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	06/29/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident's (Resident 1) blood glucose (simple sugar - the body's primary source of energy) level was checked prior to insulin (hormone that removes excess sugar from the blood can be produced by the body or given artificially via medication) administration.The failure had the potential to result in hypoglycemia (low blood glucose). Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes (chronic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels) with foot ulcer (open sore).During a review of Resident 1's Progress Notes titled Nursing advanced Clinical Admission, 6/6/2026 at 1 a.m., the notes indicated Resident 1 was alert and oriented with some confusion. The notes indicated Resident 1 and was able to move all extremities. During a review of Resident 1's Order Summary Report, 6/5/2026, the orders indicated 6/5/2026, Insulin Glargine (medication for diabetes), Inject 10 units subcutaneously (under the skin) at bedtime. During a concurrent interview and record review on 6/29/2026 at 12:17 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Medication Administration Record, (MAR), 6/2026, and medical records was reviewed. The ADON stated Resident 1 received the insulin dose on 6/6/2026 at 9 pm but there was no blood glucose level documented. The ADON stated the blood glucose level should have been checked prior to insulin administration.During an interview with the Director of Nursing (DON) on 6/29/2026 at 1:12 p.m., the DON stated that the blood glucose level needs to be checked prior to insulin administration. During a review of the facility's Policy and Procedure (P/P) titled, Nursing Care of the Resident with Diabetes Mellitus, revised 12/19/2022, the P/P indicated medication will be administered as ordered by the physician in accordance with professional standards in a timely manner.During a review of the facility's P/P titled, Medication Reordering, revised 12/19/2022, the P/P indicated the purpose of the policy was to prevent hypoglycemia and hyperglycemia (high blood glucose). The P/P indicated documentation should reflect carefully assessed diabetic resident including blood sugar results.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three residents' (Resident 1) prescription (physician ordered) medications were acquired and administered in a timely manner.The failure resulted in a disruption of Resident 1's treatment plan and had the potential to delay recovery and put Resident 1's health at risk.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes (chronic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels) with foot ulcer (open sore), end stage renal disease (ESRD -irreversible kidney failure), atherosclerosis of coronary artery bypass graft (the development or progression of fatty plaque within the surgically implanted vessels), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), stricture of artery (restricted blood flow), nonrheumatic aortic valve stenosis (narrowing of the heart's aortic valve that restricts blood flow from the left ventricle to the aorta), gastroesophageal reflux disease (GERD - chronic digestive condition where stomach acid and contents repeatedly flow back up into the esophagus), and anxiety disorder (persistent, excessive worry or fear that is disproportionate to everyday situations and interferes with daily activities).During a review of Resident 1's Progress Notes titled Nursing advanced Clinical Admission, 6/6/2026 at 1 a.m., the notes indicated Resident 1 was alert and oriented with some confusion. The notes indicated resident 1 was able to move all extremities. During a review of Resident 1's Order Summary Report, the orders indicated the following medications, 6/5/2026: 1. Aspirin 81 milligrams Oral Tablet (medication to prevent cerebrovascular accident (loss of blood flow to a part of the brain) one tablet by mouth one time a day.2. Alprazolam Oral Tablet (medication for anxiety) 0.25 milligrams, one tablet by mouth every 8 hours as needed.3. Carvedilol Oral Tablet (medication for high blood pressure)3.125 milligrams, one tablet by mouth two times a day.4. Clonazepam Tablet 0.5 milligrams (medication for anxiety) one tablet by mouth at bedtime.5. Fentanyl Patch (pain medication) 72 Hour 25 microgram per hour, one patch trans dermally (on the skin) every 72 hours.6. Midodrine Oral Tablet 5 milligrams, one tablet by mouth every morning and at bedtime for (low blood pressure).7. Sucroferric Oxyhydroxide Oral Tablet Chewable 500 milligrams (medication for GERD) one tablet by mouth in the morning.8. Xphozah Oral Tablet 30 milligrams (medication for chronic kidney disease) one tablet by mouth in the morning.9. Lactulose Solution (medication to help with bowel movement) 20 grams by mouth every morning and at bedtime.10. Farxiga Oral Tablet 5 milligrams (medication for diabetes) one tablet by mouth one time a day. 11. Megestrol Acetate Suspension (medication to help increase appetite) 400 milligrams by mouth one time a day 12. Metoprolol (medication for high blood pressure) 25 milligrams one tablet by mouth one time a day. 13. Sodium Zirconium Cyclosilicate Oral Packet 5 grams (medication for chronic kidney disease) 1 packet by mouth in the morning.14. Terazosin HCl Oral Capsule 1 MG (medication for high blood pressure) one capsule by mouth in the morning.During a concurrent interview and record review on 6/29/2026 at 12:17 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Medication Administration Record, (MAR), 6/2026, was reviewed. The ADON stated Resident 1 missed one dose of Aspirin, Clonazepam, Farxiga, Megestrol, metoprolol, Sodium Zirconium Cyclosilicate Oral Packet, Sucroferric Oxyhydroxide Oral Tablet Chewable, lactulose, and the fentanyl Patch. The ADON stated Resident 1 missed two doses of Tenapanor HCl and Midodrine. The ADON stated Resident 1 missed 3 doses of Carvedilol Oral Tablet. The ADON stated the physician was not notified of the missed doses.During a concurrent interview and record review on 6/29/2026 at 12:17 p.m., with the (ADON), Resident 1's Pharmacy Manifest and Consolidated Delivery Sheets, 6/6/2026, were reviewed. The ADON stated the Xanax, Fentanyl Patch, and Clonazepam were not delivered.During an interview with the Director of Nursing (DON) on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	6/29/2026 at 1:12 p.m. the DON stated that medications ordered need to be acquired and administered as physician ordered to help their medical condition. During a review of the facility's Policy and Procedure (P/P) titled, Medication Administration, revised 12/19/2022, the P/P indicated medication will be administered as ordered by the physician in accordance with professional standards in a timely manner.During a review of the facility's P/P titled, Medication Reordering, revised 12/19/2022, the P/P indicated acquisition of medication should be completed in a ensure medications are administered in a timely manner to meet the resident's needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 one of one resident's (Resident 1) medical records were accurate.This failure resulted in an inaccurate depiction of resident status.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes (chronic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels) with foot ulcer (open sore), end stage renal disease (ESRD -irreversible kidney failure), atherosclerosis of coronary artery bypass graft (the development or progression of fatty plaque within the surgically implanted vessels), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), stricture of artery (restricted blood flow), nonrheumatic aortic valve stenosis (narrowing of the heart's aortic valve that restricts blood flow from the left ventricle to the aorta), gastroesophageal reflux disease (GERD - chronic digestive condition where stomach acid and contents repeatedly flow back up into the esophagus), and anxiety disorder (persistent, excessive worry or fear that is disproportionate to everyday situations and interferes with daily activities).During a review of Resident 1's Progress Notes titled Nursing advanced Clinical Admission, 6/6/2026 at 1 a.m., the notes indicated Resident 1 was alert and oriented with some confusion. The notes indicated Resident 1 was able to move all extremities. During a review of Resident 1's Order Summary Report, the orders indicated the, Oxycodone HCl Tablet (pain medication) 15 milligrams one tablet by mouth every 4 hours as needed dated 6/5/2026 During a concurrent interview and record review on 6/29/2026 at 12:17 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Medication Administration Record, (MAR), 6/2026, was reviewed. The ADON stated Resident 1 received three doses of Oxycodone, on 6/6/2026 at 1:52 p.m. 6/7/2026 at 4:29 p.m., and 6/7/2026 at 11:24 p.m. During a concurrent interview and record review on 6/29/2026 at 12:17 p.m., with the ADON, the facility's Emergency Kit log was reviewed and the log indicated Resident 1 received Percocet on 6/6/2026 at 1:52 p.m. 6/7/2026 at 4:15 a.m., and on 6/7/2026 at 4:22 p.m. The ADON stated Resident 1's MAR documentation was incorrect because the resident passed away on 6/7/2026 at approximately 5:19 p.m.During an interview with the Director of Nursing (DON) on 6/29/2026 at 1:12 p.m. the DON stated that medical records need to be accurate to reflect the residents' actual condition. 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 documentation needs to be accurate and factual.