

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 04/30/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of physical abuse for one of two sampled residents (Resident 2), when Resident 2 reported to facility staff that she (Resident 2) was handled roughly by two hospital staff at a General Acute Care Hospital (GACH 1) prior to her admission to the facility (4/9/2026). And, they failed to report an injury of unknown origin when an Xray (a procedure that takes pictures of the inside of the body to diagnose broken bones and other injuries) taken on 4/24/2026 confirmed Resident 2 had a displaced fracture (when a broken bone snaps into two or more pieces and moves, causing the ends to become misaligned) of the proximal (closer to the point of attachment) shaft of the right femur (largest bone extending from the hip to the knee [hip fracture]). These deficient practices resulted in the CDPH not being aware of Resident 2's allegation of abuse and her injury of unknown origin causing a delay the CDPH's investigation and the potential for pertinent information to be lost and/or forgotten. 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 the diagnosis of osteogenesis imperfecta (a rare genetic disorder characterized by extremely fragile bones that break easily, often with little or no trauma). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 4/13/2026, the MDS indicated Resident 2's cognition was intact and Resident 2 was dependent (helper does all of the effort) on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers dated 4/23/2026 and timed at 3:22 p.m., the SBAR Summary for Providers indicated Resident 2's right hip had a prominent protrusion (something that sticks out or bulges out from a surface or its surroundings), redness and warmth. The SBAR Summary for Providers indicated the physician ordered an Xray of Resident 2's right hip. During a review of Resident 2's Nurses Progress Notes dated 4/23/2026 and timed at 4:07 p.m., the Nurses Progress Notes indicated Resident 2's Family Member (FM) reported that Resident 2 was not handled properly at GACH 1 where she was previously admitted. The FM stated Resident 2's hip was not like that (with a protrusion, red and warm) before getting admitted to GACH 1. During a review of Resident 2's Physician's Order dated 4/23/2026, the Physician's Order indicated to obtain a right hip Xray due to prominent protrusion, redness, and warmth. During a review of Resident 2's SBAR Summary for Providers dated 4/24/2026, the SBAR Summary for Providers indicated Resident 2's Xray results indicated an acute displaced right hip fracture. Resident 2 was transferred to GACH 2 for further evaluation and treatment. During a review of Resident 2's Radiology Results Report dated 4/23/2026, the Radiology Results Report indicated Resident 2 had an acute displaced fracture of the proximal shaft of the right femur. During an interview on 4/29/2026 at 3:28 p.m., Physical Therapist (PT) stated when he completed Resident 2's PT Evaluation (4/10/2026), Resident 2 reported to she had pain to her right hip and when she was at GACH 1 she was handled roughly by the nurses. PT 1 stated he did not report what Resident 2 told him because he thought her complaint of pain was related her diagnosis of osteogenesis imperfecta. PT 1 stated he should have reported it to the supervisory staff (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>at the facility. During an interview on 4/30/2026 at 12:14 p.m., Registered Nurse (RN 1) stated on 4/23/2026 when she assessed Resident 2 her right hip was protruding more than it had been on admission [DATE]. There was more redness in the inner thigh, and it was a little warm to touch. RN 1 stated Resident 2 reported to her she was rough handled by nurses at GACH 1 and that was what caused her injury. RN 1 stated Resident 2 reported she had not fallen and there was no other explanation of what might have caused her injury. During an interview on 4/29/2026 at 1:01 p.m., the Director of Nursing (DON) stated the CDPH was not notified of Resident 2's hip fracture because Resident 2 was able to explain that she did not fall or have any incident that would cause the fracture and their Consultant told them Resident 2's fracture did not need to be reported. The DON stated Resident 2's allegation of being rough handled by nurses at GACH 1 should have been reported but she (DON) was concerned with Resident 2's fracture and missed reporting it Resident 2's allegation. During a review of the facility's Policy and Procedure (P/P) titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated 12/19/2022, the P/P indicated it is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility to other appropriate agencies in accordance with current state and federal regulations with prescribed timeframes.</p>		