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	07/18/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of three sampled residents' (Resident 2 and Resident 44) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for psychotropics (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) was obtained prior to administration.This deficient practice violated Resident 2 and 44's rights to receive all information, in advance, of risks and benefits of proposed care, treatment, treatment alterative, and choose the alterative of choice which includes information for administration of psychotropic drugs.Findings: A. During a review of Resident 2's admission record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 2’s Minimum Data Set (MDS – a resident assessment tool), 6/24/2025, the MDS indicated was able to understand and be understood by others and was dependent (helper does all of the effort) for eating, toileting, bathing, and dressing. During a review of Resident 2’s Physician Order Summary, the Order Summary indicated the following: 1. Starting 3/20/2024, Resident 2 is incapable of making healthcare decisions. 2. Starting 2/5/2025, Apripiprazole (medication for bipolar disorder) five milligrams (mg- unit of measurement), every other evening for sudden shifts in mood from pleasant to extreme anger. 3. Starting 3/28/2025, Valporic Acid (medication for bipolar disorder) 250 mg/5 milliliters (ml unit of measurement for liquids), two times a day for extreme mood swings. During a concurrent interview and record review on 7/18/2025 at 11:40 a.m. with the Director of Nursing (DON), the DON stated the most recent informed consent for psychotropics for Resident 2 was dated 7/23/2024. The DON stated informed consents for psychotropics should be signed and updated every six months. The DON stated if informed consents for psychotropics are not obtained, there is a risk for unnecessary medication use and violating residents’ right to refuse. (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
	555668	A. Building B. Wing	07/18/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. During a review of Resident 44’s admission Record, the admission Record indicated Resident 44 was readmitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (mental health condition characterized by excessive fear and worry). During a review of Resident 44’s MDS, dated [DATE], the MDS indicated Resident 44’s cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was intact. During a review of Resident 44’s Order Summary Report as of 7/11/2025, the Summary report indicated the following: 1. Starting on 7/8/2025, Ativan (medication for anxiety) on mg, by mouth, every 12 hours as needed for verbalization of feeling anxious.2. Starting on 5/16/2025, Trazadone (medication for depression) 125 mg by mouth, at bedtime. During a concurrent interview and record review on 7/17/2025 at 3 p.m. with Registered Nurse (RN) 2, Resident 5's Informed consents for Ativan and Trazadone were reviewed. RN 2 stated both informed consents were incomplete and therefore not valid. RN 2 stated Ativan consent was missing the date and physician signature. RN 2 stated the Trazadone consent was also missing the date and physician signature. During an interview on 7/18/2025 at 3:30 p.m., with the DON, the DON stated informed consents should be obtained prior to the first dose of medication and need to be obtained by the medical provider who orders the medication. During a review of the facility’s policy and procedure (P&P) titled, “Informed Consent”, revised 6/27/2024, the P&P indicated It was the healthcare provider’s responsibility to obtain informed consent. During a review of the facility’s policy and procedure (P&P) titled, “Behavior/Psychoactive Medication Management”, revised 4/24/2025, the P&P indicated the residents written informed consent for treatment will be obtained and renewed every six months.

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	07/18/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct Interdisciplinary Team (IDT- a group of medical professionals from different disciplines who work together to help a resident achieve their goals) meetings quarterly and as needed for one of three sampled residents (Resident 32).This failure resulted in Resident 32 and Resident 32's Responsible Party (RP) to be unaware of the plan of care and experience worry while waiting for mammogram (x-ray of the breast to detect signs of breast cancer) results for three months. Findings: During a review of Resident 32's admission record, the admission record indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and kidney failure (condition where kidneys lose the ability to filter waste and fluid from the body). During a review of Resident 32's History and Physical (H&P), dated 6/1/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 6/18/2025, the MDS indicated Resident 32's cognition (ability to learn reason, remember, understand, and make decisions) was intact, required set-up assistance when eating, required maximal assistance (helper does more than half of the effort) for bathing and dressing, and was dependent (helper does all of the effort) for toileting. During a review of Resident 32's Physician Order Summary dated 7/18/2025, the Order Summary indicated on 3/6/2025, Resident 3 had an order for a diagnostic bilateral mammogram. During an interview on 7/15/2025 at 10:07 a.m. with Resident 32, Resident 32 stated she had a mammogram a few months ago, but has been worried because she has not received any results. During an interview on 7/15/2025 at 12:41 p.m. with Resident 32's Responsible Party (RP), the RP stated Resident 32 had a mammogram around May 2025 and has not heard any updates or results. The RP stated the last IDT meeting was over three months ago.During a concurrent interview and record review on 7/17/2025 at 1:57 p.m. with the Social Services Director (SSD), Resident 32's medical record was reviewed. The SSD stated Resident 32 had mammogram on 4/14/2025, and did not see results in Resident 32's medical record. The SSD stated the last IDT meeting was 3/19/2025. The SSD stated there should have been an IDT meeting in June 2025. The SSD stated it is important to have quarterly IDT meetings to update residents and their RP's of the plan of care. The SSD stated if there was an IDT meeting in June 2025, the mammogram results would have been discussed. During an interview on 7/18/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated IDT meetings are completed on admission, quarterly, and as needed. The DON stated IDTs are important to update residents and their families of the plan of care and give an opportunity for them to voice their concerns. During a review of the facility's policy and procedure (P&P), titled Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated the facility must provide the resident and representative, if applicable, reasonable notice of car planning conferences to enable resident and representative participation. The P&P indicated the care planning meeting will be documented in the clinical record.

