STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an effective grievance process was implemented that ensured resident concerns were documented, investigated, and resolved in a timely manner for three of four sampled residents (Resident's 1, 2, and 4).These failures resulted in the complaints not being documented, investigated, or resolved, leaving residents without recourse for lost belongings and creating a pattern of unresolved concerns.Findings:a. During a review of Resident 1 's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty walking. During a review of Resident 1's History and Physical (H&P), dated 1/31/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1 's Minimum Data Set ([MDS] a resident assessment tool) dated 1/27/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and Resident 1 required moderate assistance (helper does less than half the effort) from staff for toileting, bathing, dressing, personal hygiene, sit to stand mobility (ability to come to a standing position from sitting position), and toilet transfer (the ability to get on and off the toilet or commode). The MDS further indicated Resident 1 was occasionally incontinent (involuntary voiding of urine and stool) of bowel and bladder. During a telephone interview on 3/23/2026 at 4:44 p.m., with Resident 1's Family Member (FM) 1, FM 1 stated all of Resident 1's personal property was missing, including clothing, hamper, slippers, four blankets, robes, tank tops, and underwear. FM 1 stated the facility washed the items and did not return them to Resident 1, even though the items had been labeled with the resident's name. FM 1 stated the resident had been wearing clothing that did not belong to her, and the family had purchased replacement items, including blankets. FM 1 stated this issue occurred regularly and stated she had reported her concerns to multiple staff, including the charge nurse and the Administrator (ADM) on 3/11/2026. FM 1 stated the ADM was condescending to her and lacked empathy when she reported Resident 1's missing property. FM 1 stated the facility owed approximately $350.45 for missing items. FM 1 stated the facility has not resolved the issue and Resident 1's personal items have not been reimbursed. b. During a review of Resident 2 's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses which included orthopedic aftercare following surgical amputation (care after the removal of a limb), type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), and hypertensive heart disease (high blood pressure affecting the heart). During a review of Resident 2's History and Physical (H&P) dated 3/20/2026, the H&P indicated Resident 2 was able to make need known and make decisions. During a review of Resident 2's admission Interdisciplinary Care Conference - Section GG and Brief Interview for Mental Status ([BIMS] an assessment tool used by facilities to (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	screen and identify memory, orientation, and judgement status of the resident) Notes, dated 3/20/2026, the care conference and BIMS notes indicated Resident 2 required maximal assistance from staff for bathing and personal hygiene and Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired.During an interview on 3/24/2026 at 10:15 a.m., Resident 2 stated her purse, and wallet had been missing for approximately three weeks, which contained two checks. Resident 2 stated she reported the missing items to the facility and staff looked for the items but did not locate them. Resident 2 stated she had not been reimbursed for the missing items. Resident 2 stated she did not feel her personal property was safe in the facility. Resident 2 stated the social services department did not assist her with the loss of her property or with canceling the missing checks.c. During a review of Resident 4 's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE]. Resident 4 had diagnoses which included DM, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 4's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4 's MDS dated [DATE], the MDS indicated Resident 4's cognition was intact and was dependent (helper does all the effort) on staff for toileting and bathing and required maximal assistance (helper does more than half the effort) from staff for oral and personal hygiene. During an interview on 3/24/2026 at 10:38 a.m., with Resident 4, Resident 4 stated his personal items had been misplaced on multiple occasions over approximately five months, including hair clippers, styluses, and tweezers. Resident 4 stated when he left the facility for hospital visits, his belongings were packed, and upon return, items were missing. Resident 4 stated he reported the missing items to staff and was told the issue would be reported to a supervisor; however, he did not receive any follow-up. Resident 4 stated multiple personal items remained missing, and staff did not resolve the issue. During a review of the facility's Grievance Logs from 1/2026 to 3/2026, the logs indicated there were no grievances documented related to missing personal property for Residents 1, 2, and 4. During a concurrent interview and record review on 3/24/2026 at 1:04 p.m., with the Social Services Assistant (SSA), the facility's policy and procedures (P&P) titled Resident and Family Grievances, was reviewed. The SSA stated when items were reported missing, staff searched the laundry, resident rooms, and checked the inventory sheet. The SSA stated if the item was listed on the inventory sheet and could not be located, the resident would be reimbursed. The SSA stated if receipts were not available, staff attempted to match the price of similar items. The SSA stated missing items should be documented in the resident's progress notes and reported to Administration for follow-up. The SSA stated she spoke with FM regarding Resident 1's missing clothing and stated she was waiting for FM to provide a detailed list of missing items