

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 08/21/2025
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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</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 0573</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** Based on interview and record review, the facility failed to provide medical records within two working days of a written request from an authorized representative ([AR] a person who is legally authorized to act on behalf of) per the facility's policy and procedure (P&P) titled, Resident Access to Protected Health Information (PHI), for two of three sampled residents (Residents 1 and 2). Findings: a. During a review of Resident 1's admission Record (Face sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including muscle weakness (a lack of muscle strength), type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Face Sheet indicated Resident 1 was discharged on 10/2/2024. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 9/11/2024, the MDS indicated Resident 1 had moderate cognitive (thought process) impairment. During a review of the request for medical records from the LA dated 7/28/2025, the request indicated the LA was requesting a copy of Resident 1's complete medical records including all records and documents that may be stored physically, digitally, and/or electronically, including but not limited to nonmedical records from 1/1/2024 to the present date. During a telephone interview on 8/21/2025 at 9:53 a.m., with the LA, the LA stated she hand delivered Resident 1's medical records request in writing to the facility on 7/30/2025. LA stated that Resident 1's medical records were received on 8/15/2025, 12 days after she requested Resident 1's documents. During a review of the facility's Log Resident Requests for Access to Protected Health Information (PHI) any information about your health or healthcare that can identify you. This includes your medical history, test results, and even payment information for healthcare services, whether in a paper record, electronic file, or even an email), dated 8/2025, the Log indicated Resident 1's AR requested Resident 1's medical records on 7/30/2025, and the medical records were sent to AR 1 on 8/19/2025. b. During a review of Resident 2's admission Record (Face Sheet), the Face sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including muscle weakness, type 2 diabetes mellitus, and gastro-esophageal reflux disease ([GERD] a chronic condition that occurs when stomach contents move up into the esophagus, causing irritation). During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 7/22/2025, the MDS indicated Resident 2's had moderate cognitive impairment. During a review of the request for medical records from the AR dated 7/22/2025, the request indicated the AR was requesting a copy of Resident 2's complete medical records including all non-privileged physical, digital, and hand-written medical records including records from 7/17/2025 to present. During a review of the facilities Log of Resident Requests for Access to PHI, dated 7/2025, the Log indicated Resident 2's AR 2 requested Resident 2's medical records on 7/22/2025 and the medical records were submitted to Resident 2's representative on 8/15/2025, 16 days after the request date. During an interview on 8/21/2025 at 11:21 a.m., with medical records (MR), MR stated some of her job functions are to gather, file and retain medical records in chronological order. Maintain medical records, release health information records and maintain medical records in the active charts. MR stated to be unaware of how long the process of submitting medical records when they are requested in writing should be. During a concurrent interview and record review on 8/21/2025 at 12:07 p.m., with Medical Records (MR), the facility's P&P titled, Resident Access to Protected Health Information (PHI), revised 11/1/2025 was reviewed. The P&P indicated the facilities MR will provide the residents representatives with a copy of the medical records within two working days after receiving a written request. MR stated that it is her responsibility to ensure that this process is done in a timely manner. MR stated Resident 1's and 2's medical records request process was not done within the two working days because she needed to wait until she received the ok from legal services and facility consultant prior to releasing the records and when she was notified it was ok to release the records, it was already past the two working days. During a concurrent interview and record review on 8/21/2025 at 2:27 p.m., with the Director of Nursing (DON), the Logs of Resident Requests for Access to Protected Health Information dated 7/2025 and 8/2025 were reviewed. The DON stated the process of releasing medical records is to be submitted immediately and it should not take more than 24 hours for the residents or their AR to receive the requested documents. The DON stated that it took the facility over two working days to have Resident 1's and Resident 2's medical records submitted to their representatives. The DON stated this process was not done in a timely manner and resulted in a delay</p>		