| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555668 | A. Building<br>B. Wing | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwalk Skilled Nursing & Wellness Centre, LLC | 11510 Imperial Highway<br>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) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: Initiate a care plan for Resident 1's impulsive behavior that was identified in the first fall dated 1/22/2026.Implement a recommendation that was addressed during the Interdisciplinary Team (IDT: Resident's healthcare team consisting of various specialties that share and combine their knowledge and information to create the best possible care plan for the resident) meeting on 3/1/2026.Implement a care plan for Resident 1's known diagnosis of osteopenia (condition where bone mineral density if lower than normal). This deficient practice increased the potential risk of additional falls for the residents. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted on [DATE] and was re-admitted to the facility on [DATE] with diagnoses including osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of hip, left knee, left shoulder, dementia (group of thinking and social symptoms that interfere with daily functioning), and other specified disorders of bone density and structure. During a review of Resident 1's IDT Progress Notes - Falls dated 1/24/2026 at 8:39 a.m. the IDT Progress Notes indicated the contributing factors for Resident 1's fall included impulsivity. During a review of Resident 1's care plan titled, Resident 1 has had an actual fall with no injury related to poor balance, poor communication/comprehension, and unsteady gate, the care plan goals included Resident 1 would resume usual activities without further incident. The care plan interventions were to ensure the bed had low sides and floor mats dated 2/26/2026. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 1 was moderately cognitively (ability to make decisions of daily living) impaired. The MDS indicated Resident 1 was dependent on staff for bathing, required substantial assistance (Helper does more than half the effort) from staff for toileting hygiene, required partial assistance (Helper does less than half the effort) from staff for upper body (waist above) and lower body (below waist) dressing, personal hygiene, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer, walk 10 feet, required supervision for oral hygiene, roll left to right, sit to lying, and required set up for eating. The MDS indicated Resident 1 had impairments for the upper extremity (arms/shoulders) bilaterally and utilized a walker and wheelchair. During a review of Resident 1's Change of Condition (COC) dated 5/13/2026 at 7:52 p.m., the COC indicated Resident 1 was found sitting on the floor facing his bed and was assisted back to bed with a two person assist. The COC indicated Resident 1 reported he was attempting to get up from the bed prior to falling. During a review of Resident 1's history and physical (H&P) dated 5/21/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During an interview on 6/2/2026 at 1:18 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated if a resident (general) had a tendency to try and get out of bed without calling for assistance, facility staff would care plan it. RNS 1 stated care plans are the focal point of an individualized care and have to follow interventions for the safety and wellbeing of the residents. RNS 1 stated if care plans are not followed, incidents may occur. During a concurrent interview and record review on 6/2/2026 at 3:49 p.m., with the Director of Nursing (DON), the IDT progress note dated 1/24/2026<br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was reviewed. The DON stated the IDT progress note indicated, Resident 1 was impulsive as he tried to get out of bed on his own (without calling for assistance) and had poor safety awareness. The DON stated the fall risk intervention of floor mats means floor mats are placed on both sides of the bed. The DON stated on 5/13/2025 after dinner, Resident 1 had a habit of sitting at the side of the bed and attempted to transfer on his own and was found sitting on the floor attempting to self-transfer from the bed to the wheelchair. The DON stated Resident 1's impulsive behavior contributed to his falls. The DON stated Resident 1 was supposed to have floor mats on each side of the bed incase he tried to get out of bed on the left side or the right side. The DON stated a care plan was a guide to provide the appropriate care, and without a care plan, they would not have a guide and would not be able to identify problems, have goals, and interventions. The DON stated Resident 1 was identified as having osteopenia, facility staff should create a care plan to alert the staff that Resident 1 has osteopenia and less bone density and even repositioning Resident 1 could break his bones. During a review of the facility's policy and procedures (P&P), Comprehensive Person-Centered Care Planning, effective date 9/7/2023, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest, physical, mental, and psychosocial well-being. During a review of the facility's P&P titled, Person-Centered Care Planning, effective date 5/22/2025, the P&P indicated person-centered care plan means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what is important to each resident with regard to daily routines and preferred activities and having an understanding of the resident's life before coming to reside in nursing facility. Interventions are actions, treatments, procedures, or activities designed to meet an objective. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her needs. The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. Comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. During a review of the facility's P&P titled, FA01 Fall Management Program, effective date 11/11/2025, the P&P indicated the facility will maintain an environment free of accident hazards, provide adequate supervision and assistive devices to prevent avoidable accidents, and implement an interdisciplinary fall prevention program that includes risk screening, individualized care planning, targeted interventions, and robust post-fall management. Falls: an event in which a person inadvertently comes to rest on the ground, floor, or lower level but not as a result of an overwhelming external force (e.g., resident pushes another resident). Avoidable accident: occurs when a facility fails to properly identify and address resident risks of environment hazards, implement and monitor appropriate interventions (such as supervision and assistive devices), and adjust the care plan as needed to reduce or eliminate risks in line with professional standards of practice. Purpose is to reduce the risk of avoidable falls and fall-related injuries and to ensure timely, evidence-based post-fall evaluation and management consistent with best practices, federal and state guidance requirements for resident safety, supervision, and quality of care. During a review of the facility's P&P titled, P-FA01 Fall Management Program, effective date 11/11/2025, the P&P indicated the Interdisciplinary Team (IDT) and/or licensed nurse will develop a care plan according to the identified risk factors. The licensed nurse will evaluate the Resident's response to the interviews<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | weekly and update the Resident's care plan as necessary. Once the Post -Fall Evaluation is completed the licensed nurse will update the care plan with recommendations. The Post-Fall Evaluation form and documentation of the post-fall investigation will go to the IDT meeting for review and updating of the care plan, as appropriate. The IDT will review the circumstances surrounding the fall then summarize their conclusions in an IDT note. The IDT will review and revise the care plan, as necessary. |