and receipts. The SSA stated the missing items had been discussed; however, she did not indicate a grievance had been initiated regarding the missing property. The SSA stated Resident 4 reported missing money and personal items. The SSA stated the money was not listed on the inventory sheet and was not reimbursed. The SSA stated she was unaware of additional missing items and stated if items had been reported, they should have been documented and a grievance filed. The SSA stated Resident 2 had not reported missing items to her regarding a purse or checks and stated those items were not listed on the inventory sheet. The SSA stated if missing items had been reported, they should have been documented and a grievance filed. The SSA stated grievances should be initiated when residents or family members report concerns, including missing property. The SSA stated she did not usually handle grievances and was unsure of the grievance process, as the Social Services Director (SSD) was responsible for that role and was currently on leave. The SSA stated grievances had not been documented for the reported missing property concerns and acknowledged the grievance process was not clear. The SSA stated when grievances were not processed, residents and family members did not receive follow-up and did not (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know the outcome of their concerns, and stated lack of follow-up could cause frustration for residents and familiesDuring an interview on 3/25/2026 at 3:24 p.m., with the Director of Nursing (DON), the DON stated when a complaint cannot be resolved immediately, the facility should follow the grievance process. The DON stated missing personal property should have been handled as a grievance because it required investigation and follow-up. The DON acknowledged that no grievances were filed for the missing property complaints from Resident 1, 2, or 4, and that the lack of a grievance process meant the issues were ignored and unresolved.During an interview on 3/25/2026 at 4:44 p.m., with the ADM, the ADM stated when property is lost, the Social Services department should follow up and, if needed, replace or reimburse the resident. The ADM stated the grievance process should be used to ensure things are done in a timely and efficient manner. The ADM acknowledged he would ensure the Social Services Department understood and followed the grievance process going forward. During a review of the facility's P&P titled Resident and Family Grievances, dated 12/19/2022, revised 2/8/2023 and 2/22/2023, the P&P indicated the facility supports each resident's and family member's right to voice grievances without discrimination or reprisal. The P&P indicated a Social Services designee is designated as the Grievance Official and is responsible for receiving, tracking, investigating, and resolving grievances, issuing written grievance decisions, and maintaining confidentiality. The P&P indicated residents or family members may voice grievances regarding care, treatment, or other concerns, and grievances may be submitted verbally or in writing. The P&P indicated staff receiving a grievance will document the grievance, take immediate action as needed, and forward the grievance to the Grievance Official. The P&P indicated the Grievance Official will take steps to resolve the grievance, including investigation and follow-up, and will provide a written decision that includes findings and any corrective actions. The P&P indicated the facility will keep the resident informed of the progress toward resolution and will make prompt efforts to resolve grievances.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) remained clean, comfortable, and remained in a dignified manner.This failure resulted in Resident 1 being left undressed from the waist down and lying in urine-soiled linens for an extended period. Resident 1 was not able to receive her scheduled shower due to being cold from being soiled. These failures placed Resident 1 at risk for skin breakdown and infection.Findings:During a review of Resident 1 's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty walking. During a review of Resident 1's History and Physical (H&P) dated 1/31/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1 's Minimum Data Set ([MDS] a resident assessment tool) dated 1/27/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and Resident 1 required moderate assistance (helper does less than half the effort) from staff for toileting, bathing, dressing, personal hygiene, sit to stand mobility (ability to come to a standing position from sitting position), and toilet transfer (the ability to get on and off the toilet or commode). The MDS further indicated Resident 1 was occasionally incontinent (involuntary voiding of urine and stool) of bowel and bladder. During a review of Resident 1's Care Plan dated 1/26/2026, the Care Plan indicated Resident 1 was at risk for skin breakdown (damage to skin from prolonged moisture or pressure). Under this Care Plan a goal for the Resident 1 was to maintain intact skin. The Care Plan's interventions included monitoring Resident 1's skin condition and providing care to Resident 1 to prevent skin breakdown. During a review of Resident 1's Care Plan dated 1/27/2027, the Care Plan indicated Resident 1 was incontinent of bowel and bladder. The Care Plan's interventions included checking Resident 1 frequently for incontinence, providing incontinence care, and changing Resident 1 after episodes of incontinence.During a review of Resident 1's Care Plan dated 1/27/2026, the Care Plan indicated Resident 1 was at risk for urinary tract infection ([UTI] an infection in the bladder/urinary tract) related to occasional bowel and bladder incontinence. The Care Plan's interventions included checking Resident 1 at least every two to three hours for incontinence, providing perineal care (cleaning of the genital area) after each incontinence