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	02/13/2026

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for one of three sampled residents (Resident 2), who was continent of bowel and bladder functions, that he was not made to wear an adult brief (diaper) and not asked to urinate in it. This deficient practice resulted in Resident 2's inability to use the restroom and feeling like a child when made to wear diapers. This deficient practice had the potential for Resident 1's ability to use the restroom to diminish over time. 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]. Resident 2's diagnoses included essential primary hypertension ([HTN] high blood pressure), spinal stenosis (narrowing spaces in the spine causing pain and numbness) and type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During a review of Resident 2's History and Physical (H&P), the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 1/1/2026, the MDS indicated Resident 2 required substantial /maximal assistant (helper dose more than half the effort) with sit to lying and he was dependent (helper does all the effort) with toilet transfer, tub/ shower transfers and sit to stand. During a review of Resident 2's Bowel and Bladder Evaluation dated 1/28/2026, the Bowel and Bladder Evaluation indicated Resident 2 was continent (ability to control your bladder). During a review of Resident 2's Care Plan dated 1/30/2026/, the Care Plan indicated Resident 2 had a deficit in performing his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily)) related to spinal stenosis. XXXX The Care Plan's interventions indicated Resident 2 needed two-persons to assist him with toilet transfers and to encourage him to participate to the fullest extent possible with each interaction. During an observation of Resident in his room and a concurrent interview on 2/11/2026 at 11:13 a.m., Resident 2 was observed pulling on an adult brief he was wearing, and stated he was placed in this adult brief and told to use the rest room in it. Resident 2 stated a nurse told him if he had to use the restroom just go in your adult brief. Resident 2 stated they could have given him a bedpan or a bedside commode to use and wearing an adult brief made it difficult for him to urinate, like his body was shutting down and he felt like a baby wearing adult briefs. During an interview on 2/11/2026 at 3:10 p.m., Certified Nursing Assistant (CNA) 1 stated she put an adult brief on Resident 2 because when he uses a urinal (a plastic container males use to urinate in) he urinates everywhere. CNA 1 stated she puts adult briefs on all her residents unless she is told not to do so. During an interview on 2/11/2026 at 3:35 p.m., Registered Nurse (RN) 1 stated Resident 2 was continent of bowel and bladder and did not need to wear adult briefs. RN 1 stated Resident 2 should be allowed to use a bedside commode if that was what he wanted to do. During an interview on 2/12/2026 at 4 p.m., the Director of Staff Development (DSD) stated continent residents should be made to wear adult briefs. The DSD stated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Rose Villa Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9028 Rose Street Bellflower, CA 90706	

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were not instructed to tell residents to go in their diaper by placing diapers on continent residents, they could possibly lose the urge to control their bladder and become incontinent. During an interview on 2/13/2026 at 1:30 p.m., the Director of Nursing (DON) stated if a resident does not want to wear adult briefs they should not be made to wear them. During a review of the facility's Policy and Procedure (P&P) dated 11/2021 titled, Residents Rights the P&P indicated it was the policy of this facility that all residents be treated with kindness dignity and respect.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility staff failed to document the accurate intake and output (I&O) for one of three sampled residents (Resident 1), who was admitted to the facility with an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) . This deficient practice resulted in the inability of the facility to accurately gauge the amount urine output and quality of urine for Resident 1 and had the potential for urinary inconsistencies to be unrecognized.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 a diagnosis of urinary retention (inability to fully empty your bladder). During a review of Resident 1's History and Physical (H&P), the H&P indicated Resident 1 did not have the capacity to understand and make decisions and her compacity to understand fluctuated. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/7/2026, the MDS indicated Resident 1 required supervision with toilet hygiene. During a record review of Resident 1's Care Plan dated 1/7/2026, the Care Plan indicated Resident 1 had an indwelling urinary catheter due to a diagnosis of urinary retention. The Care Plan's goal was for Resident 1 to remain free form catheter related trauma and will show no s/s of urinary tract infection. The Care Plan's interventions were to monitor and document Resident 1's I&Os and to monitor for signs and symptoms (s/s) of discomfort and frequency on urination. During a review of Resident 1's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/3/2026, the MAR indicated Resident 1's I&Os were documented as follows: Day Shift1/4/2026 - 1/16/2026 Resident 1's I&O was documented as x2 Evening Shift1/4/2026 - 1/16/2026 Resident 1's I&O was documented as x2 Night Shift1/4/2026 - 1/8/2026 and 1/10/2026 - 1/16/2026 Resident 1's I&O was documented as x2 During an interview on 2/13/2026 at 3:49 p.m., Registered Nurse (RN) 2 stated when a resident is admitted to the facility with an indwelling urinary catheter we monitor the I&O to make sure the resident is not retaining urine. RN 2 stated the indwelling urinary bag collects the resident's urine and is emptied and measured, documenting x2 is not how the urine output should be measured. During an interview on 1/13/2026 at 1:30 p.m., the Director of Nursing (DON) stated after each shift the CNAs empty the residents' urinary bag and report the amount of urine collected to the licensed Nurse assigned to the resident. The DON stated the Licensed Nurses document on the MAR the amount of urine output in CCs and should not document the urine output as x1, x2. During a review the facility's Policy and Procedure (P&P, titled, Intake and Output Documentation revised 1/2015, the P&P indicated it is the policy of this facility that fluid intake and output shall be recorded for each resident with an indwelling catheter The intake and output information is to be recorded at the end of each shift by a licensed nurse.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure medications were administered as prescribed by the physician and not left unattended on the bedside table of one of three sampled residents (Resident 4). This deficient practice resulted in Resident 4 not receiving his prescribed medication and had the potential for the unattended medication to be taken and/or ingested by other residents causing unnecessary medication administration and/or harm.Findings: During a review of Resident 4's admission Record (Face Sheet) the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including essential primary hypertension ([HTN] high blood pressure), unspecified atrial fibrillation ([a-Fib] irregular heart rhythm) , and anemia (low red blood cell count). During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 4 required supervision with toilet hygiene, shower /bathe self and independent with eating and oral hygiene. During a review of Resident 4's Medication Administration Record ([MAR] a daily documentation record used by licensed nurse to document medications and treatments given to a resident) dated 2/2026, the MAR indicated the following medications were administered to Resident 4 on 2/11/2026 at 9:00 a.m. 1. Chlorthalidone oral tablet 50 milligram ([mg] a metric unit of measurement, used for medication dosage and/or amount) give 1/2 tablet daily for congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). 2. Ferrous Sulfate (Iron) 325 mg one tablet daily as a supplement. 3. Memantine HCL 5 mg one tablet daily for Alzheimer's disease, unspecified. 4. Multi -Vitamin one tablet daily as a supplement. 5. Docusate Sodium 100 mg one capsule two times for bowel management. 6. Hydrochlorothiazide 50 mg tablet daily for edema (swelling). During an observation on 2/11/2026 at 9:45 a.m., Licensed Vocational Nurse (LVN) 1 entered Resident 4's room with a medication cup then left the room. At 10 a.m., and a subsequent observation at 11:29 a.m., a medication cup with 6 pills in it was observed on Resident 4's bedside table. During an interview on 2/11/2026 at 12:21p.m., LVN 1 stated she placed the medication cup with pills in it, on Resident 4's bedside table and left the room, because she was called to help another resident. LVN 1 stated it was not her usual practice to leave medication unattended on a resident's bedside table because another resident could ingest it, but she got busy. During an interview on 2/12/2026 at 4:15 p.m., the Director of Nursing (DON) stated licensed nurses should not to leave medication unattended at the resident's bedside because another resident could be harmed if they took it. During a review of the facility's Policy and Procedure (P&P) dated 9/2010 titled, Medication Administration the P&P indicated for residents not in their room or otherwise unavailable to receive medication on the pass, the MAR is flagged (e.g., tags colored plastic strips or paper clip). After completing the medication pass, the nurse returns to the missed resident to administer the medication. The resident is always observed after administration to ensure the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.

