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	04/27/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure a resident (Resident 2) who was assessed as a high fall risk, had a history of falls, and an inability to communicate his needs, staff implemented interventions timely and developed a Care Plan addressing his inability to communicate his needs for one of three sampled residents (Resident 2). These failures resulted in Resident 2 falling on 2/11/2026 and 2/12/2026, and placed Resident 2 to at risk for serious injuries, including head, back, hip, or neck injuries, fractures (a break in the bone), internal brain bleed (a life-threatening condition that occurs when a blood vessel in the brain bursts or leaks blood), or death.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] and readmitted on [DATE] with diagnoses including a subarachnoid hemorrhage (a life-threatening bleeding into the space surrounding the brain), muscle weakness, failure to thrive (decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and history of falls.During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 1/27/2026, the MDS indicated Resident 2's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 2 was completely dependent (helper does all of the effort, or the assistance of 2 or more helpers required) on staff for all activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's Physician Orders, dated 1/27/2026, the order indicated to transfer Resident 2 to the GACH for further evaluation of failure to thrive and episodes of pocketing food.During a review of Resident 2's Nurses Notes, dated 1/27/2026, the Nurses Notes indicated Resident 2 was transferred to the GACH at 4:10 p.m.During a review of the General Acute Care Hospital (GACH) Attending Team Progress Note, dated 2/9/2026, the Attending Team Progress Note indicated Resident 2 presented to the emergency department for evaluation of failure to thrive with a concern for not eating well, concern for dehydration, and a history of falls beginning 1/2026.During a review of Resident 2's Nursing admission Assessment, dated 2/10/2026, the Nursing admission Assessment indicated Resident 2 was readmitted to the facility and was assessed as a high fall risk. The Nursing admission Assessment indicated Resident 2 was alert and oriented to name only.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was severely impaired (worsened from 1/27/2026). The MDS indicated Resident 2 was completely dependent on staff for all ADLs.During a review of Resident 2's Care Plan dated 1/23/2026, the Care Plan indicated Resident 2 was at risk for falls due to being unaware of safety needs, diagnosis of traumatic subdural hemorrhage, and had a history of falls in 1/2026. The Care Plan's goal included Resident 2 was to be free from falls. The Care Plan's interventions included to be sure the call light is within reach and to encourage Resident 2 to use it to call for assistance as needed. The Care Plan did not include interventions addressing Resident 2's disorientation and inability to communicate his needs or use the call light when needing assistance due to confusion/disorientation.During a review of Resident 2's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	04/27/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of condition among the residents) Communication Form, dated 2/11/2026 at 11:10 a.m., the SBAR Communication Form indicated Resident 2 was found on the floor on his knees. The SBAR indicated there was urine observed on the floor. During a review of Resident 2's Care Plan, dated 2/11/2026, the Care Plan indicated Resident 2 had a fall on 2/11/2026 due to disorientation, poor balance, and unsteady gait (walking). The Care Plan's goals indicated Resident 2 would resume usual activities without further incident. The Care Plan did not include interventions addressing Resident 2's disorientation and inability to communicate his needs or use the call light when needing assistance.During a review of Resident 2's Unwitnessed Fall Report, dated 2/11/2026 and timed at 11:10 a.m., the report indicated Resident 2 was found by Licensed Vocational Nurse (LVN) 1 on his knees with urine observed on the floor. The Unwitnessed Fall Report indicated Resident 2 had no noted injuries and was unable to describe the event due to disorientation. The Unwitnessed Fall Report indicated Resident 2's predisposing fall factors included confusion, gait imbalance, incontinence, and recent admission within the last 72-hours.During a review of Resident 2's SBAR, dated 2/12/2026 at 4:35 p.m., the SBAR Communication Form indicated Resident 2 was found on the floor in a sitting position.During a review of Resident 2's Care Plan, dated 2/12/2026, the Care Plan indicated Resident 2 had a fall on 2/12/2026 due to unsteady gait. The Care Plan's goal indicated Resident 2 would resume usual activities without further incident. The Care Plan did not include interventions addressing Resident 2's disorientation or his inability to communicate his needs or use the call light when needing assistance.During a review of Resident 2's Unwitnessed Fall Report, dated 2/12/2026 and timed at 4:30 