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	07/18/2025

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility staff failed to inform, and give notice of and information of a room change for one of three sampled resident's (Resident 75) . This deficient practice had the potential to affect Resident 75's self-esteem, self-worth, and cause confusion due to sudden room change. Findings:During a review of Resident 75's admission Record, the admission Record indicated Resident 75 was originally admitted to the facility on [DATE] with diagnoses including encephalopathy (a change in the brain function due to injury or disease) unspecified, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) unspecified and muscle weakness (a reduced ability of muscles to generate force, making it harder to perform tasks that require effort, even with a maximal effort). During a review of Resident 75's history and physical (H&P) dated 11/9/2024, the H&P indicated resident 75 had fluctuating capacity to understand and make decisions. During a review of Resident 75's MDS (a residents assessment tool) dated 7/3/2025, the MDS indicated Resident 75 was dependent (resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) for toilet transfers, chair/bed to chair transfer, toilet hygiene, bathing, dressing the upper and lower body , eating, and oral hygiene. During an interview on 7/16/2025 at 2:24.p.m.,with Resident 75's family member (FM) 1, FM 1 stated, he often finds his son has been moved to a new room, with no prior notice. FM 1stated the facility does not notify him when Resident 1 has been moved to a different room. During an interview on 7/17/2025 at 10:15 a.m., with Registered Nurse 2 (RN 2), RN 2 stated the resident (general), and the resident's family must always be notified of a room change in advance. RN 2 stated we must explain why the room was changed because we must get their permission to make a room change, even if a resident is moving from bed A to bed B. During an interview and record review on 7/17/2025 at 2:02 p.m., with the Social Services Director (SSD) , Resident 75's medical records were reviewed. The SSD stated Resident 75 was transferred to a new room on the dates as follows -room [ROOM NUMBER] B on 1/8/2025-room [ROOM NUMBER] C on 3/2/2025 -room [ROOM NUMBER] B on 6/22/2025The SSD stated there was no documentation of prior notice to Resident 75 or his family of the room changes . The SSD stated when changing a resident's room, we notify the resident and if he is not the decision maker the family is notified, we must get their consent. The DDS stated when a resident is moved from bed A to bed B (in the same room) the resident and family still need to be notified. The SSD stated there was no documentation Resident 75 and his family were notified of the room changes on 1/8/2025, 3/2/2025 and 6/22/2025. The SSD stated it was important to notify the residents and family of room changes so they can know where their family member is going, to ensure the family is aware of his care. The SSD stated residents get used to their normal surroundings and changing their environment suddenly can be bad and we can upset the family. During an interview on 7/18/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated when we make room changes we must notify the resident if he is the person responsible, if not we must notify the residents responsible party. The DON stated the individual must know the reason for the move and can refuse to be moved, since it is their home and their right. The DON stated this must be charted in the social nurse's notes giving the reason for the room change, this is the residents' right. During a review of the facility's P&P titled Room or Roommate Change revised on March 2018, the P&P indicates to ensure that a resident is able to exercise his/her right to change rooms or roommates. Prior to changing a room or roommate assignment , the resident, the resident's representative (if available), and the resident's new roommate will be provided timely advance notice of such a change.

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	07/18/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure there was an appropriate indication for the use of antipsychotic (medication used to treat mental illness) medication for one of six sampled residents (Resident 4) when Resident 4 had haloperidol (a medication used to treat certain mental health) on an as-needed (prn) basis without a specific diagnosis or documented justification for administration of haloperidol. The deficient practice had the potential for use of unnecessary medications on Resident 4.Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 9/30/2021, and readmitted on [DATE] with diagnoses including depression (a mental health condition characterized by persistent sadness and a loss of interest in activities that were once enjoyable) and vascular dementia (mental illness marked by a decline in thinking skills caused by condition that disrupt blood flow to the brain, leading to damage in blood vessels and brain tissue). During a review of Resident 4's physician Progress note, dated 5/19/2025, the progress note indicated that Resident 4 did not have the capacity to understand and make medical decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 7/2/2025, the MDS indicated that Resident 4's cognitive (to think, pay attention, process information, and remember things) ability was severely impaired. The MDS indicated that Resident 4 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene. During a review of Resident 4's Order Summary Report, orders as of 7/16/2025, the Order Summary Report indicated starting 7/12/2025, administer Haloperidol 0.5 milligram (mg-unit does) by mouth every 8 hours as needed for anxiety manifested by agitation During a concurrent interview and record review on 7/17/2025 at 8:50 a.m., with Registered Nurse (RN) 1, Resident 4's Order Summary Report, orders as of 7/16/2025 were reviewed. RN 1 stated that the physician ordered Haloperidol, an antipsychotic medication, for Resident 4's anxiety. RN 1 stated that Resident 4 did not have a specific diagnosis supporting antipsychotic use. RN 4 stated staff should verify the order with the ordering physician for the right indication for antipsychotic use or it could lead to misuse of antipsychotic causing side effects such as sedation. During an interview on 7/18/2025 at 3:23 p.m., with the Director of Nursing (DON), the DON stated that staff needed to avoid unnecessary use of antipsychotic medications, and if there was no specific diagnosis, and condition for the use of antipsychotic medications, the medications should be discontinued to avoid harm. The DON stated, if she was the resident, she would not want Haloperidol administered to her without the proper indication. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic medications, revised 4/24/2025, the P&P indicated the following:1. Anti-psychotic medications are to be used only to treat specific mental health diagnoses.2. Antipsychotic and antidepressant medications are not to be administered on a prn (as needed) basis.3. Antipsychotic medications may be used to treat the following conditions:i. Schizophreniaii. Schizoaffective disorderiii. Schizophreniform disorderiv. Tourette's disorderv. Huntington's diseasevi. Nausea, hiccups, itchingvii. A physical behavior problem which causes the resident to:a. Present a danger to self or others, orb. Interferes with resident's ability to participate in the plan of care.viii. Psychotic symptoms such as hallucinations or delusions which impair the resident's functional capacity (eating, sleeping, toileting, etc.).4. Anti psychotic medications should not be used if one or more of the following conditions is the only manifestation: restlessness, nervousness, fidgeting.

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	07/18/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document the 's Minimum Data Set (MDS - a resident assessment tool) for one of five sampled residents (Resident 3). This failure had the potential to result in a delay of care or not receiving the appropriate services or treatment. Findings: During a review of Resident 3's admission record , the admission record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cellulitis (a skin infection that causes swelling and redness) of left finger, sepsis (a life-threatening blood infection), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of hands, knees, and elbows. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 4/3/2025, the MDS indicated Resident 3's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired, and was dependent (helper does all of the effort) for eating, toileting, bathing, and dressing. During a review of Resident 3's Physician Order Summary, the Order Summary indicated Resident 3 has an order for oxygen as needed at 2 liters (L-unit of measurement)/minute starting 3/12/2025. During a concurrent interview and record review on 7/18/2025 at 12:09 p.m. with the MDS Coordinator (MDSC), Resident 3's medical record was reviewed. The MDSC stated if the MDS data was submitted on 4/3/2025, they would have reviewed and referenced observations and documented data during the date range of 3/21/2025 to 4/3/2025. The MDSC stated Resident 3's medical record indicated oxygen use on 3/21/2025, 3/22/2025, 3/23/2025, 3/28/2025, and 3/29/2025. The MDSC stated the MDS dated [DATE] does not indicate or reflect Resident 3 uses oxygen. The MDSC stated it was miscoded and should have indicated that Resident 3 uses oxygen. The MDSC stated it is important that the MDS accurately reflects the residents to show what treatment is ordered and received. During an interview on 7/18/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated it the MDS is not accurate, there is a risk that the resident may not be receiving the appropriate services or treatment. During a review of the facility's policy and procedure (P&P), titled RAI Process, dated 10/04/2016, the P&P indicated the facility is to provide resident-assessments that accurately depict and identify resident specific issues and objectives as required.

