

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/28/2024
NAME OF PROVIDER OR SUPPLIER  Norwalk Skilled Nursing & Wellness Centre, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  11510 Imperial Highway 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45537</p> <p>Based on interview and record review, the facility failed to ensure one of seven sampled residents (Resident 6) was treated with dignity and respect by assisting Resident 6 to use the toilet in a timely manner.</p> <p>This failure left Resident 6 feeling frustrated because she had to crawl her way to the toilet to prevent herself from having an incontinence in her bed.</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record (Face sheet), the Face sheet indicated Resident 6 was admitted at the facility on 3/26/2024 with a diagnosis including asthma (a condition in which the airways narrow and swell, produce extra mucus that can result to difficulty in breathing/ shortness of breath, trigger coughing and a wheezing or whistling sound during breathing out), diabetes mellitus (a serious condition when the blood glucose, also known as blood sugar is too high) and morbid obesity (a condition in which a person's weight is higher than what is healthy for their height and can increase the risk of the person's risk for many health problems).</p> <p>During a review of Resident 6's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/2/2024, the MDS indicated Resident 6 was able to make decisions that were reasonable despite periods of disorientation, was dependent to two- persons assist to complete her activities of daily living such as dressing, bathing, hygiene, toileting, and was occasionally incontinent (loss of control) of her bladder and bowel functions.</p> <p>During a review of Resident 6's SBAR (Situation Background Assessment and Recommendation) dated 5/6/2024, the SBAR indicated Resident 6 she crawled out of bed on a Saturday morning (5/4/2024) at 1 a.m., to go to the bathroom.</p> <p>During an interview on 5/28/2024 at 11:38 a.m., Resident 6 stated she pressed the call light and was waiting for the nurses to assist her to the toilet. Resident 6 stated she had to lower down her bed, crawl her way to the restroom and she was scared that she could have hurt or fell in the bathroom. Resident 6 stated she did not want to wet herself and although she felt ashamed and frustrated, she had to do what she had to do.</p> <p>(continued on next page)</p>

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/28/2024 at 1:19 p.m., Certified Nursing Assistant 6 (CNA 6) stated Resident 6 was always patient to wait for her turn to be assisted with her activities of daily living. CNA 6 stated Resident 6 must have waited for a while for assistance that she decided to crawl to use the toilet and that was undignified.</p> <p>During an interview on 5/28/2024 at 1:30 p.m., Licensed Vocational Nurse 7 (LVN 7) LVN 7 stated there was a lack of assistance for Resident 6 to decide to crawl to use the toilet and such can cause Resident 6 to feel frustrated and humiliated.</p> <p>During an interview on 5/28/2024 at 1:52 p.m., Registered Nurse Supervisor 1 (RNS 1) stated Resident 6 must have felt helpless, shamed, and undignified crawling to use the toilet.</p> <p>During an interview and record review on 5/28/2024 at 2:10 p.m., Social Service Director (SSD) confirmed Resident 6 filed a grievance about the lack of assistance from the nursing staff and her decision to crawl to use the toilet.</p> <p>During an interview on 5/28/2024 at 3:23 p.m., the Administrator (ADM) stated it must be an unpleasant and undignified experience for Resident 6 to crawl to use the toilet and should never have happened.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Resident Rights revised 1/1/2012, the P/P indicated all residents must be treated with respect and dignity.</p> <p>During a review of the facility' Policy and Procedure (P/P) on Resident Rights-Accommodation of Needs revised 1/1/2012, the P/P indicated the facility must provide an environment and services that meet the residents' needs to assist the resident in achieving independent functioning and maintaining the residents' dignity and well-being.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45537</p> <p>Based on interview and record review, the facility failed to supervise two of seven sampled residents (Resident 1 and Resident 6).</p> <p>A. The facility failed to ensure Resident 1 did not leave the facility premises unsupervised and without the staff knowledge and this failure had the potential for Resident 1 to be exposed to elements of extreme weather conditions, traffic accident, safety/ fall incident and/or be subjected to any forms assault (physical attack) which could be detrimental to her health and well-being.</p> <p>B. The facility failed to ensure Resident 6 was assisted to use the toilet in a timely manner. This failure left Resident 6 feeling frustrated because she had to crawl her way to the toilet to prevent herself from having an incontinence in her bed.