

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 04/13/2026
NAME OF PROVIDER OR SUPPLIER Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 1), who had a history of falls and was assessed as a high fall risk, room door remained open for visibility for one of five sampled residents (Resident 1). This failure had the potential to prevent nursing staff from observing Resident 1 and identifying her care and safety needs in a timely manner. 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]. Resident 1 had diagnoses including dementia (a progressive state of decline in mental abilities), polyneuropathies (a type of nerve disorder that affects multiple nerves outside the brain and spinal cord), muscle weakness, and difficulty walking. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/27/2026, the MDS indicated Resident 1 was not able to make decisions that were reasonable and consistent and required one person assistance from staff to complete her activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 was incontinent (involuntary voiding) of bowel (urine) and bladder (stool). During a review of Resident 1's Fall Risk assessment dated [DATE], and timed at 4:36 p.m., the Fall Risk Assessment indicated Resident 1 had a score of 16 (high fall risk). The Fall Risk Assessment indicated Resident 1 was a risk for fall because of her history of falls, intermittent (on and off) confusion, poor balance while standing, and was taking three or more medications with three or more predisposing (influencing) diseases. During a review of Resident 1's untitled Care Plan dated 1/26/2026, the Care Plan indicated Resident 1 was at risk for falls and injury with goals including Resident 1 will be free from falls and/or minor injury and will not sustain a serious injury. The Care Plan's interventions included anticipating and meeting Resident 1's needs, providing Resident 1 with appropriate footwear when ambulating, and providing a safe environment. During a review of Resident 1's Change in Condition Evaluation (COC) dated 1/31/2026 and timed at 2:30 p.m., the COC indicated Resident 1 informed a licensed nurse that she (Resident 1) fell early in the morning and sustained a left elbow skin tear. During a review of Resident 1's Interdisciplinary Care Conference ([IDT] a group of professionals from different fields that collaborate on shared patient goals) Notes dated 2/2/2026, the IDT Notes indicated a care conference was implemented after Resident 1 had a fall. The IDT Notes indicated Resident 1 was assessed to be impulsive with a balance deficit and she (Resident 1) tried to ambulate beyond her capabilities and without assistance. The IDT Notes indicated recommendations including providing Resident 1 with frequent visual checks, timely assistance as needed and reminding the nurses for Resident 1's safety precautions and plan of care. During an interview on 4/9/2026 at 4:25 p.m., Responsible Party (RP) 1 stated she has observed on multiple occasions when she visited the facility, Resident 1's door was always closed. RP 1 stated Resident 1 had fallen in the past and she was worried that the facility staff will not be able to monitor Resident 1. RP 1 stated Resident 1 was unsafe because she was inaccessible to the nursing staff. During an observation on 4/13/2026 at 9:25 a.m., in the facility hallway, Resident 1's room door was observed closed. During a concurrent observation and interview on 4/13/2026 at 9:26 a.m., in (continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's room, Resident 1 was observed standing barefoot by the foot part of her bed. Resident 1 stated she just came out of the bathroom and does not know why her room door was closed. During an interview on 4/13/2026 at 9:30 a.m., Licensed Vocational Nurse (LVN) 1 stated and confirmed Resident 1's door was closed and the nursing staff should have kept Resident 1's door open because Resident 1 was a fall risk. LVN 1 stated Resident 1 should be visible at all times to ensure safety. During an interview on 4/13/2026 at 10:07 a.m., Certified Nursing Assistant (CNA) 1 stated he was informed during the nursing huddle (a brief ten to fifteen minute stand-up meeting held at the start of the shift or workday to align the team, discuss patient safety and proactively address potential issues) that Resident 1 was a fall risk, but he was not aware of how often he needed to check on Resident 1. CNA 1 stated Resident 1 wanted her door closed and he did not inform the licensed nurses about it. CNA 1 stated he should have communicated this occurrence to the licensed nurse because Resident 1 was confused and can fall. During an interview on 4/13/2026 at 1:10 p.m., Registered Nurse Supervisor (RNS) 1 stated Resident 1 was a fall risk since admission at the facility. RNS 1 confirmed Resident 1 had an unwitnessed fall on 1/31/2026, sustained a left elbow skin tear and the IDT recommended providing Resident 1 with frequent visual checks, timely assistance as needed and reminding the nurses for Resident 1's safety precautions and plan of care. RNS 1 stated she have observed Resident 1 was closing the door of her care area multiple times since last week (did not specify the date) but she was unable to call RP1, inform the attending physician and formulate a plan of care to address this safety concern. RNS 1 stated the nursing staff will not be able to monitor Resident 1 and attend to her care and safety needs in a timely manner if her door remains closed. During an interview on 4/13/2026 at 2:45 p.m., the Director of Nursing Services (DON), the DON stated CNA 1 should have informed LVN1 of Resident 1's door being closed to ensure Resident 1's safety and well-being. The DON stated the nursing staff of the facility should work together to ensure the residents' care areas are accessible to provide the residents' care needs in a timely