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	07/18/2025

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 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 develop a person-centered care plan for one of two sampled residents (Resident 4) for the used of antipsychotic medication, haloperidol (a medication used to treat certain mental health illnesses) .This failure had the potential to result in inappropriate medication use, lack of behavioral monitoring, and increased risk of adverse drug effects. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 9/30/2021, and readmitted on [DATE] with diagnoses including depression (a mental health condition characterized by persistent sadness and a loss of interest in activities that were once enjoyable) and vascular dementia (decline in thinking skills caused by condition that disrupted blood flow to the brain, leading to damage in blood vessels and brain tissue). During a review of Resident 4's physician Progress note, dated 5/19/2025, the progress note indicated Resident 4 did not have the capacity to understand and make medical decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 7/2/2025, the MDS indicated Resident 4's cognitive (functions your brain uses to think, pay attention, process information, and remember things) ability was severely impaired. The MDS indicated Resident 4 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene.During a review of Resident 4's Order Summary Report, orders as of 7/16/2025, the Order Summary Report indicated that starting 7/12/2025, administer Haloperidol 0.5 milligram (mg-unit does) by mouth every 8 hours as needed for anxiety manifested by agitation During a concurrent interview and record review on 7/17/2025 at 8:50 a.m., with Registered Nurse (RN) 1, Resident 4's care plan, as of 7/17/2025 was reviewed. RN 1 stated there was no care plan for Haloperidol, an antipsychotic medication use for Resident 4. RN 1 stated that a care plan was essential as it outlines the care needed, what staff should monitor, such as behaviors the medication is being used for, and provides the basis for the use of antipsychotics.During an interview on 7/18/2025 at 3:23 p.m., with the Director of Nursing (DON), the DON stated that staff needed to develop a person-centered care plan for the use of antipsychotic medications on residents.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated followings:1. 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. 2. Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident.3. The comprehensive care plan will also be reviewed and revised at the following times: a. Onset of new problems, b. To address changes in behavior and care; and c. Other times as appropriate or necessary. During a review of the facility's P&P titled, Behavior/Psychoactive Medication Management, revised 4/24/2025, the P&P indicated that the IDT will reassess the effectiveness of the psychoactive medication at least quarterly during the IDT Care plan meeting, or psychoactive behavior management committee.

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	07/18/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of two sampled residents' (Resident 40) care plan for smoking was updated. The deficient practice had the potential to result in poor quality of care and a delay in care and services.Findings:During a review of Resident 40's admission Record, the admission record indicated Resident 40 was originally admitted to the facility on [DATE] with diagnosis including acute respiratory failure (when the air sacs of the lungs cannot release enough oxygen into the blood), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 40's Minimum Data Set ([MDS] a resident assessment tool) dated 5/16/2025, the MDS indicated Resident 40's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 40 needed set up assistance when eating and oral hygiene supervision with toileting hygiene and partial assistance (helper does less than the effort to perform task) with showring and personal hygiene. During a review of Resident 40's Smoking and Safety, dated 5/13/2025, the document indicated Resident 40 was a smoker.During a review of Resident 40's Order Summary as of 7/17/2025, the summary indicated, starting 7/10/2025, Oxygen at 1-5 liters/minute via nasal canula (device that supplies oxygen through the nose) as needed for shortness of breath. During an observation on 7/15/2025 at 1:18 p.m., in the designated smoking patio, Resident 40 was observed with a nasal canula hanging on his chest. During a concurrent interview and record review on 7/17/2025 at 2:15 p. m. with Registered Nurse (RN) 2, Resident 40's smoking care plan, initiated 5/10/2025, was reviewed. RN 2 stated Resident 40's care plan did not indicate interventions to address Resident 40's oxygen use. RN 2 stated the care plan should have been updated when Resident 40 started using oxygen.During an interview on 7/18/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the interventions to residents' smoking care plans need to be updated and individualized to prevent risk for fire, for the residents and all the residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated a comprehensive, person-centered care plan must be reviewed and revised periodically, based on assessed needs of the resident.

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	07/18/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one out of three residents (Resident 44) received assistance with toileting hygiene as needed. The deficient practice had the potential increased risk of skin breakdown and loss of dignity.Findings:During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was readmitted to the facility on [DATE] with diagnoses including weakness, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 44's Minimum Data set ([MDS], A resident assessment tool), dated 6/25/2025, the MDS indicated Resident 44's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was intact. The MDS indicated Resident 44 needed moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene.During a concurrent observation and interview on 7/15/2025 at 9:45 a.m., with Resident 44 in her room, Resident 44 was observed sitting in bed in her night gown. Resident 44 stated getting help to get cleaned and assistance with toileting hygiene takes a while. Resident 44 stated she has been wet with urine since 5 a.m. and the staff knew about the resident's need for assistance.During an interview on 7/15/2025 at 9:48 a.m. with Certified Nurse Assistant (CNA)1, CNA 1 stated she was aware Resident 44 needed to be changed. CNA 1 stated she arrived at 6:30 a.m. and was busy with another resident. During an observation on 7/15/2025 at 10:00 a.m., with Resident 44, in Resident 44's room, CNA 1 was observed assisting Resident 44 with toileting and personal hygiene.During an interview on 7/18/2025 at 3:30 p.m., with the Director of Nursing (DON), the DON stated all residents should be assisted with toileting hygiene because as we age balance and coordination is different, and the residents need supervision. The DON stated not assisting the residents can put residents at risk for falls, infection, poor self-esteem, and skin breakdown. During a review of the facility's policy and procedure (P&P) titled, Grooming, revised 1/1/2012, the P&P indicated the Facility will work with residents to promote hygiene, comfort, self-esteem and dignity by assisting with the appropriate types and amount of assistance.During a review of the facility's P&P titled, Resident Rights - Accommodation of Needs, revised 1/1/2012, the P&P indicated the facility will provide services that meet residents' individual needs.