episode, and changing Resident 1's clothing and linens as needed.During an observation on 3/24/2026 at 10:45 a.m., while in Resident 1's room, Resident 1 was observed lying in bed with her head covered by a blanket. Resident 1's room door was closed and the air in the room was blowing strongly from the vents. Resident 1 stated, I am cold! Resident 1 was observed dressed only in a thin blue shirt and was undressed from the waist down. Resident 1 did not have on briefs or underwear. Resident 1's bed sheets were soiled with yellowish stains, and the stains were covered with a towel and a chuck pad (an absorbent pad with a waterproof backing that is placed under a resident to protect the mattress or chair from urine, stool, or other bodily fluids). During a concurrent observation and interview on 3/24/2026 at 12 p.m., with Certified Nursing Assistant (CNA) 1, in Resident 1's room, Resident 1 was observed lying in bed undressed from the waist down. Resident 1's linens were soiled and covered with a towel and chucks pad. CNA 1 acknowledged she had not checked on Resident 1 since the start of her shift at 7 a.m. CNA 1 stated the chucks pad and towel under the resident had been placed by the previous shift. CNA 1 stated it was not appropriate for a resident to be left lying on soiled linens without a brief and undressed from the waist down. CNA 1 stated leaving Resident 1 unattended on wet, soiled linens were unsanitary and could cause skin breakdown. CNA 1 stated she was running behind on her shift and took responsibility for not checking on Resident 1 and leaving her soiled for several hours. CNA 1 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated leaving a resident in that condition could affect dignity, comfort, and emotional well-being. During an interview on 3/24/2026 at 12:21 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 should not have been left undressed from the waist down or lying on soiled, wet linens. LVN 1 stated Resident 1 could develop moisture damage or a urinary tract infection. LVN 1 stated it was not appropriate for Resident 1 to remain unchecked for five hours and stated leaving Resident 1 in that condition could cause discomfort. LVN 1 acknowledged she passed medications at 9 a.m. but did not check Resident 1's condition. During a concurrent interview and record review on 3/24/2026 at 2:41 p.m., with LVN 1, Resident 1's Bathing Schedule and Task ADL - Bathing Flow Sheet dated 3/24/2026 were reviewed. The Bathing Schedule indicated Resident 1 had been scheduled for a shower that morning. The Bathing Flow Sheet indicated Resident 1 had not received a shower. LVN 1 stated CNA 1 was assigned to Resident 1 was running behind and had not yet given Resident 1 a shower. LVN 1 stated when nursing assistants are running behind, it was her responsibility to assist or report the delay to the Director of Staff Development (DSD) so scheduling adjustments could be made. LVN 1 stated she did not assist the CNA 1 and did not report the delay to the DSD. During an interview on 3/25/2026 at 3:24 p.m., with the Director of Nursing (DON), the DON stated LVN 1 should have intervened or obtained assistance when the CNA 1 reported being behind. The DON stated the delay should have been reported to her or the DSD so assistance could be arranged. The DON stated Resident 1 should not have been left in urine or on soiled linens. The DON stated failure to provide a scheduled shower was a hygiene issue, placed the resident at risk for skin breakdown, and affected the resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Skin Integrity - Incontinence Associated Dermatitis (IAD), revised 12/19/2022, the P&P indicated residents who are incontinent will receive appropriate treatment and services for the prevention and management of incontinence-associated dermatitis. The P&P indicated prolonged contact with urine or stool may lead to skin breakdown (damage to skin from prolonged moisture), infection, and irritation. The P&P indicated care included to cleanse the skin promptly after each episode of incontinence, included to use gentle cleansing techniques, and included to apply moisture barrier products to protect the skin.During a review of the facility's P&P titled, Incontinence, revised 12/19/2022, the P&P indicated residents who are incontinent will receive appropriate treatment and services to prevent complications, including UTIs. The P&P indicated the facility was responsible to provide appropriate care and interventions to manage incontinence and prevent infection.During a review of the facility's P&P titled, Activities of Daily Living (ADLs), revised 12/19/2022, the P&P indicated the facility will ensure residents receive necessary services to maintain personal hygiene, including bathing, grooming, and toileting. The P&P indicated residents who are unable to perform ADLs will receive assistance to maintain hygiene and overall well-being. During a review of the facility's P&P titled, Resident Rights, revised 12/19/2022, the P&P indicated residents have the right to be treated with dignity and respect, and to receive care in a manner that maintains their comfort and well-being. During a review of the facility's P&P titled, Promoting/Maintaining Resident Dignity, revised 12/19/2022, the P&P indicated the facility will treat each resident with respect and dignity and provide care in a manner that maintains the resident's quality of life. The P&P indicated staff were responsible to respond to residents' needs in a timely manner and to maintain resident privacy during care. During a review of the facility's P&P titled, Safe and Homelike Environment, revised 12/19/2022, the P&P indicated the facility will provide a clean, sanitary, and comfortable environment. The P&P indicated care included to maintain cleanliness, included to ensure soiled linens were addressed promptly, and included to maintain an environment that does not pose a health or safety risk to residents.