STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to administer intravenous fluids (IVF - fluids administered through the vein) as ordered by the physician for one of one sampled resident (Resident 1). This failure had the potential to result in Resident 1 experiencing hypovolemic shock (not enough blood in the body to support organ function) and decreased urine output. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including fracture of left tibia (long bone in the lower leg) and acute (sudden onset) kidney failure. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 1 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, and was dependent for oral hygiene, toileting hygiene, bathing, and upper and lower body dressing. During an observation on 12/23/2025 at 12:24 p.m., Resident 1 was observed receiving IVF 0.45% Sodium Chloride (fluid administered for hydration) at a rate of 50 milliliters (mL - a unit of measurement)/hour. During a concurrent observation and interview on 12/23/2025 at 12:38 p.m., the Director of Nursing (DON) was observed changing the IVF rate from 50 mL/hour to 100 mL/hour. During a concurrent interview and record review on 12/23/2025 at 2:36 p.m., with Registered Nurse (RN) 1, Resident 1's physician's orders were reviewed. Resident 1's orders indicated to start Resident 1 on Intravenous Fluid (IVF) 0.45% Normal Saline at 100 mL/ hour for 24 hours for hydration to start on 12/23/2025. RN 1 stated the IVF were initially administered at a rate of 50 mL/hour, but the order stated to administer the IVF at 100mL/hour. During an interview on 12/23/2025 at 3:30 p.m., with the DON, the DON stated it was important that facility staff administered medications according to the physician's order or it could negatively affect Resident 1. The DON stated the IVF for Resident 1 was incorrectly running at a rate of 50 mL/hour. The DON stated she corrected the IVF rate to 100ml/hour. During a review of the facility's policy and procedure (P&P), titled Medication Administration, dated January 2012, the P&P indicated to ensure the accurate administration of medications for residents in the facility, medications and treatments will be administered as prescribed to ensure compliance with dose guidelines.

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