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	07/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	07/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents with a diagnosis of Diabetes Meletus Type II (DM - a condition wherein the body can not regulate consumption and use of sugar which may result in poor wound healing) (Resident 28)'s:a. Physician was notifiedb. Change of condition (COC) was initiatedWhen Resident 28 had repeated hyperglycemic (level of blood sugar is higher are higher than normal [reference range70-99 milligram/deciliter (mg/dL- a unit of measurement used to express blood glucose levels) mg/dl]) events. This failure had the potential to result in delayed interventions, life-threatening emergencies such as diabetic ketoacidosis (a serious complication of diabetes where the body starts breaking down fat for energy instead of sugar at a very fast rate, producing substances that are harmful to the body), resulting in dehydration, potentially life -threatening conditions.Findings: During a review of Resident 28's admission Record, the admission Record indicated the facility admitted Resident 28 on 1/7/2022 and readmitted on [DATE] with diagnoses including type two diabetes mellitus (DM- a condition where your blood sugar levels are too high) and chronic obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breathe). During a review of Resident 28's History and Physical (H&P), dated 6/6/2025, the H&P indicated Resident 28 did not have the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated 6/2/2025, the MDS indicated Resident 28 was severely cognitively (to think, pay attention, process information, and remember things) impaired. The MDS indicated Resident 28 was dependent (helper does all the effort) on staff with oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 28's Order Summary Report, orders as of 7/15/2025, the Order Summary Report indicated the following physician orders:a. Starting 6/13/2025, Humulin R (a short acting medication used to lower and regulate blood sugar levels) solution 100 unit/milliliter (unit/ml-a measure of a substance) inject subcutaneously (administer under first layer of skin) four times a day for DM as per sliding scale (a tool used to manage diabetes by adjusting insulin doses based on current BS levels) If BS is <60 mg/dL, call MD.If BS is 60-250 mg/dL, give 0 unit of Humulin RIf BS is 251-300 mg/dL, give 2 units of Humulin R.If BS is 301-350 mg/dL, give 3 units of Humulin R.If BS is 351-400 mg/dL, give 4 units of Humulin R.If BS is 401-500 mg/dL, give 5 units of Humulin R and call the physician.b. Starting 6/6/2025, inject Lantus (a long acting medication to treat DM) Solution 20 units subcutaneously at bedtime for DM, rotate injection sites, and hold if BS is less than 100 mg/dL. During a concurrent interview and record review on 07/17/2025 at 12:13 p.m., with Registered Nurse (RN)1, Resident 28's Medication Administration Record (MAR) and change of condition (COC) assessment, for the months of May, June and July 2025 were reviewed. RN 1 stated that staff need to call the physician when the blood sugar level is lower than 60mg/dL or above 401mg/dL, as these are considered critical values and a change of condition unless the physician indicates other wise. RN 1 stated if Resident 28 has a hyperglycemic episode, staff must assess Resident 28 and document on the SBAR, notify the physician and RP, and follow up with 72-hour monitoring of Resident 28 to allow for early intervention and prevent a life-threatening emergency. RN 1 stated that Resident 28 had multiple hyperglycemic episodes and staff did not assess the Resident 28 using SBAR form (for the COC), staff did not monitor Resident 28 for 72-hours after the hyperglycemic episodes, and staff did not notify the physician and family on following days of Resident 28's hyperglycemic episodes: On 7/16/2025 at 5:36 a.m., 420mg/dL On 7/16/2025 at 11:17a.m. 471mg/dL On 6/8/2025 at 8:33 p.m. 441mg/dL On 5/1/2025 at 11:21 425mg/dL, at 8:50p.m. 528mg/dL On 5/4/2025 at 9:00 p.m. 489mg/dL On 5/6/2025 at 12:19 p.m. 459mg/dL On 5/11/2025 at12:30 a.m. 474mg/dL, at 4:57p.m. 471mg/dL, at 8:25 p.m. 471mg/dL On 5/15/2025 at 11:54 a.m. 499mg/dL On 5/16/2025 at 11:30 a.m. 457mg/dL On 5/17/2025 at 12:45 p.m. 485mg/dL On 5/18/2025 at 12:22 p.m. 485mg/dLDuring an interview on 7/18/2025 at 3:23 p.m., with the Director of Nursing (DON), the DON stated that staff needed to call the physician when a resident was hyperglycemic episode, when BS is above 400mg/dL, it's a change of condition and the SBAR should be assessed for early intervention and monitoring. During a review of the facility's policy and procedure (P&P) titled, Diabetic Care, revised 1/2012, the P&P indicated that in any case where the resident's blood sugar is less than 70mg/dL or greater than 350 mg/dL, the attending physician must be notified: unless otherwise noted on the Physician's order. A Licensed Nurse must notify the resident and/or the resident's family/representative of blood glucose results beyond the defined parameters. During a

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	07/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	07/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement accident risks and hazard interventions for two of Three sampled residents (Resident 38 and Resident 75) by: 1.Failed to ensure there was no smoking sign for a Resident 38 who is on oxygen.2.Failed to ensure Resident 75's bed was in the lowest position.3.Failing to ensure Resident 75 was placed in a low bed (a bed frame designed to sit closer to the ground than a traditional bed). This deficient practice had the potential to result in injury . Findings:a.During a review of Resident 38's admission Record, the admission Record indicated, Resident 38 was initially admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a long term lung disease that blocks airflow to the lungs making it difficult to breathe), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood) and hypertension(high blood pressure). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 38's cognitive (mental action or process of acquiring knowledge and understanding) skills were moderately impaired. The MDS indicated Resident 38 was dependent (resident does none of the effort to complete the activity) with toilet hygiene, shower/bathe self, personal hygiene, substantial/maximum assistant (helper lifts, holds or supports trunk or limbs but provide less than half the effort) with oral hygiene lower and upper body dressing. The MDS indicated, Resident 38 receives oxygen therapy. During a review of Resident 38's Order Summary report (OSR) dated [DATE], the OSR indicated an order for oxygen at 2 liters per minute (the unit used to measure the flow rate of oxygen being delivered to a patient) by nasal cannula(a thin flexible tube with two prongs that are inserted into the nostrils to deliver oxygen) maintain oxygen saturation (a measure of how much oxygen is carried in your blood) above 94% every shift. During a concurrent observation and interview on [DATE] at 10:24 a.m., Resident 38 was in bed and one tank of oxygen was next to the bedside there was no No Smoking sign present. Licensed Vocational Nurse (9) stated there needed to be a no Smoking Sign on resident 38's door as she was taping the no smoking sign to the wall next to resident's room door. During an interview on [DATE] at 09:30 a.m., with Registered Nurse 2 (RN 2), RN 2 stated when residents are on oxygen there needs to be a sign letting everyone know the resident is on oxygen RN 2 stated this can be dangerous if someone had a flammable object. RN 2 stated it is everyone's responsibility to make sure there is a sign indicating oxygen use. During an interview on [DATE] at 2:30 p.m., with the Director of Nursing (DON), the DON stated there needs to be a sign so everyone can be aware the resident is on oxygen because oxygen is highly flammable, and this can cause a fire . DON stated it is everyone's responsibility to make sure a sign is on the wall of a resident who is receiving oxygen. b.During a review of Resident 75's admission Record, the admission Record indicated Resident 75 was originally admitted to the facility on [DATE] with diagnoses including encephalopathy (a change in the brain function due to injury or disease) unspecified, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) unspecified and muscle weakness (a reduced ability of muscles to generate force, making it harder to perform tasks that require effort, even with a maximal effort) and epilepsy (a brain disorder that causes recurrent seizures), unspecified, not intractable(hard to control), without status epilepticus (prolong or multiple seizures {a disruption of normal brain activity, causing unusual movements) . During a review of Resident 75's history and physical (H&P) dated [DATE], the H&P indicated resident 75 has fluctuating capacity to understand and make decisions. During a review of Resident 75's MDS (a residents assessment tool) dated [DATE], the MDS indicated Resident 75 was dependent (resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) on toilet transfer, chair/bed to chair transfer, toilet hygiene, bathing, dressing the upper and lower body , eating, and oral hygiene. During a record review of Resident 75's Care Plan Report (CPR) dated [DATE], the CPR indicated the resident is high risk for falls related to epilepsy, unspecified and potential for injury dated [DATE] with an intervention place personal items within reach , increased monitoring/more frequent checks, low bed , bed at right height, bed alarm bed moves to more observable area for increased supervision. During an observation and interview on [DATE] at 11:00 a.m. with the Certified Nurse Assistant (CNA) Resident 75 was in bed, the bed was raised at a high position. CNA stated I was told Resident 75's bed should be in a low position because of his seizures he can fall and be injured. During interview [DATE] at 10:15 a.m. with the Registered Nurse 2 (RN 2), RN 2 stated it is the RN's responsibility to assess the resident for fall risk resident 75 is at risk for seizures and should