manner and to prevent a fall and/or injury. During a review of the facility's policy and procedure (P&P) titled, Accidents and Supervision, revised 12/19/2022, the P&P indicated the residents' environment shall be free of accident hazards and the residents shall receive adequate supervision to mitigate risk and/or prevent accidents by: a. identifying hazards and risks b. evaluating and analyzing hazards and risks c. implementing interventions to reduce hazards and risks, and d. monitor for effectiveness and modifying interventions when necessary. During a review of the facility's P&P titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated the facility shall provide each resident care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The P&P indicated the facility shall provide each resident with universal environmental interventions that decrease the risk of resident falling, including, but not limited to: a. a clear pathway to the bathroom and bedroom doors b. shoes, slippers and/or socks with non-slip soles when ambulating, and c. increased frequency of rounds.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (Resident 1), who had a history of falls and was assessed as a high fall risk, care plan interventions were revised after Resident 1 had an unwitnessed fall on 1/31/2026. This deficient practice had the potential for the nursing staff to be unaware of Resident 1's current fall risk precautions and interventions that could delay and/or affect delivery of her care. 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]. Resident 1 had diagnoses including dementia (a progressive state of decline in mental abilities), polyneuropathies (a type of nerve disorder that affects multiple nerves outside the brain and spinal cord), muscle weakness, and difficulty walking. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/27/2026, the MDS indicated Resident 1 was not able to make decisions that were reasonable and consistent and required one person assistance from staff to complete her activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 was incontinent (involuntary voiding) of bowel (urine) and bladder (stool). During a review of Resident 1's Fall Risk assessment dated [DATE], and timed at 4:36 p.m., the Fall Risk Assessment indicated Resident 1 had a score of 16 (high fall risk). The Fall Risk Assessment indicated Resident 1 was a risk for fall because of her history of falls, intermittent (on and off) confusion, poor balance while standing, and was taking three or more medications with three or more predisposing (influencing) diseases. During a review of Resident 1's untitled Care Plan dated 1/26/2026, the Care Plan indicated Resident 1 was at risk for falls and injury with goals including Resident 1 will be free from falls and/or minor injury and will not sustain a serious injury. The Care Plan's interventions included anticipating and meeting Resident 1's needs, providing Resident 1 with appropriate footwear when ambulating, and providing a safe environment. During a review of Resident 1's Change in Condition Evaluation (COC) dated 1/31/2026 and timed at 2:30 p.m., the COC indicated Resident 1 informed a licensed nurse that she (Resident 1) fell early in the morning and sustained a left elbow skin tear. During a review of Resident 1's Interdisciplinary Care Conference ([IDT] a group of professionals from different fields that collaborate on shared patient goals) Notes dated 2/2/2026, the IDT Notes indicated a care conference was implemented after Resident 1 had a fall. The IDT Notes indicated Resident 1 was assessed to be impulsive with a balance deficit and she (Resident 1) tried to ambulate beyond her capabilities and without assistance. The IDT Notes indicated recommendations including providing Resident 1 with frequent visual checks, timely assistance as needed and reminding the nurses for Resident 1's safety precautions and plan of care. During a continued review of Resident 1's untitled Care Plan dated 1/26/2026, the Care Plan indicated Resident 1 was at risk for falls and injury. There was no documentation indicating revisions and/or updates of Resident 1's fall risk interventions after Resident 1 fell on 1/31/2026. During an interview on 4/13/2026 at 10:07 a.m., Certified Nursing Assistant (CNA) 1 stated he was informed during the nursing huddle (a brief ten to fifteen minute stand-up meeting held at the start of the shift or workday to align the team, discuss patient safety and proactively address potential issues) that Resident 1 was a fall risk, but he was not aware of how often he needed to check on Resident 1. During an interview on 4/13/2026 at 1:10 p.m., Registered Nurse Supervisor (RNS) 1 stated Resident 1 was a fall risk since admission at the facility. RNS 1 confirmed Resident 1 had an unwitnessed fall on 1/31/2026, sustained a left elbow skin tear and the IDT recommended providing Resident 1 with frequent visual checks, timely assistance as needed and reminding the nurses for Resident 1's safety precautions and plan of care. RNS 1 stated Resident 1's fall risk interventions should have been revised and updated after Resident 1's fall incident to ensure timely monitoring and provision of her care needs. During an interview on 4/13/2026 at 2:45 p.m., the (continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Director of Nursing Services (DON) stated Resident 1's interventions for fall risk precautions should have been revised and/or updated by the licensed nurses as soon as the IDT has identified Resident 1's safety needs. The DON stated it was important for Resident 1's plan of care to be updated so the nursing staff can implement the current fall risk precautions and interventions to prevent another fall and/or injury. 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. 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.</p>		