</p> <p>Findings:</p> <p>A. During a review of Resident 1's Admission record (Face sheet), the Face sheet indicated Resident 1 was admitted at the facility on 4/13/2023 with a diagnosis including diabetes mellitus (a disease that occurs when the blood glucose, also known as the blood sugar, is too high), osteoporosis (a disease in which the bones become fragile and more likely to break), hypertension (a condition of a high or raised blood pressure when the blood is pumping with more force than normal through the arteries) and dementia (the loss of cognitive functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/14/2024, the MDS indicated Resident 1 had able to make decisions despite periods of disorientation (forgetfulness) and uncooperativeness to care and required supervision with one- person assist to complete her activities of daily living such as dressing, bathing, hygiene, toileting, bed mobility (turning and repositioning) and transferring from chair/bed to chair.</p> <p>During a review of Resident 1's care plan (CP) on The Resident has Diabetes Mellitus undated, the CP indicated a goal for Resident 1 to be free from signs and symptoms of hyperglycemia (high blood sugar level) and hypoglycemia (low blood sugar level) and complications related to diabetes. The CP indicated the following interventions for Resident 1 avoid exposure to extreme heat or cold.</p> <p>During a review of Resident 1's undated care plan (CP) on The Resident has impaired cognitive function/dementia or impaired thought processes the CP indicated a goal for Resident 1 to develop skills to cope with cognitive decline and maintain safety. The CP interventions indicated for Resident 1to be supervised, as needed.</p> <p>During a review of Resident 1's Progress Notes dated 5/21/2024 at 5 a.m., the Progress Notes indicated Resident 1 was nowhere to be found at 4:18 a.m. in the dining room. The Progress Notes indicated Resident 1 was alert to self and her situation and was confused, and she left the facility unwitnessed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/24/2024 at 5:58 a.m., Certified Nursing Assistant 3 (CNA 3) stated Resident 1, who was disoriented and was confused at times, has been up in her wheelchair in the dining room since 10:30 p. m. and she checked on Resident 1 every 40 minutes. CNA 3 stated at 3 a.m. on 5/21/2024, Resident 1 was nowhere to be found and Resident 1 left her wheelchair in the dining room. CNA 3 stated Resident 1 was ambulatory. CNA3 stated she did not hear any door alarming that night.</p> <p>During an interview on 5/24/2024 at 6:17 a.m., Licensed Vocational Nurse 3 (LVN 3) stated Resident 1 was ambulatory, alert to self and her situation but had periods of forgetfulness. LVN 3 stated Resident 1 likes to stay up in the dining room watching television and usually goes to sleep at 3 a.m. LVN 3 stated Resident 1 was allowed to stay in the dining room by herself because the CNA checks on her every hour and the alarm system was working; therefore, Resident 1 was safe. LVN 3 stated she did not hear any door alarming that night and she was concerned of how Resident 1 was able to leave the facility premises because it was dangerous for Resident 1 to be out there by herself.</p> <p>During an interview on 5/24/2024 at 8:48 a.m., Dietary Supervisor (DS) stated he and another facility staff found Resident 1, approximately 7 miles away from the facility, sitting under a tree wearing her personal clothes and a pair of socks. DS stated Resident 1 stated she was hungry, and a restaurant gave her something to eat, and she refused to go back to the facility.</p> <p>During an interview on 5/24/2024 at 9:01 a.m., Assistant Director of Rehab (DAR) stated he was with DS when they both saw Resident 1 was looking more confused than usual, sitting by a tree wearing only a pair of socks and her personal clothes. DAR stated Resident 1 was not in a safe situation because she was exposed to weather elements and could also step on sharp objects and get injured. DAR stated Resident 1 was not in her right mind and could have been assaulted or could have unsafely cross a busy street.</p> <p>During an interview on 5/24/2024 at 10:34 a.m., Minimum Data Set Registered Nurse (RN MDS) stated Resident 1 cognition was moderately impaired and needed supervision to complete her activities of daily living. RN MDS stated Resident 1, given her diagnosis, should have been often supervised and checked for safety reasons. RN MDS stated with all of Resident 1's preexisting conditions and her being out of the facility by herself, she could have suffered complications from fluctuations of blood sugar levels and blood pressure, accidents such as a fall and/or motor vehicular demise which she could have incurred an injury, extreme cold and extreme heat, and subjected to any forms of assault. RN MDS stated the residents' safety was a must.</p> <p>During an interview on 5/24/2024 at 11:20 a.m., the Administrator (ADM) stated Resident 1 could have been unsafe out there because of her diagnosis and her vulnerability. The ADM stated the facility was responsible of all the residents' safety.</p> <p>B. During a review of Resident 6's Admission Record (Face sheet), the Face sheet indicated Resident 6 was admitted at the facility on 3/26/2024 with a diagnosis including asthma (a condition in which the airways narrow and swell, produce extra mucus that can result to difficulty in breathing/ shortness of breath, trigger coughing and a wheezing or whistling sound during breathing out), diabetes mellitus (a serious condition when the blood glucose, also known as blood sugar is too high) and morbid obesity (a condition in which a person's weight is higher than what is healthy for their height and can increase the risk of the person's risk for many health problems).