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	07/18/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Facility failed to ensure that the urinary catheter bag (a urine drainage bag is a small bag that collects urine when you have a catheter inserted into your bladder) for one of three sampled residents (Resident 8) did not touch the floor.This failure had the potential to result in contamination of the catheter system and an increased risk of urinary tract infection (UTI an infection in your urinary system, which includes your kidneys, bladder, and urethra) or other complications for Resident 8.Findings: During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 3/18/2025 with diagnoses including multiple sclerosis (a chronic, often disabling disease that attacks the central nervous system [brain and spinal cord]), malignant neoplasm (a cancerous tumor) of bladder and Extended-spectrum beta-lactamase (ESBL an antibiotic resistant infectious organism). During a review of Resident 8's History and Physical (H&P), dated 3/19/2025, the H&P indicated, Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 5 required maximal assistance (helper does more than half the effort to complete task) with toileting hygiene, showering, lower body dressings, putting on/taking off footwear, personal hygiene, moderate assistance (helper does less than half the effort to complete the task) with upper body dressing, supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with oral hygiene and supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with eating. During a review of Resident 8's Order Summary Report, orders as of 7/15/2025, the Order Summary Report indicated the following physician orders:a. Starting 3/26/2025, change foley catheter, every day shift starting on the 15th and ending on the 15th of every month.b. Starting 3/26/2025, change urinary catheter bag per schedule when foley is changed and as needed (foley catheter change schedule), set to same date as foley catheter change schedule. During a concurrent observation and interview on 7/15/2025 at 10:25 a.m., with licensed Vocational Nurse (LVN) 3, in Resident 8's room, Resident 8's urinary catheter bag touched the floor. LVN 3 stated that the urine bag was touching the floor, which could lead to infection. During a concurrent interview and record review on 7/16/2025 at 12:37 p.m., with Registered Nurse (RN) 1, Resident 8's treatment administration record (TAR), dated July 2025 and June 2025, were reviewed. RN 1 stated Resident 8 was a high risk for getting a UTI. RN 1 stated that staff should make sure the urine bag, including the dignity bag, was not touching the floor to prevent Resident 8 from getting a UTI. During an interview on 7/18/2025 at 3:23 p.m., with the Director or Nursing (DON), the DON stated the urine bag should be kept off the floor for infection control. During a review of the facility's P&P titled, Job Description Manual- Certified Nursing Assistant (CNA), undated, the P&P indicated that CNA must keep the drainage bag off the floor when resident is in bed or in wheelchair. During a review of the facility's P&P titled, Job Description Manual - Charge nurse, undated, the P&P indicated charge nurse must ensures that all safety and infection control practices are followed and supervise to assures that all personnel follow established Infection control practices.

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	07/18/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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	07/18/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) orders, in accordance with physician orders and facility policy and procedures (P&P) titled, Feeding Tube - Medication Administered, for one of five sampled residents (Resident 28) by failing to ensure: (Cross Reference F726, F759 and F760) Resident 28's GT placement was checked by aspiration prior to medication administration via GT Resident 28's GT was flushed with prescribed amount of water before medication administration Resident 28 was administered medication via GT by gravity (utilizing the natural downward pull of gravity to deliver the medication into the stomach through the GT/feeding tube) in accordance with facility's P&P This deficient practices had the potential to increase the risk of medication errors, which could result in Resident 28's GT becoming clogged (blocked), dislodged, causing pain, discomfort, harm, delay in care or hospitalization of the resident. Findings:During a review of Resident 28's admission Record (facesheet) , the admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dysphagia (difficulty swallowing), DM II, epilepsy (is a neurological condition that causes unprovoked, recurrent seizures [is a sudden rush of abnormal electrical activity in the brain]), hypertension (HTN, high blood pressure), blindness, right eye, and gastrotomy status (GT)During a review of Resident 28's Minimum Data Set ([MDS] a resident assessment tool) , dated 6/2/2025, the MDS indicated Resident 28's cognitive skills for daily decisions making was severely impaired (ability to think and reason). The MDS indicated Resident 28 was dependent and required two or more staff physical assistance for all ADL.During a review of Resident 28's History and Physical (H&P) dated 6/6/2025, indicated the resident does not have the capacity to understand and make decisions. During a review of an Order Summary with active orders as of 7/16/2025 included the following orders for:1. Enteral Feed Order every shift check for placement (ensures the tube is correctly placed into the stomach), patency (involves verifying the GT's ability to drain stomach contents, flush with water, and assessing for any signs of blockage or dislodgement, where the GT comes out of the stomach) and residual (measuring the amount of stomach contents remaining in the stomach before a feeding or medication administration). If residual is more than 60 milliliters (ml, unit of measurement by volume) or reaches an amount indicated by the physician hold feeding until residual diminishes, order date 6/6/20252.Enteral Feed Order every shift flush tube (GT) with 50 ml water, order date 6/6/20253.Enteral Feed Order every shift flush GT with 10 ml to 15 ml water between medications4.Clopidogrel (used to prevent blood clots) Oral Tablet 75 mg, give one tablet via GT one time a day for cerebrovascular accidents (CVA or stroke), order date 6/6/20255. Gabapentin Capsule 300 mg, give one capsule via GT three times a day for Neuropathic pain (nerve pain), order date 6/6/20256.Losartan Potassium Tablet 50 mg, one tablet via GT one time a day for HTN. Hold if SBP is less than 110 mmHg, or HR is less than 60 bpm, order date 6/6/20257.Oxcarbazepine Oral Suspension 300 mg/ 5ml, give 15 ml via GT two times a day for seizures (900 mg = 15 ml), order date 6/6/20258.Keppra (Levetiracetam) Oral Solution 100 mg.ml, give 15 ml via GT two times a day for seizure, order date 6/6/20259.Dilantin (Phenytoin) Oral Tablet Chewable 50 mg, give four (4) tablets (200 mg) via GT two times a day for seizure disorder, order date 6/24/202510.Aspirin 81 mg Oral Tablet Chewable, give one tablet via GT one time a day for CVA prophylaxis (preventative treatment), order date 6/6/2025During a review of Resident 28's Care Plan (CP) included the following interventions:1.The resident has hypertension (HTN) related to (r/t) inappropriate diet and lifestyle choices. Medication use: Losartan Potassium Tablet 50 mg. Give one tablet by mouth one time a day for HTN hold if systolic blood pressure less than 110 mmhg (unit of pressure), give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure that occurs upon standing from a sitting or lying down position) and increased heart rate (Tachycardia) and effectiveness. Date initiated: 5/23/2025.2.The resident requires GT feeding r/t Dysphagia, chewing problem.The resident needs the head of the bed (HOB) elevated 45 degrees during and thirty minutes after GT feed. Check for GT placement and gastric contents/residual volume per facility protocol and record.Monitor/document/report as needed (PRN) and signs and symptoms (s/sx) of aspiration, fever, shortness of breath (SOB), GT dislodged, infection at GT site, self-extubation (removal of a GT by a patient/resident), GT dysfunction or malfunction, abnormal breath/lung sounds, abnormal laboratory (lab) values, abdominal pain, distension, tenderness, constipation or fecal impaction