p.m., the report indicated Resident 2 was found on the floor in a sitting position in his room by LVN 2. The Unwitnessed Fall Report indicated Resident 2 had facial grimacing due to buttock pain and an X-Ray of the hip was ordered by the physician. The Unwitnessed Fall Report indicated Resident 2 was unable to give a description of what happened due to disorientation. The Unwitnessed Fall Report indicated Resident 2's predisposing fall factors included confusion, gait imbalance, incontinence, and recent admission within the last 72-hours. During a review of Resident 2's Interdisciplinary ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Post Event Review, dated 2/13/2026, the IDT Post Event Review indicated contributing factors to the two unwitnessed falls on 2/11/2026 and 2/12/2026 included Resident 2's diagnosis, comorbidities, functional and cognitive limitations, recent readmission status with unfamiliar environment, adjustment period, and impaired safety awareness. The IDT Post Event Review indicated the Care Plan was to be updated to include a tab alarm (a safety device used in healthcare to prevent falls, consisting of a monitor with a cord that clips to a resident's clothing; if the resident attempts to get up, the tab is pulled from the monitor, triggering an audible alert), low bed, bilateral (both sides) floor mattresses (intended to reduce possible injuries from a fall), and to continue therapy to address mobility, strength, and safety awareness.During a review of Resident 2's Order Audit Report (Physician's Orders), dated 2/16/2026, the Order Audit Report indicated orders were placed for Resident 2's bed to be in a low position with bilateral floor pads for injury prevention, to apply tab alarm when in bed to alert staff if Resident 2 was getting out of bed unassisted, and to apply a bilateral grab bar (is a securely mounted rail designed to provide support, stability, and balance to individuals).During a review of Resident 2's Care Plans, dated 2/16/2026 to 4/24/2026, there was no documentation indicating the ordered interventions which included placing Resident 2's in a low position with bilateral floor pads, applying a tab alarm when in bed to alert staff if Resident 2 was getting out of bed, and applying a bilateral grab bar, had been added or updated in Resident 2's Care Plans. During an interview on 4/24/2026 at 1:34 p.m., Registered Nurse (RN) 1 stated upon readmission on [DATE] Resident 2 was a high fall risk because during his admission assessment Resident 2 was confused, and for someone who was confused like Resident 2 increased monitoring once an hour was something that should have been included in his Care Plan, but that Resident 2 fell before the baseline Care Plan was due to be completed. RN 1 stated there should have been some system in place where Resident 2 should have been monitored (continued on next page)

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	04/27/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more frequently due to his confusion, which lead to his falls on 2/11/2026 and 2/12/2026. RN 1 stated for his post fall Care Plans there were no interventions addressing his confusion which led to his second fall and could have possibly led to more falls.During an interview on 4/27/2026 at 10:23 a.m., the Director of Nursing (DON) stated there was no documentation in the chart, Care Plans, or physician orders addressing Resident 2's confusion to prevent falls when he was admitted [DATE] which led to his falls on 2/11/2026 and 2/12/2026. The DON stated Resident 2's baseline confusion on readmission on [DATE] should have been addressed right away to prevent his falls. The DON stated the discussion the IDT had on 2/13/2026 to implement the tab alarm and bilateral floor mattresses for Resident 2 was an oversight that these interventions were not ordered until 2/16/2026 and not put on the post fall Care Plans.During a review of facility's policy and procedure (P&P) titled Care Planning, dated 10/2023, the P&P indicated the purpose of the policy was to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual needs. The P&P indicated the comprehensive Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. The P&P indicated the Comprehensive Care Plan will describe any services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.During a review of facility's P&P titled Fall Risk Evaluation, dated 2/24/2026, the P&P indicated the purpose of the P&P was to maintain an environment as free of accident hazards as is possible and provide adequate supervision and assistance to prevent accidents. The P&P indicated the facility assesses residents upon admission, quarterly, after a fall occurrence, with a change of condition and as needed for their risk of falling. The P&P indicated the facility uses this information to develop both a person-centered care plan and facility-wide fall prevention measures. The P&P indicated based on the initial evaluation, the IDT will identify and implement appropriate interventions to reduce the risk of falls, and the care plan will be updated to address new risk factors or modify interventions that have not been effective.