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 was able to make decisions that were reasonable despite periods of disorientation, was dependent to two- persons assist to complete her activities of daily living, such as dressing, bathing, hygiene, toileting, and transferring from chair/bed to chair and was occasionally incontinent (loss of control) of her bladder and bowel functions.</p> <p>During a review of Resident 6's SBAR (Situation Background Assessment and Recommendation), dated 5/6/2024, the SBAR indicated Resident 6 she crawled out of bed on a Saturday morning (5/4/2024) at 1 a.m., to go to the bathroom.</p> <p>During an interview on 5/28/2024 at 11:38 a.m., Resident 6 stated she pressed the call light and was waiting for the nurses to assist her to the toilet. Resident 6 stated she had to lower down her bed, crawl her way to the restroom and she was scared that she could have hurt or fell in the bathroom. Resident 6 stated she did not want to wet herself and although she felt ashamed and frustrated, she had to do what she had to do.</p> <p>During an interview on 5/28/2024 at 1:19 p.m., Certified Nursing Assistant 6 (CNA 6) stated Resident 6 was always patient to wait for her turn to be assisted with her activities of daily living. CNA 6 stated Resident 6 needed assistance to get up from the bed to use the Front Wheel [NAME] (a mobility aid to help a person to walk steadily) to use the toilet. CNA 6 stated Resident 6 must have waited for a while for assistance that she decided to crawl to use the toilet unsupervised.</p> <p>During an interview on 5/28/2024 at 1:30 p.m., Licensed Vocational Nurse 7 (LVN 7) LVN 7 stated there was a lack of assistance for Resident 6 to decide to crawl to use the toilet. LVN 7 stated the nursing staff at all shifts, whether there are call lights or not, must perform resident rounds as frequently as possible to identify residents' safety risks, changes in condition, anticipate the residents' needs and prevent complications.</p> <p>During an interview on 5/28/2024 at 1:52 p.m., Registered Nurse Supervisor 1 (RNS 1), the nursing staff must assist the residents with their activities of daily living to prevent a fall and/or other injuries.</p> <p>During an interview on 5/28/2024 at 3 p.m., the Director of Nursing Services (DON) stated Resident 6 was a high risk for fall and the nursing staff should have aided Resident 6 in a timely manner. The DON stated the facility staff were advocates of the residents' safety and well-being.</p> <p>During an interview on 5/28/2024 at 3:23 p.m., the Administrator stated there was no excuse for Resident 6 to be unsupervised with her needs because the facility is operating 24 hours and the nursing staff are skilled and trained to render timely and quality care to the residents.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Resident Safety, revised 4/15/2021, the P/P indicated the facility should provide a safe environment for the residents and to ensure the safety and well-being of the residents, the staff must perform a resident check every 2 hours around the clock or more frequent safety checks depending on the person- centered care plan to prevent an unsafe situation.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	During a review of the facility's Policy and Procedure (P/P) on Communication- Call System revised 1/1/2012, the P/P indicated the call system is a mechanism for residents to promptly communicate with the nursing staff and the nursing staff are expected to promptly answer the residents call lights.		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45537</p> <p>Based on interview and record review, the facility failed to ensure two of seven sampled residents (Resident 1 and Resident 6) were provided psychological (emotional and mental state) assessment and follow-up when:</p> <p>a. Resident 1 left the facility unnoticed and was found by facility staff under a tree with bare minimum clothes and no shoes, and</p> <p>b. Resident 6 crawled on the floor to use the toilet when there was no supervision provided for Resident 6.</p> <p>This failure had the potential to result in the residents' unmet psychosocial needs and concerns which could potentially affect their quality of life.</p> <p>Findings:</p> <p>A. During a review of Resident 1's Admission record (Face sheet), the Face sheet indicated Resident 1 was admitted at the facility on 4/13/2023 with a diagnosis including diabetes mellitus (a disease that occurs when the blood glucose, also known as the blood sugar, is too high), osteoporosis (a disease in which the bones become fragile and more likely to break), hypertension (a condition of a high or raised blood pressure when the blood is pumping with more force than normal through the arteries) and dementia (the loss of cognitive functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/14/2024, the MDS indicated Resident 1 had able to make decisions despite periods of disorientation (forgetfulness) and uncooperativeness to care and required supervision with one- person assist to complete her activities of daily living such as dressing, bathing, hygiene, toileting, bed mobility (turning and repositioning) and transferring from chair/bed to chair.</p> <p>During a review of Resident 1's Progress Notes dated 5/21/2024 at 5 a.m., the Progress Notes indicated Resident 1 was nowhere to be found at 4:18 a.m. in the dining room. The Progress Notes indicated Resident 1 was alert to self but was confused, and she left the facility unwitnessed.