STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the attending physician (AP) 1 performed and documented an initial physical assessment for a resident (Resident 1) who was newly admitted to the facility for one of three sampled residents (Resident 1). This deficient practice resulted in AP 1's failure to identify, assess, and document Resident 1's condition and/or well-being. This deficient practice had the potential for an undetected decline in Resident 1's medical, health, or psychosocial status and a delay in the initiation of appropriate care, treatment, and services.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 diagnoses including subarachnoid hemorrhage (a serious life-threatening type of stroke [loss of blood flow to a part of the brain] caused by bleeding into the space surrounding the brain) and cerebral infraction (the death of brain tissue caused by a loss of blood flow to a part of the brain).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/14/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and required two-person assistance from staff to complete her ADLs including bathing, dressing, transferring, and repositioning from sitting to lying. The MDS indicated Resident 1 was incontinent (involuntary voiding of urine and stool) of both bowel and bladder.During a review of Resident 1's Medical Record, dated 3/2026, there was no documentation indicating AP 1 evaluated Resident 1, conducted a history and physical (H&P) assessment, or documented physician progress notes following Resident 1's admission 3/10/2026.During a concurrent interview and record review on 4/2/2026 at 11:58 a.m. with Medical Records Assistant (MRA), Resident 1's Medical Record, dated 3/2026, was reviewed. There was no documentation indicating AP 1 saw Resident 1 in the facility or completed a H&P or an initial progress note. The MRA confirmed AP 1 did not evaluate Resident 1 nor document an H&P or any progress notes for Resident 1. The MRA stated that AP 1 saw other residents in the facility on 3/16/2026, but for an unknown reason, did not see Resident 1. During an interview on 4/2/2026 at 12:17 p.m., the Medical Record Director (MRD) stated she notified Resident 1's AP on 3/11/2026 of Resident 1's admission to the facility. The MRD stated she did not make a follow-up call after the initial notification but should have reminded AP 1 on 3/12/2026 to assess Resident 1 to ensure timely evaluation and documentation of Resident 1's condition.During an interview on 4/2/2026 at 12:25 p.m., AP 1 stated she does not follow the facility's policy regarding physician services and visits because she typically sees residents on Mondays and Thursdays. AP 1 stated she was unsure if the facility staff called and reminded her of Resident 1's admission to the facility because if the facility staff did, she should have completed an initial assessment and documented Resident 1's H&P and progress note on 3/12/2026. AP 1 stated she should have assessed Resident 1 in a timely manner, performed a thorough physical examination, and informed Resident 1 and his responsible party of the care and services that Resident 1 needed, including providing an update on Resident 1's condition.During an interview on 4/2/20206 at 1:24 p.m., the Director of Nursing Services (DON) stated AP 1 was supposed to personally perform a physical examination to Resident 1 three days after admission to identify Resident 1's current condition and to (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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inform Resident 1 and his family and/or responsible party of Resident 1's goals, care and treatment services and provide guidance to the nursing staff for Resident 1's care. The DON stated the facility should have made a follow up call with Resident 1's AP to remind of Resident 1's admission to prevent potential delay of care and services.During an interview on 4/2/2026 at 2:30 p.m., the Administrator (ADM) stated all primary care providers and/or attending physicians of the residents must follow the facility's policy on physician services and visits and should assess/reassess the residents in a timely manner.During a review of the facility's policy and procedure (P&P) titled, Physician Services & Visits, dated 10/1/2023, the P&P indicated the facility shall provide residents with care under an attending physician. The P&P indicated the resident's attending physician participates in the resident's assessment and care planning, monitors the residents' change in their medical status, provides consultation or treatment to the residents and perform patient evaluation including a written report of the physical examination within 5 days prior to admission or within seventy-two hours after admission.

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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 Certified Nursing Assistant (CNA) 5 accurately documented activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) for one of six sampled residents (Resident 1). This failure resulted in an inability to determine the care and services provided to Resident 1 and had the potential for delayed or unmet care needs. 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 diagnoses including subarachnoid hemorrhage (a serious life-threatening type of stroke [loss of blood flow to a part of the brain] caused by bleeding into the space surrounding the brain) and cerebral infraction (the death of brain tissue caused by a loss of blood flow to a part of the brain).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/14/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and required two-person assistance from staff to complete her ADLs including bathing, dressing, transferring, and repositioning from sitting to lying. The MDS indicated Resident 1 was incontinent (involuntary voiding of urine and stool) of both bowel and bladder.During a review of Resident 1's Care Plan dated 3/11/2026, the Care Plan indicated Resident 1 had a self-care deficit for ADLs. Under this Care Plan a goal for Resident 1 was to be able to participate in his care with caregiver assistance to the maximum of his physical and cognitive (relating to mental processes of thinking, knowing, learning and understanding) capabilities while maintaining safety and reducing risk of complications. The Care Plan's interventions included providing maximal assistance for all ADLs including grooming, hygiene, dressing, bathing, and toileting, repositioning every two hours and implementing pressure-injury prevention measures such as cushions, heel protectors, and appropriate support surfaces as needed.During a review of Resident 1's Task Sheet dated 3/14/2026, there was no documentation on the Task Sheet indicating ADLs were provided to Resident 1 on 3/14/2026 from the 3 p.m. to 11 p.m. shift.During a telephone interview on 4/2/2026 at 10:43 a.m., CNA 5 stated on 3/14/2026 during the 3 p.m. to 11 p.m. shift, she provided Resident 1 with ADL care such as oral care, incontinence care, and repositioning. CNA 5 stated she forgot to document the care provided and should have documented these tasks on the Task Sheet to show the care she completed for Resident 1. During a concurrent interview and record review on 4/2/2025 at 12:53 p.m., with the Director of Staff Development (DSD), Resident 1's Task Sheet dated 3/14/2026 was reviewed. There was no documentation indicating CNA 5 provided ADL care to Resident 1 during the 3 p.m. to 11 p.m. shift on 3/14/2026. The DSD confirmed CNA 5 did not document the care provided and stated the care should have been documented on the Task Sheet to accurately reflect the care delivered to Resident 1. During an interview on 4/2/2026 at 1:24 p.m., the Director of Nursing (DON) stated all nursing staff are responsible for timely documentation of each resident's status and their response to care, in order to prevent delays in treatment. The DON stated that residents' medical records must remain complete and accurate at all times.During a review of the facility's policy and procedure (P&P) titled Documentation-Nursing, dated 10/1/2023, the P&P indicated the facility shall provide documentation of the resident status and care given by the nursing staff. The P&P indicated the nursing documentation shall be concise, clear, pertinent and accurate and the ADL documentation must be documented either manually or electronically by the CNA who provided the care according to the date and shift the services were provided.During a review of the facility's P&P titled Medical Record Content, 10/1/2023, the P&P indicated the facility shall ensure adequate and accurate documentation of care provide to each resident while at the facility. The P&P indicated the facility shall maintain a medical record for each resident that contains sufficient information to identify the resident, support the diagnoses, justify the medical necessity for treatment and facilitate continuity of care among health care providers.