STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nurse Assistant (CNA) 1 did not allow a resident (Resident 1) who was assessed as a fall risk, had a history of a fall, and required substantial/maximum assistance (helper does more than half of the effort) from staff for transfers and mobility, ambulate to the bathroom alone, and without assistance for one of three sampled residents (Resident 1). This failure resulted in Resident 1 falling from the bed on 11/8/2025 and had the potential for Resident 1 to sustain more serious injuries such as brain injury, fractures (a partial or complete break in the bone), and death. Resident 1 was transferred to a General Acute Hospital (GACH) for further evaluation. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 had diagnoses including cerebral infarction (a type of stroke caused by a blockage or blood flow to part of the brain), difficulty walking and muscle weakness.During a review of Resident 1's History and Physical (H&P), dated 10/28/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 10/30/2025, the MDS indicated Resident 1's cognition (ability to register and recall information) intact was able to understand and be understood by others. The MDS indicated Resident 1 required substantial/maximum assistance from staff for rolling left to right (ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (ability to move from sitting on side of the bed to lying flat on the bed), lying to sitting on the side of the bed (ability to move from lying on the back to sitting on the side of the bed with no back support), and sit to stand (ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). The MDS indicated Resident 1 was frequently incontinent (involuntary voiding of urine and stool) in both his bowel and bladder functions. The MDS indicated Resident 1 had impairment on side of his body affecting both his upper and lower extremities. During a review of Resident 1's Fall Risk Evaluation, dated 10/25/2025, the Fall Risk Evaluation indicated Resident 1 was at risk for falls.During a review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/25/2025, the SBAR indicated Resident 1 had an unwitnessed fall and was reported to have rolled out of bed on 10/25/2026 at approximately 3:38 a.m.During a review of Resident 1's SBAR, dated 11/8/2025, the SBAR indicated Resident 1 had witnessed fall on 11/8/2025 at approximately 5:20 p.m. The SBAR indicated CNA 1 asked Resident 1 if Resident 1 needed help, Resident 1 stated he wanted to go the restroom, but he did not need any help walking and going to the bathroom. The SBAR indicated Resident 1 stood up, took a few steps before losing strength in his left leg falling on his left side onto the floor and rolling onto his back. During a review of Resident 1's Order Summary Report (Physician's Orders), dated 11/8/2025, the Physician's Orders indicated an order was written to transfer Resident 1 to a GACH for further evaluation to determine whether he sustained injuries resulting from the fall. During a review of Resident 1's Transfer Form, dated 11/8/2025, the Transfer (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Form indicated Resident 1 was transferred to a GACH on 11/8/2025 at 8:47 p.m.During a review of Resident 1's GACH Discharge Documents, dated 11/8/2025, the Discharge Documents indicated Resident 1 underwent laboratory tests, Computed Tomography ([CT] an imaging test that uses multiple Xˆray [an imaging test that uses a small amount of radiation to create pictures of structures inside the body, such as bones and organs] pictures and a computer to create detailed images of the inside of the body) scan of the head, Electrocardiogram ([EKG] a test that records the electrical activity of the heart), and X-ray during the emergency department evaluation. No serious findings were identified and Resident 1 returned to the facility on [DATE].During a telephone interview on 6/23/2026 at 3 p.m., CNA 1 stated that on 11/8/2025 she entered Resident 1's room and asked if he needed assistance. Resident 1 said he needed to use the restroom. CNA 1 stated she did not know Resident 1's level of functioning and asked if he needed help ambulating. Resident 1 told her he could go alone. CNA 1 stated she watched Resident 1 stand up from the bed and take a few steps before he fell to the floor. She stated she could not prevent the fall because she was unable to stop or catch him. CNA 1 also stated she did not know Resident 1 required maximum assistance to stand and ambulate and acknowledged she should have provided the appropriate level of assistance when he said he wanted to go to the restroom.During an interview on 6/23/2026 at 3:55 p.m., the Physical Therapist (PT) stated that based on his review of Resident 1's Physical Therapy evaluation dated 10/25/2025, Resident 1 required substantial to maximum assistance (resident performs 25 percent or less of the physical effort required to complete a task, such as standing, transferring, or walking. Staff provide most or all physical support, which may include lifting, stabilizing, guiding movement, or supporting the resident's weight to ensure safety during the activity) for transfers, including moving from sitting to standing. The PT stated Resident 1 could ambulate 10 feet only with substantial or maximum assistance and to maintain Resident 1's safety, bedside staff must be present to provide this level of assistance whenever Resident 1 attempts to get out of bed to use the restroom.During an interview on 6/23/2026 at 4:30 p.m., the Director of Nursing (DON) stated the nursing staff should have provided the appropriate level of assistance to Resident 1 when he stated he wanted to ambulate to the restroom. The DON noted that at the beginning of the shift, the staff discusses residents ?needs and their plan of care during huddles. The DON stated verbal communication can be inconsistent and stated the facility would benefit from an alternative method to support staff awareness of residents' required assistance levels. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, (ADLs), revised 12/19/2022, the P&P indicated the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable, care and services may consist of the following activities of daily activities such as bathing, dressing, grooming, and oral care, transfer and ambulation, toileting.During a review of the facility's P&P titled, Fall Prevention Program, revised 4/2026, the P&P indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individual level of risk to minimize the likelihood of falls.