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	07/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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	07/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of three sampled residents (Resident 28 and 53) by not following the facility's own policy and procedure. a. For Resident 28, Facility failed to receive the physician's order for the use of oxygen and date on the nasal cannular (NC- a simple device used to deliver oxygen to the nose) while in use. b. For Resident 53, Facility failed to date on the NC while in use. a. During a review of Resident 28's admission Record, the admission Record indicated the facility admitted Resident 28 on 1/7/2022 and readmitted on [DATE] with diagnosis including chronic obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breathe). During a review of Resident 28's History and Physical (H&P), dated 6/6/2025, indicated, Resident 28 did not have the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated 06/2/2025, indicated Resident 28 was cognitive (functions your brain uses to think, pay attention, process information, and remember things) was severely impaired. The MDS indicated Resident 28 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 28's Order Summary Report, orders as of 7/15/2025, the Order Summary Report indicated that there was an order from 5/22/2025 administer 2 to 5-liter (L-unit dose)/min (every minute) via (by way of) NC to keep oxygen saturation (the percentage of oxygen carried by hemoglobin in your blood) above 92% (readings between 90% and 94% might be acceptable for some individuals with chronic conditions) and the order was discontinued on 6/6/2025. During a concurrent observation and interview on 07/15/2025 at 1:18 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 28's room, observed Resident 28 wearing a NC. LVN 2 stated Resident 28 was receiving one L/min oxygen though the NC. LVN 2 stated that the date written on the NC was after the observation date, written as 7/22/2025 and LVN 2 stated that the date did not make sense, it should be changed once a week and as needed to prevent bacteria collection and prevent infection. During a concurrent interview and record review on 7/16/2025 at 2:50 p.m. with Registered Nurse (RN) 1, Resident 28's Order Summary Report, as of 7/15/2025 was reviewed. RN 1 stated that oxygen is a medication requiring the physician's order to use, but there was no oxygen order for the resident to use during the previous observation date. RN 1 stated that COPD residents could receive more oxygen than needed when they received oxygen without the order, which can cause respiratory problems. RN 1 also stated that the NC should be changed weekly and dated to prevent the infection. b. During a review of Resident 53's admission Record, the admission Record indicated the facility admitted Resident 53 on 1/24/2023, and readmitted on [DATE] with diagnoses including chronic pulmonary edema (along-term buildup of fluid in the lungs, making it hard to breathe, especially during physical activity or when lying down) and pleural effusion (when there's too much fluid buildup in the space between your lungs and your chest wall). During a review of Resident 53's Minimum Data Set (MDS- a resident assessment tool), dated 5/27/2025, indicated Resident 53 was cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 53 required supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with eating, maximal assistance (helper does more than half the effort to complete task) with oral hygiene, upper body dressing, personal hygiene, was dependent (helper does all of the effort) with toileting hygiene, showering, lower body dressing, and putting on/ taking off foot wear. During a review of Resident 53's Physician Order Report: active orders as of 7/15/2025, the report indicated the following:1. Starting 5/31/2025, administer oxygen 2-5L/min, titrate via NC to keep oxygen saturation above 92% for shortness of breath related to the pleural effusion diagnosis. 2. Starting 5/31/2025, change oxygen tube every Saturday night shift.During a concurrent observation and interview on 7/15/2025 at 1:13 p.m. with LVN 7 in the hallway by the outside of Resident 53's door, observed Resident 53 sitting in a wheelchair and receiving oxygen via NC. LVN 7 stated that Resident 53 was receiving oxygen 3 L/min, there was no date marked on the NC. LVN 7 stated that the NC should be dated to indicate when to replace it, it could be there for a long time.During a concurrent interview on 07/16/2025 at 2:50 p.m. with Registered Nurse (RN) 1, RN 1 stated that staff should date on Resident 53's NC upon placement to prevent the infection. During an interview on 7/8/2025 at 3:23 p.m. with the Director of Nursing (DON), the DON stated that oxygen is a medication, staff need to get the physician's

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	07/18/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents (Resident 5) received dialysis care and services based on professional standards. The facility failed to:a. Ensure Resident 5's fluid intake was being monitored.b. Ensure Resident 5 was assessed after the resident returned from the dialysis center. These deficient practices had the potential to result in complications from dialysis like fluid overload, infection and low blood pressure. Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis.During a review of Resident 5's Minimum Data Set (MDS), a resident assessment tool, dated 6/4/2025, the MDS indicated Resident 5's cognition (ability to think) was intact. The MDS indicated Resident 5 needed supervision with eating and oral hygiene and was dependent (helper does all the effort to complete task) on staff for showering, personal hygiene, and toileting hygiene. During a review of Resident 5's Physician Order Report: active orders as of 7/17/2025, the report indicated the following:1. Starting 6/30/2025, hemodialysis procedure to an outpatient dialysis center Monday, Wednesday, Thursday, and Friday. 2. Starting 7/15/2025, fluid restriction of 1000 milliliters in 24 hours, dietary to provide 360 milliliters, and Nursing 7 a.m. to 3 p.m. shift to provide 340 milliliters, 3 p.m. to 11 p.m. shift to provide 200 milliliters, and 11 p.m. to 7 a.m. shift to provide maximum of 100 milliliters.During an observation and interview on 7/15/2025 at 11:37 a.m. with Activities staff (AS)1, Resident 5 was noted with a filled water pitcher at Resident 5's bedside table. AS 1 stated confirmed Resident 5 had a pitcher at the bedside. During an interview and record review on 7/15/2025 at 3:10 p.m. with Registered Nurse (RN) 2, Resident 5's Dialysis Binder, Post Dialysis Evaluations, and nurse progress notes for 7/2025 were reviewed and Resident 5's assessment after coming back from dialysis on 7/4/2025, 7/7/2025, 7/9/2025, 7/10/2025, 7/11/2025, and 7/14/2025 were not completed. RN 2 stated the residents coming back from dialysis need to be assessed to ensure the resident was stable after dialysis treatment. RN 2 stated Resident 5 should not have a pitcher at the bedside to ascertain fluid intake was being monitored.During an interview on 7/18/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated residents need to be assessed after returning from dialysis treatment because they go through rigorous fluid removal which makes them high-risk for complications like bleeding or hypotension (low blood pressure). The DON stated if the assessment was not documented it was not done. The DON stated dialysis residents should not have a pitcher at the bedside because staff need to monitor intake to avoid fluid overload (too much fluid in the body). During a review of the facility's policy and procedure (P&P) titled, Dialysis Management revised 1/25/2024, the P&P indicated the following: 1. The facility should ensure that each resident receives care and services consistent with professional standards of practice. 2. Post dialysis evaluation will be completed by the licensed nurse. 3. Fluid restrictions will be followed as ordered.

