STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056104	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Villa Health Care Center	9028 Rose Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During interview and record review, the facility failed to ensure two of three sampled residents (Resident's 1 and 2), who were assessed at a high fall risk, and had previous falls, and were cognitively (the ability to think and reason) impaired, were capable of following Care Plan interventions which included using the call light for assistance. The facility failed to investigate and review causal factors per Resident 2's Care Plan interventions after Resident 2 fell on [DATE].These deficient practices resulted in Resident's 1 and 2 getting up unassisted without the knowledge of staff resulting in Resident 1 falling on 10/28/2025, and Resident 2 falling 11/22/2025. These failures increased the risk of future falls, potential injuries, and unnecessary hospitalizations for Resident's 1 and 2. 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 including diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), speech and language deficits, repeated falls, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness or loss of strength on one side of the body, affecting the arm, leg, and sometimes the face, making everyday tasks difficult) following a cerebral infarction ([stroke] loss of blood flow to a part of the brain) affecting the right dominant side.During a review of Resident 1's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 10/9/2025, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 was dependent on staff for toileting hygiene, required moderate assistance (helper does less than half the effort) for personal hygiene, and required maximum assistance (helper does more than half the effort) for walking up to 10 feet.During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 1 was at a high risk for falls.During a review of Resident 1's At Risk for Falls Care Plan dated 10/5/2025, the Care Plan indicated Resident 1 was at risk for falls related to poor balance and gait (walking). The Care Plan goal indicated Resident 1 to be free from falls and had interventions which included making sure Resident 1's call light is within reach, and for staff to encourage Resident 1 to use the call light for assistance as needed.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 10/13/2025, and timed at 4:10 p.m., the SBAR indicated Resident 1 fell in the restroom on 10/13/2025 at 4:10 p.m. During a review of Resident 1's Post-Event Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Review, dated 10/13/2025, the Post-Event IDT Review indicated Resident 1 was found on the restroom floor and stated when he used the restroom his foot got stuck between the wheelchair when trying to wash his hands, then lost his balance and fell. The Post-Event IDT review indicated Resident 1 stated did not want to use the call light to bother anyone since he thought he could do it (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to a past fall he had they were instructed to keep an eye on him, which although it was not specified, she would check on him at least once an hour. CNA 2 stated Resident 2 was able to ambulate on his own and required assistance to the restroom only. During an interview on 1/15/2026 at 12:13 p.m., the Director of Rehabilitation (DOR) stated Resident 2 was not allowed to walk alone and needed someone within arm's reach when ambulating because he was at a high fall risk due to his cognition, multiple history of falls, and required moderate assistance from staff when ambulating. The DOR stated that after a resident falls, the rehabilitation (rehab) department will evaluate the residents within three days of the fall to determine if there was an injury and to determine the cause of the fall for safety reasons. The DOR stated during the evaluation, the rehab department will interview the resident and the nurses to determine what happened and discuss it with the team in order to minimize the risk of future falls. The DOR stated rehab did not evaluate Resident 1 after this second fall on 10/28/2025, and because of that they had not discussed this with the IDT team. The DOR stated rehab services, and an IDT meeting should have occurred after Resident 1's fall on 10/28/2025, to prevent any potential future falls.During an interview on 1/16/2026 at 12:37 p.m., the Director of Nursing (DON) stated Resident 1 had cognitive impairment and was not sure if he was assessed for his ability to understand and follow instructions on using the call light. The DON stated Resident 2 also had cognitive impairment and she was not sure about his ability to learn to use the call light. The DON stated that because Resident 1 and Resident 2 had not used the call light when needing help, the intervention was ineffective, and other interventions should have been in place like more frequent rounds and monitoring at least once every 2 hours. The DON stated that after every fall the facility will investigate the fall and the team will have a meeting and write their investigation in the conclusion in the Post-Event IDT note, however they did not do a Post-Event IDT note after Resident 1's second fall on 10/28/2025 or Resident 2's first fall on 11/22/2025. The DON stated the reason why they investigate the fall is to find the cause and update the care plan to prevent more falls, and that not investigating the fall 10/28/2025 and 11/22/2025 could have led to another fall for Resident 1 and Resident 2. The DON stated they communicate fall risk residents during rounds and report, and that all staff should be aware of the high risk for fall residents and what interventions should be done. The DON stated she was not sure why some of the staff believed it was appropriate for Resident 2 to ambulate without assistance, but this could cause him to fall again if staff are unaware that he needs assistance for all ambulating activities. The DON stated they did not investigate the fall for Resident 2 because he was hospitalized the next day and at the time they anticipated his return.During a review of facility's policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning, dated 1/2022, the P&P indicated the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated interventions are measurable; able to be evaluated or quantified.During a review of facility's P&P titled Fall Management System, dated 1/2022, the P&P indicated the facility will provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs. The P&P indicated the care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. The P&P indicated review of the fall incident will include investigation to determine probably causal factors and will be reviewed by the IDT.