to discuss Resident 2's care concerns and interventions after her fall on 12/25/2025. During a telephone interview on 2/24/2026 at 11:51 a.m., Registered Nurse (RN) 1 stated Resident 2 had an unwitnessed fall on 12/25/2025 at the change of shift (between 3 p.m. to 11 p.m. to 7 a.m.) and the paramedics transferred Resident 2 to the GACH for further treatment. RN 1 stated Resident 2 was transferred back to the facility the same day at 11 p.m. to 7 a.m. shift and he informed the Certified Nursing Assistant (CNA unknown) assigned to Resident 2 to perform frequent visual checks to ensure Resident 2's safety. RN 1 stated he was unable to review and revise Resident 2's risk for fall care plan and did not formulate a care plan for an actual fall. RN 1 stated it was the responsibility of the licensed nurses to update and revise the care plan of the residents to prevent another fall.During a concurrent interview and record review on 2/24/2026 at 12:31 p.m. with the Director of Rehab (DOR), Resident 2's Clinical Record was reviewed. The DOR stated Resident 2 had poor safety awareness and required assistance during transfer and walking because she was unsteady. The IDT had a meeting after Resident 2's fall on 12/25/2026 to discuss Resident 2's fall precautions and revision of care plan interventions. The DOR confirmed there was no IDT meeting documented in Resident 2's Clinical Record and Resident 2's risk for falls care plan had not been revised and/or updated. The DOR stated the IDT should have conducted an interdisciplinary meeting with Resident 2's emergency contacts so the emergency contacts could share recommendations and participate in the planning and/or revising of Resident 2's plan of care.During an interview and concurrent record review on 2/24/2026 at 3:03 p.m., the DON stated and confirmed Resident 2's risk for falls care plan was not revised and/or updated after Resident 2 had a fall on 12/25/2025. The DON stated Resident 2's care plans should have been updated and revised by the licensed nurses after Resident 2's fall to reflect the accurate fall precautions and/or interventions to ensure awareness of the nursing staff and to prevent delay of care of Resident 2.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, revised 12/19/2022, the P&P indicated the facility shall develop, implement and revise a comprehensive person- centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet the residents' medical, nursing, mental and psychosocial needs based in the resident's comprehensive assessment. The residents' comprehensive care plan will be prepared by the facility's interdisciplinary team that includes, but is not limited to:a. The attending physicianb. A registered nursec. A nurse aided. A member of the nutrition servicese. The resident and the resident's representativef. Other staff or professionals involved in care of the residents such as therapists, social workers, activity personnel, family members, administrator, discharge coordinator, mental health professionals and chaplain.During a review of the facility's P&P titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated the facility shall review the residents' care plan and update as indicated.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 1) was provided with his preferred activities. This failure resulted in Resident 1 feeling sad and frustrated and had the potential to further affect Resident 1's emotional well-being, which may impact his quality of life and mental health. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including depression (a mood disorder that cause feelings of persistent feeling of sadness and loss of interest affecting the way a person feel, think and behave that affects the normal day to day activities). During a review Resident 1's History and Physical (H&P), dated 9/19/ 2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent and required partial/moderate assistance from staff to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 1 did not ambulate and used a manual wheelchair for mobility. During a review of Resident 1's Activity Assessment, dated 11/10/2025 and timed at 5:26 p.m., the Activity Assessment indicated Resident 1's activity interests included outdoor patio activities, outings and shopping.During a review of Resident 1's Activity Assessment, dated 2/10/2026 and timed at 10:23 a.m., the Activity Assessment indicated Resident 1's activity interests included outdoor patio activities, outings and shopping.During a review of Resident 1's Care Plan, dated 2/9/2025 and revised 5/24/2025, the Care Plan indicated Resident 1 had depression. The Care Plan's goal was for Resident 1 to be free from signs and symptoms of distress and not to exhibit indicators of depression such as a sad mood or anxiety (extreme worry). The Care Plan's interventions included assisting Resident 1 in developing and providing him with activities that were meaningful and of interest. During a review of the facility's Activity Calendar dated 11/2025, 12/2025 and 1/2026, there was no activities which included resident outings and shopping. During a telephone interview on 2/22/2026 at 8 p.m., Resident 1 stated there are days when the weather is good and would like to leave the facility to purchase items from a store; however, the facility does not provide outings or shopping activities for residents. Resident 1 stated that remaining inside the facility makes him feel sad and frustrated and would like to do something outside and/or away from the facility so he could feel like a normal human being. During an interview on 2/23/2026 at 1:08 p.m., Restorative Nursing Assistant (RNA) 1 stated she accompanied Resident 1 to a medical appointment a few weeks ago and Resident 1 told her that he would like to go shopping at a store sometimes, but the facility mostly provides indoor activities rather than outings. RNA 1 stated Resident 1 told her that he feels sad sometimes and wished he could spend a few hours away from the facility. During an interview on 2/23/2026 at 1:43 p.m., the Activity Director (AD) stated the facility has not provided a group outing activity for the residents because she needs to apply for a government ride permit for each resident. The AD stated she should have planned and implemented residents' activities of choice to honor their individual preferences and if the residents' families are not available to take the residents out for an outside activity, the facility should be able to provide outings and shopping because these activities are essential to the residents' mental health and wellbeing. During an interview on 2/24/2026 at 3:03 p.m., the Director of Nursing (DON) stated Resident 1's activity interests should have been provided by the facility to promote meaningful experiences.During an interview on 2/24/2026 at 3:49 p.m., the Administrator (ADM) stated the facility should have offered and provided Resident 1 with (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities of his choice while he was at the facility to ensure his comfort and quality of life.During a review of the facility's policy and procedure (P&P) titled, Activities, revised 12/19/2023, the P&P indicated the facility shall provide an ongoing program to support the residents in their choice of activities based on their comprehensive assessment, care plan and preferences to encourage independence and interaction within the community. The facility shall sponsor group, individual and independent activities that are designed to meet the interests of each resident, as well as support their physical, mental and psychosocial well-being.