</p> <p>During an interview on 5/24/2024 at 8:48 a.m., Dietary Supervisor (DS) stated he and another facility staff found Resident 1, approximately 7 miles away from the facility, sitting under a tree wearing her personal clothes and a pair of socks. DS stated Resident 1 stated she was hungry, and a restaurant gave her something to eat, and she refused to go back to the facility.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/24/2024 at 9:01 a.m., Assistant Director of Rehab (DAR) stated he was with DS when they both saw Resident 1 was looking more confused than usual, sitting by a tree wearing only a pair of socks and her personal clothes. DAR stated Resident 1 was not in a safe situation because she was exposed to weather elements and could also step on sharp objects and get injured. DAR stated Resident 1 was not in her right mind and could have been assaulted or could have unsafely cross a busy street.</p> <p>During an interview and record review on 5/24/2024 at 9:46 a.m., Social Services Director stated she found Resident 1 in the street unaccompanied but Resident 1 was alert and coherent (the state of being logical/making sense and not confused) and refused to go back to the facility. SSD confirmed there was no psychosocial assessment and support provided and documented for Resident 1. SSD stated it was part of her job to provide residents with psychosocial management and/or support and offer services to meet their quality of life.</p> <p>During an interview on 5/24/2024 at 10:34 a.m., Minimum Data Set Registered Nurse (RN MDS) stated the facility staff must also ensure that the psychosocial and holistic aspect of the residents have been addressed because it must be traumatizing for Resident 1 to be out there by herself exposed to all kinds of danger and weather elements.</p> <p>During an interview on 5/24/2024 at 11:20 a.m., the Administrator (ADM) stated she sent the SSD to where Resident 1 was located to ensure an emotional and psychological support was offered and provided to Resident 1.</p> <p>B. During a review of Resident 6's Admission Record (Face sheet), the Face sheet indicated Resident 6 was admitted at the facility on 3/26/2024 with a diagnosis including asthma (a condition in which the airways narrow and swell, produce extra mucus that can result to difficulty in breathing/ shortness of breath, trigger coughing and a wheezing or whistling sound during breathing out), diabetes mellitus (a serious condition when the blood glucose, also known as blood sugar is too high) and morbid obesity (a condition in which a person's weight is higher than what is healthy for their height and can increase the risk of the person's risk for many health problems).</p> <p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 was able to make decisions that were reasonable despite periods of disorientation, was dependent to two- persons assist to complete her activities of daily living, such as dressing, bathing, hygiene, toileting, and transferring from chair/bed to chair and was occasionally incontinent (loss of control) of her bladder and bowel functions.</p> <p>During a review of Resident 6's SBAR (Situation Background Assessment and Recommendation) dated 5/6/2024, the SBAR indicated Resident 6 she crawled out of bed on a Saturday morning (5/4/2024) at 1 a.m., to go to the bathroom.</p> <p>During an interview on 5/28/2024 at 11:38 a.m., Resident 6 stated she pressed the call light and was waiting for the nurses for an hour to assist her to the toilet. Resident 6 stated she had to lower down her bed, crawl her way to the restroom and she was scared that she could have hurt or fell in the bathroom. Resident 6 stated she did not want to wet herself and although she felt ashamed and frustrated, she had to do what she had to do.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/28/2024 at 1:52 p.m., Registered Nurse Supervisor 1 (RNS 1) stated Resident 6 must have felt helpless, shamed, and undignified crawling to use the toilet.</p> <p>During an interview and record review on 5/28/2024 at 2:10 p.m., Social Service Director (SSD) confirmed Resident 6 filed a grievance about the lack of assistance from the nursing staff and her decision to crawl to use the toilet. SSD confirmed and stated she did not provide and document a psychosocial assessment and follow-up for Resident 6. SSD stated she was an advocate for the residents, and she should address and provide psychological assistance and/ or referrals for residents who might need it.</p> <p>During an interview on 5/28/2024 at 3:23 p.m., the Administrator (ADM) stated it must be an unpleasant and undignified experience for Resident 6 to crawl to use the toilet. The ADM stated the SSD has an important role in making sure the residents' concerns and grievances are addressed and psychological assessments are conducted, and services offered to ensure the residents' emotional needs are provided.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Social Service Assessment revised 12/1/2013, the P/P indicated a social service assessment must be conducted to address the residents' psychosocial needs.