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	07/18/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 was competent in administering medication via a gastrostomy tube (GT and/or Enteral Feeding Tube, a tube inserted through the abdomen that delivers nutrition and/or medication directly to the stomach) in accordance with the facility's policy and procedure (P&P) titled, Medication Administration with Enteral Formulas Competency Validation.This failure had the potential for the facility not to be able to assess the skills necessary to provide services to assure resident safety.Findings:During a concurrent interview and record review on 7/17/2025, at 2:54 p.m., with Director of Staff Development (DSD), reviewed Licensed Vocational Nurse (LVN) 2 employment file. DSD stated new hire staff are followed for hand hygiene. DSD stated she follows staff during competency review for simple medication pass observation with return demonstration. DSD stated GT/Feeding Tube medication administration requires a return demonstration and is documented on a form titled, Medication Administration with Enteral Formulas Competency Validation. DSD stated LVN 2's Medication Administration with Enteral Formulas Competency Validation was not on file and was missing. DSD stated LVN 2 competencies should be in the employee records.During a concurrent interview and record review on 7/17/2025, at 3:23 p.m., with DSD and the Director of Nursing (DON), inside of the DON's office, reviewed LVN 2 employment file, DON stated for LVN 2 she did not see a Medication Administration with Enteral Formulas Competency Validation, on file. The DSD stated for LVN 2 there was no Medication Administration with Enteral Formulas Competency Validation, inside of LVN 2's employee records and there should have been. The DON stated, she had not looked at LVN 2's employee file and did not know if LVN 2 had complete a Medication Administration with Enteral Formulas Competency Validation. The DSD stated she forgot to document a review date on some of LVN 2's new hire competencies. DSD acknowledged there was no review date on the following initial competencies for LVN 2: - Hand Hygiene (Hand Washing) Competency Validation- Medication Administration Competency Validation- Head to Toe Assessment Competency Validation During an interview on 7/17/2025 at 3:42 p.m., with the DSD and the DON, the DSD stated the facility does not have documentation of which nursing station the new hire nurse (LVN 2) was orientated on. The DON stated the LVNs, including LVN 2 must be orientated for the station she/he will work on to know the diagnoses and the residents she/he are taking care of.During a review of the facility's undated form titled, , Medication Administration with Enteral Formulas Competency Validation, include a spaces for initial, annual, and re-evaluation, date of review, date of hire, and if competency rating was met or not met. Facility's form, Medication Administration with Enteral Formulas Competency Validation, indicated the competency description required the licensed nurse, To be able to pass medications safely and in accordance with the physician order when the resident cannot take medication orally. During a review of facility's P&P titled Personal Protective Equipment, dated 1/2012, the P&P indicated, Facility Staff receive training relative to the use of gloves and other protective equipment prior to being assigned tasks that involve potential exposure to blood or body fluids and when new or modified protective equipment or procedures are introduced into the workplace.During a review of the facility's P&P titled, Hand Hygiene, dated 9/2020, the P&P indicated, Facility staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections (HAI)

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	07/18/2025

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 - Some	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 observations, interview, and record review the facility failed to:A. Document one dose of Acetaminophen in the July 2025 Medication Administration Record ([MAR] - a record of mediations administered to residents) for Resident 1B. Maintain accurate accountability records for controlled medication ([CM]- medications which have a potential for abuse and may also lead to physical or psychological dependence), Tramadol on 7/16/2025 and 7/17/2025 for Resident 4 in one of two inspected medication carts (East Station Medication Cart)C. Ensure one of one resident (Resident 44) received lactulose (medication to treat constipation) as needed for no bowel movement in 48 hours. These failures increased the risk of medication errors for Residents 1, 4, and 44 to receive more or less medications than prescribed, adverse reactions (harmful or unpleasant reaction, resulting from an intervention related to the use of a medication) such as: uncontrolled pain, constipation, harm, and inability to readily identify the loss or drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of controlled medications.Findings: A. During a review of Resident 1's admission record (facesheet), the admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs) and sepsis (a life-threatening blood infection). During a review of Resident 1’s Minimum Data Set (MDS – a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 1’s cognition (ability to learn reason, remember, understand, and make decisions) was moderately impaired and was dependent (helper does all of the effort) when eating, toileting, bathing, and dressing. During a review of Resident 1’s Physician Order [NAME], the Order Summary indicated an order starting 5/5/2025 for Acetaminophen (medication to relieve pain or fever) tablet 325 milligram (mg- a unit of measurement), give 2 tablets every six hours as needed for fever, temperature greater than 100.4, not to exceed over 3 grams (G-a unit of measurement) in 24 hours. During a review of Resident 1’s Nursing Progress Note dated 7/16/2025 at 2:24 p.m., the Progress Note indicated Resident 1 had a fever of 101.7 degrees Fahrenheit (F), and was given an as needed (PRN) medication that decreased Resident 1’s temperature to 98.1 degrees F. During a concurrent interview and record review on 7/17/2025 at 2:45 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 1’s July 2025 Medication Administration Record (MAR) was reviewed. The MAR did not indicate acetaminophen was administered to Resident 4 on 7/16/2025. LVN 4 stated they administered the acetaminophen and forgot to document it. During an interview on 7/18/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated it is important to document medication administration to prevent duplicate administration of any medication. The DON stated not documenting the acetaminophen puts Resident 1 at risk for adverse reactions due to excessive acetaminophen. (continued on next page)