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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 observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 accurately documented the medication administration for one of three sampled residents (Resident 4). This deficient practice resulted in Resident 4 not receiving medication as prescribed to him, but his clinical records indicating it was. This deficient practice had the potential to negatively impact Resident 4's health, mismanagement of his medication regimen and result in non-continuity of care.Findings: During a review of Resident 4's admission Record (Face Sheet) the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including essential primary hypertension ([HTN] high blood pressure), unspecified atrial fibrillation ([a-Fib] irregular heart rhythm) , and anemia (low red blood cell count). During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 4 required supervision with toilet hygiene, shower /bathe self and independent with eating and oral hygiene. During a review of Resident 4's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/2026, the MAR indicated the following medications were administered to Resident 4 on 2/11/2026 at 9:00 a.m. 1. Chlorthalidone oral tablet 50 milligram ([mg] a metric unit of measurement, used for medication dosage and/or amount) give 1/2 tablet daily for congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). 2. Ferrous Sulfate (Iron) 325 mg one tablet daily as a supplement. 3. Memantine HCL 5 mg one tablet daily for Alzheimer's disease, unspecified. 4. Multi -Vitamin one tablet daily as a supplement. 5. Docusate Sodium 100 mg one capsule two times for bowel management. 6. Hydrochlorothiazide 50 mg tablet daily for edema (swelling). During an observation on 2/11/2026 at 9:45 a.m., Licensed Vocational Nurse 1 (LVN) 1 entered Resident 4's room with a medication cup then left the room. At 10 a.m., and a subsequent observation at 11:29 a.m., a medication cup with six pills in it was observed sitting on resident 4's bedside table. During an interview on 2/11/2026 at 12:21 p.m., and a concurrent review of Resident 4's MAR dated 2/2026, the MAR indicated Chlorthalidone 50 mg, Ferrous Sulfate 325 mg, Memantine HCL 5 mg, Docusate Sodium 100 mg, and hydrochlorothiazide 50 mg were documented as given at 9:55 a.m. LVN 1 stated she placed the medication cup with pills in it on Resident 4's bedside table and left the room, because she was called to help another resident. LVN 1 stated it was not her usual practice to leave medication unattended at a resident's bedside because another resident could ingest it, but she got busy. LVN 1 stated she should not have signed Resident 4's MAR indicating he received his medication when he did not receive it During an interview on 2/12/2026 at 4:15 p.m., the Director of Nursing (DON) stated the correct way to pass medications is to is to pour the medication, pass the medication and sign the MAR. Signing the MAR before the medications are administered is false documentation. During a review of the facility's Policy and Procedure (P&P) dated 9/2010, titled, Medication Administration the P&P indicated s for residents not in their room or otherwise unavailable to receive medication on the pass, the MAR is flagged (e.g., tags colored plastic strips or paper clip). After completing the medication pass, the nurse returns to the missed resident to administer the medication. The individual that administers the medication dose records the administration on the resident's MAR directly after the medication is given. Pour- Pass -Chart is the acceptable method for medication preparation, administration and documentation.