</p> <p>During a review of the facility's Job Description Manual on Social Service Coordinator Job Description the Job Description indicated the Social Service Coordinator must ensure the residents' psychosocial and concrete needs are identified and met in accordance with the federal, state and company requirements and must assess the psychosocial, mental, and emotional needs of the residents.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45537</p> <p>Based on observation, interview and record review, the facility failed to ensure the alarm system located at the rear entrance/exit door of the building was functioning properly.</p> <p>This failure has resulted in the elopement (resident leaving premises without knowledge of staff) of one of seven sampled residents (Resident 1) which could have negatively caused Resident 1 her safety and well-being.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission record (Face sheet), the Face sheet indicated Resident 1 was admitted at the facility on 4/13/2023 with a diagnosis including diabetes mellitus (a disease that occurs when the blood glucose, also known as the blood sugar, is too high), osteoporosis (a disease in which the bones become fragile and more likely to break), hypertension (a condition of a high or raised blood pressure when the blood is pumping with more force than normal through the arteries) and dementia (the loss of cognitive functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/14/2024, the MDS indicated Resident 1 was able to make decisions despite periods of disorientation (forgetfulness) and uncooperativeness to care and required supervision with one- person assist to complete her activities of daily living (ADL), such as dressing, bathing, hygiene, toileting, bed mobility (turning and repositioning) and transferring from chair/bed to chair.</p> <p>During an interview on 5/24/2024 at 5:58 a.m., Certified Nursing Assistant 3 (CNA 3) stated Resident 1 was disoriented and was confused at times. CNA3 stated Resident 1 has been up in her wheelchair in the dining room since 10:30 p.m. and she (CNA3) checked on Resident 1 every 40 minutes. CNA 3 stated at 3 a.m. on 5/21/2024, Resident 1 was nowhere to be found and she left her wheelchair in the dining room. CNA 3 stated Resident 1 was ambulatory. CNA 3 stated she was not sure if Resident 1 was allowed to stay in the dining room by herself. CNA3 stated she did not hear any door alarming that night.</p> <p>During an interview on 5/24/2024 at 6:17 a.m., Licensed Vocational Nurse 3 (LVN 3) stated Resident 1 was ambulatory, alert to self and her situation and had periods of forgetfulness. LVN 3 stated Resident 1 likes to stay up in the dining room watching television and usually goes to sleep at 3 a.m. LVN 3 stated Resident 1 was allowed to stay in the dining room by herself because the CNA checks on her every hour and the alarm system was working; therefore, Resident 1 was safe. LVN 3 stated she did not hear any door alarming that night and she was concerned of how Resident 1 was able to leave the facility premises because it was dangerous for Resident 1 to be out there by herself. LVN 3 stated the alarm system should be working properly because there were residents who were forgetful and might leave the facility and it was the staff responsibility to ensure their safety.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/28/2024
NAME OF PROVIDER OR SUPPLIER  Norwalk Skilled Nursing & Wellness Centre, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  11510 Imperial Highway 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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/24/2024 at 6:39 a.m., Licensed Vocational Nurse 4 (LVN 4) stated 2 weeks ago, the batteries of the alarm system of the rear entrance exit door have started to come off loose due to a broken back cover. LVN 4 stated damaged alarm system can cause malfunction and the residents to be unprotected which could also lead the residents to leave the facility unnoticed.</p> <p>During an observation and interview on 5/24/2025 at 9:03 a.m., Maintenance Supervisor (MS) confirmed the alarm system at the rear entrance and exit door was wrapped in a black tape and stated the tape was not secure enough and could cause the batteries of the alarm system to fall off. MS stated the batteries of the alarm must be secured by a cover to ensure the batteries were in place, thus, preventing a malfunction.</p> <p>During an interview on 5/28/2024 at 2:51 p.m., the Director of Staff Development (DSD) stated the alarms were instituted in the facility for the residents and staff safety and the alarm system's integrity must be repaired immediately.</p> <p>During an interview on 5/28/2024 at 3 p.m., the Director of Nursing Services (DON) stated it was everyone's responsibility in the facility to ensure the alarm system is fixed and working properly.</p> <p>During an interview on 5/28/2024 at 3:23 p.m., the Administrator (ADM) stated the alarm system was an added protection and was part of safe and homelike environment to ensure the residents whereabouts are located.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Resident Rooms and Environment revised 1/1/2012, the P/P indicated the facility must provide the residents with a safe, clean, comfortable, and homelike environment.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Entrance to and Exit from the Facility revised 1/1/2012, the P/P indicated the facility must provide a safe environment for the residents, visitors and staff while maintaining the rights of the residents.</p>