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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 ensure Registered Nurse (RN) 1 accurately documented vital signs (essential measurements taken by the healthcare team providers to check the body's most basic and life sustaining functions) for one of three sampled residents (Resident 2) when Resident 2 had a change of condition on 12/25/2026 and was transferred to a General Acute Care Hospital via 911 for further evaluation. This deficient practice had the potential for Resident 2's change of condition to be unrecognized, undetermined, or inadequately identified. This deficient practice also had the potential to negatively impact Resident 2's health status, interrupt the continuity of care, and impair timely and accurate communication among facility team members and with emergency personnel. Findings:During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (temporary or permanent damage to the brain due to lack of glucose, oxygen or other metabolic agent, or organ dysfunction), dementia (a progressive state of decline in mental abilities), and difficulty walking.During a review of Resident s's Minimum Data Set ([MDS] a resident assessment tool) dated 7/8/2025, the MDS indicated Resident 2 was not able to make decisions that were reasonable and consistent and required partial/moderate assistance (helper does more than half the effort) from staff to complete her activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily), such as toilet transfer, repositioning from sitting to standing ,position and transferring from the bed/chair-to- chair. The MDS indicated Resident 2 was incontinent of bowel and bladder (involuntary voiding of urine and stool).During a review of Resident 2's Change of Condition Evaluation (COC) dated 12/25/2025 and timed at 12:58 a.m., the COC indicated Resident 2 had a fall and was found sitting on the lobby floor with blood on her face. There was no documentation indicating Resident 2's vital signs were documented during the change of condition.During a review of Resident 2's Change in Condition Progress Notes dated 12/26/2025 and timed at 1:59 a.m., the Change in Condition Progress Notes indicated Resident 2 was found on the floor by the nursing station with a quarter sized cut on the forehead actively that was actively bleeding. The Change in Condition Progress Notes indicated the paramedics (a group of individuals trained to provide emergency medical care to people who are injured or ill outside the GACH) were called and Resident 2 was transferred to a general acute care hospital (GACH) via 911 for further treatment. There was no documentation indicating Resident 2's vital signs were documented during Resident 2's change of condition.During a telephone interview on 2/24/2026 at 11:51 a.m., RN 1 stated Resident 2 had an unwitnessed fall on 12/25/2025 at the change of shift (between 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.). RN 1 stated he was able to assess and monitor Resident 2 vital signs during her change of condition but did not document Resident 2's vital signs in her clinical record. RN 1 stated he should have documented Resident 2's vital signs in the clinical record to depict Resident 2's accurate well-being after the fall.During an interview on 2/24/2026 at 3:03 p.m., the Director of Nursing (DON) stated RN 1 should have documented Resident 2's assessments and monitoring during the change of condition to include current vital signs to reflect the accurate well-being of Resident 2 after her fall and her condition and/or deterioration was determined. The DON stated it was the responsibility of the nursing staff to ensure the residents' records are complete.During a review of the facility's policy and procedure (P&P) titled, Documentation in Medical Record, revised 12/19/2022, the P&P indicated the following:a. The residents' medical records shall contain a representation of the residents' experiences and should reflect enough information to provide a picture (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the residents' progress, andb. The nursing staff shall document all accurate, relevant and complete assessments, observations, and services provided and all documentation must be completed at the time of service.