

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Studebaker Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13226 Studebaker Rd Norwalk, CA 90650	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross referenced to F713Based on interview and record review the facility failed to follow up with the physician and/or the Medical Director for one of three sampled resident's (Resident 1), when Resident 1's physician did not respond to a text message sent to him on 8/20/2025 regarding Resident 1's change of condition (COC). In addition the facility failed to ensure Resident 1's complete COC was relayed to his physician via the text messages and documentation of the interaction with the physician, to include, the time of the text message, method of communication and endorsement to other staff, was completed. These deficient practices resulted in Resident 1 feeling increased anxiety (persistent an excessive worry which interferes with daily activities), a delay in care and treatment and the inability to ascertain via documentation the sequence of events as it related to physician contact and response. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including amyotrophic lateral sclerosis ([ALS] a progressive disease that leads to muscle weakness and eventual loss of the ability to move, speak, swallow, or breathe), diabetes type 2 ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest) During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/8/2025, the MDS indicated Resident 1 was cognitively intact (no impairment in the ability to think, learn, remember, use judgement, and make decisions) and had the ability to understand and be understood by others. During a review of Resident 1's Nurses Notes, dated 8/20/2025 and timed at 12:45 a.m., the Nurses Notes indicated at the beginning of the shift Resident 1 complained of a headache and requested to have his blood pressure ([B/P] 117/86, normal range 120/80) checked, Resident 1 then complained of a cough and congestion. The Nurses Note indicated Resident 1 was administered Ibuprofen (Tylenol) at 12:11 a.m., for a headache, and at 2:15 a.m., Cepacol (a medication used to treat a sore throat) was administered to Resident 1 for a sore throat. The Nurses Note indicated Resident 1 wanted to lie down but voiced fear of choking and wished to remain sitting for the remainder of shift. The Nurses Note indicated Resident 1's physician was notified of Resident 1's complaints of congestion and cough (via text message at 12:22 a.m. and 3:40 a.m.), only, and not that he felt he might choke or his B/P. During a review of Resident 1's Change of Condition (COC), dated 8/20/2025 and timed at 3:41 a.m., the COC indicated Resident 1 had a cough and congestion. During a review of the Charge Nurse Cell Phone Log dated 8/20/2025, the Charge Nurse Cell Phone Log indicated LVN 1 sent text messages to Resident 1's physician related to Resident 1's symptoms of a cough and congestion on 8/20/2025 at 12:22 a.m. and again at 3:40 a.m. The Charge Nurse Cell Phone Log indicated Resident 1's physician responded via text message on 8/20/2025 at 8:56 a.m. (over eight hours after the first text message was sent to him). During a review of Resident 1's Nurses Notes dated 8/21/2025 and timed at 7:10 a.m., the Nurses Notes indicated Resident 1's family called 911 because Resident 1 was not feeling well. The Nurses Notes indicated paramedics transferred Resident 1 to a General Acute Care Hospital (GACH). During a review of the GACH's Face Sheet, the Face Sheet indicated Resident 1 was admitted to GACH on 8/21/2025 at 11:14 a.m., with diagnoses including pneumonia (an infection/inflammation of the lungs), secondary to the Covid 19 virus (a potentially severe respiratory illness caused by a coronavirus and characterized by fever, coughing, and shortness of breath) and hypoxia (low levels of oxygen in your body tissue causing symptoms like, restlessness and difficulty breathing). During an interview on 9/8/2025 at 10:30 a.m., Resident 1 stated on 8/20/2025 shortly after 12 a.m., he was feeling short of breath (SOB) and was afraid to lie down in bed because he was afraid that he might choke. Resident 1 stated he asked LVN 1 to call his physician to inform him that he (Resident 1) was having difficulty breathing and was SOB. Resident 1 stated for the majority of the 11 p.m. - 7 a.m. shift on 8/20/2025, he sat up on the edge of his bed or in a wheelchair because it helped him breathe. Resident 1 stated LVN 1 gave him pain medicine for his headache and cough drops for his throat which really didn't help. Resident 1 stated he felt increasingly anxious and nervous and thought the nursing staff did not believe he was having difficulty breathing. Resident 1 stated his family called 911 on 8/21/2025 and he was transferred to the GACH on 8/21/2025 at approximately 7 a.m. During a telephone interview on 9/9/2025 at 12:10 a.m., LVN 1 stated on 8/20/2025 at approximately 12 a.m., she observed Resident 1 with a cough and congestion, he was restless and agitated but did not appear to be SOB. LVN 1 stated Resident 1 did not want to lay in bed because he thought he</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the results of multiple grievances filed by one of three sampled resident's (Resident 1) and/or their responsible party (RP). This deficient practice resulted in Resident 1 and/or his RP not being aware of the outcome/resolution of the grievances filed by him and his RP, which led to distrust toward the facility. This deficient practice had the potential to delay the delivery of care and services to Resident 1 and could negatively impact Resident 1's mental health and emotional well-being. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including amyotrophic lateral sclerosis ([ALS] a progressive disease that leads to muscle weakness and eventual loss of the ability to move, speak, swallow, or breathe), diabetes type 2 ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest) During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/8/2025, the MDS indicated Resident 1 was cognitively intact (no impairment in the ability to think, learn, remember, use judgement, and make decisions) and had the ability to understand and be understood by others. During a review of Resident 1's Resident Grievance/Complaint Investigation reports dated 8/6/2025, 8/8/2025, 8/10/2025, 8/20/2025, 8/26/2025 and 9/3/2025, the Resident Grievance/Complaint Investigation reports indicated the grievances were investigated by the facility, but documentation on the reports did not indicate that Resident 1 and/or Resident 1's RP were notified regarding the results/resolution of the facility's investigation. During an interview on 9/8/2025 at 10:30 a.m., Resident 1 stated he had filed multiple grievances since his admission to the facility in 4/2025, regarding what he believed were violations of resident rights and substandard quality of care. Resident 1 stated he made his complaints known to the licensed nurses, the Social Services Director (SSD), the Director of Nursing (DON) and the Administrator, verbally and in writing. Resident 1 stated his family also filed grievances on his behalf. Resident 1 stated he had not been provided an update on the status of his grievances and was unsure if the facility investigated his concerns and whether there had been any resolutions. Resident 1 stated he felt stressed, helpless and frustrated at the lack of communication regarding his grievances, so he escalated the complaints to the California Department of Public Health (CDPH). Resident 1 stated he feels hopeless and was scared that in few months his disease would progress and prevent him from speaking and he wanted to know that he could trust the facility to address his concerns while he could still speak. Resident 1 stated, he had asked repeatedly for the status of his grievances to be given to him in writing, but his request fell on deaf ears. During an interview on 9/9/2025 at 2:42 p.m., the SSD stated Resident 1's Resident Grievance/Complaint Investigation reports dated 8/6/2025, 8/8/2025, 8/10/2025, 8/20/2025, 8/26/2025 and 9/3/2025, were discussed with him, however, the status/update of those grievances were not provided to him in writing because she thought it was sufficient to discuss the outcomes in person. The SSD stated Resident 1 should have received the status/outcome of his grievances in writing, per his request, and not doing so could contribute to his distrust toward facility staff. During an interview on 9/11/2025 at 2:20 p.m., the DON stated, residents have the right to be updated timely on the status of their grievances. The DON stated failure to provide timely updates to Resident 1 could cause mistrust toward the facility and potentially delay the delivery of care and services to Resident 1. During a review of the facility's Policy and Procedure (P/P) titled, Grievances and complaints, dated 10/1/2023, the P&P the purpose of the policy is to ensure that residents, family members and representatives know about the procedure for filing grievances and complaints. The P/P indicated upon receiving a resident grievance/complaint form, the Grievance official or designee begins an investigation into the allegations. the facility will inform the resident or his or her representative of the finding of the investigation and any corrective actions recommended in a timely manner, if the resident is not satisfied with the result of the investigation or recommended actions, he may file a written complaint to local Long Term Ombudsman office or to the Department of Public Health. During a review of the facility's policy, and procedure (P/P) titled, Grievances and complaints, dated October 1, 2023, the P&P the purpose of the policy is to ensure that residents, family members and representatives know about the procedure for filing grievances and complaint, any resident, representative, family member or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, theft of property without fear of</p>		

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or arrange emergency care by a doctor 24 hours a day.</p> <p>(continued on next page)</p>

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Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including amyotrophic lateral sclerosis ([ALS] a progressive disease that leads to muscle weakness and eventual loss of the ability to move, speak, swallow, or breathe), diabetes type 2 ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest) During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/8/2025, the MDS indicated Resident 1 was cognitively intact (no impairment in the ability to think, learn, remember, use judgement, and make decisions) and had the ability to understand and be understood by others. 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