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	07/18/2025

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 - Some	B. During a review of an admission Record (face sheet), the admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dysphagia (difficulty swallowing), contractures (the abnormal shortening of muscles, tendons, ligaments, or skin, which restricts the normal range of motion of a joint or body part) of right and both elbows, both knees, and both ankles. During a review of Resident 4’s MDS, dated [DATE], the MDS indicated Resident 4’s cognitive skills for daily decisions making were severely impaired (ability to think and reason). The MDS indicated Resident 4 was dependent and required two or more staff physical assistance for all activities of daily living (ADL, include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). During a review of Resident 4’s History and Physical (H&P) dated 5/19/2025, the H&P indicated Resident 4 does not have the capacity to understand and make decisions. During a review of Resident 4’s Order Summary with active orders as of 7/16/2025 included the following orders for: -Tramadol (treat moderate to severe pain) Oral Tablet 50 mg, give 0.5 tablet (25 mg) by mouth two times a day for pain management r/t (related to) osteoarthritis (a form of arthritis in which cartilage that cushions the ends of bones in a joint gradually wears away, causing pain, stiffness, and reduced movement) of left hand and fingers, order date 5/17/2025 During a review of Resident 4’s Care Plan (CP) titled, “High Risk for Pain/Discomfort related to generalized body aches and osteoarthritis”, dated 8/9/2024 and revised 7/16/2025, the CP goals and interventions indicated the following: Order: Tramadol Oral Tablet 50 mg, Black Box Warning: Risk of medication errors. Ensure accuracy when prescribing, dispensing, and administering tramadol … Because the use of tramadol exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death…Accidental ingestion of even one dose of Tramadol, especially by children, can result in a fatal overdose of Tramadol.” During an observation on 7/17/2025 at 2:42 p.m., with a LVN 5, at the East Station Medication Cart, there was a discrepancy in the Individual Narcotic Record or Controlled Drug Record (inventory and accountability record for CM) form and the prescription label on the two bubble packs (a medication packaging system that contains individual doses of medication per bubble) for Resident 4 and the physician order for Tramadol as follow: Resident 4’s first pharmacy prescription label indicated the bubble pack contained Tramadol 50 mg tablets, with an order to administer one-half (1/2 = 25 mg) tablet by mouth 2 (two) times a day, with a fill date of 7/15/25 with a sticker that indicated ‘MORNING’ Resident 4’s first corresponding ‘Individual Narcotic Record,’ which was handwritten indicated, “Tramadol 75 mg,” with instructions to administer 1 (one) tab (tablet) PO (by mouth) “2X/Day,” and documented that Resident 4 was administered a dose of 50 mg twice on 7/16/25 at 9:00 a.m. and on 7/17/2025 at 8:00 a.m. (continued on next page)

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	07/18/2025

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 - Some	Resident 4’s second pharmacy prescription label indicated the bubble pack contained Tramadol 50 mg tablets, with an order to administer one-half (1/2 = 25 mg) tablet by mouth 2 (two) times a day, with a fill date of 7/15/25 with a sticker that indicated ‘P.M.’ (evening) Resident 4’s second corresponding ‘Individual Narcotic Record,’ which was handwritten indicated, “Tramadol 25 mg,” with instructions to administer 1 tab PO 2X/Day, and documented that Resident 4 was administered a dose of 25 mg once on 7/16/25 at 4:00 p.m. During a concurrent interview and record review on 7/17/2025 at 2:42 p.m., with LVN 5, Resident 4’s records dated 7/16/2025 and 7/17/2025 were reviewed that include a review of the resident’s Individual Narcotic Record, Bubble Packs containing Tramadol, physician order for Tramadol, and the resident’s Administration Details for the administration on of Tramadol to the resident that included discrepancies between the prescribed dose, prescription label and the hand written Individual Narcotic Record. LVN 5 stated that a different nurse transcribed from the pharmacy label onto Resident 4’s Individual Narcotic Record Tramadol 25 mg because the facility was administering one-half tablet of Tramadol 50 mg even though the prescription label indicated “Tramadol 50 mg” and to give one-half tablet. During an interview on 7/17/2025 at 4:19 p.m., with the Director of Nursing (DON), the DON stated what is on the Narcotic Count Sheet (Individual Narcotic/Controlled Drug Record) received from the facility’s pharmacy should be exactly the same as it is written when transcribed or rewritten on each resident’s Individual Narcotic Record inside of the book. The DON stated whoever is transcribing must include the exact same information from the pharmacy label. The DON stated using the Narcotic Count Sheet provided by the pharmacy would be more accurate and having nurses transcribe the information increases the risk for medication errors and potential for controlled medication misuse. During a review of the facility’s P&P titled, “Ordering and Receiving Controlled Medications”, dated 4/2008, the P&P indicated Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. The director of nursing and the consultant pharmacist maintain the facility’s compliance with federal and state laws and regulations in the handling of controlled medications… The pharmacy dispenses medications listed in Schedules II, III, IV, and V in readily accountable quantities and containers designed for easy counting of contents… An individual resident’s-controlled substance record is prepared by the pharmacy or the facility for each controlled substance medication prescribed for a resident. The following information is completed: 1) Name of resident 2) Prescription number 3) Drug name, strength (if designated), and dosage form of medication (continued on next page)

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	07/18/2025

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 - Some	4) Date received 5) Name of person receiving the medication supply 6) Dispensing pharmacy information C. During a review of Resident 44’s admission Record, the admission Record indicated Resident 44 was readmitted to the facility on [DATE] with diagnoses including Parkinson’s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (mental health condition characterized by excessive fear and worry). During a review of Resident 44’s MDS 6/25/2025, the MDS indicated Resident 44’s cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was intact. The MDS indicated Resident 44 needed moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene. During a review of Resident 44’s Order Summary as of 7/17/2025, the order summary indicated, starting 6/28/2025, Lactulose 30 milliliters by mouth every 12 hours as needed for no Bowel movement in 48 hours. During an interview on 7/15/2025 at 9:52 a.m., with Resident 44, Resident 44 stated she has not had a bowel movement in days and does not remember the last one, but it was more than a week. During a concurrent interview and record review on 7/17/2025 at 2:18 p.m. with Registered Nurse (RN)2, Resident 44’s Documentation Survey Report, for bowel elimination, 7/2025 and Medication Administration Records for 7/2025 were reviewed. RN 2 stated Resident 44’s last bowel movement was on 7/9/2025 and 5 days later 7/14/2025. RN 2 stated Resident 44 should have been offered lactulose at least once between 7/9/2025 and 7/14/2025 to promote comfort. During an interview on 7/18/2025 at 3:30 p.m., with the Director of Nursing (DON), the DON stated medications should be administered as ordered. During a review of the facility’s policy and procedure (P&P) titled, “Medication - Administration”, revised 1/1/2012, the P&P indicated medication will be administered.

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	07/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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	07/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure it was free of medication error rate of five percent or greater, as evidence by the identification of three medication errors out of 25 opportunities, to yield a facility error rate of 12 percent (%) for two of two Residents (Resident 4 and Resident 28) by failing to: 1. Ensure for Resident 4, Licensed Vocational Nurse (LVN) 2, LVN 3, and Registered Nurse (RN) 2 failed to follow facility's policies and procedures (P&P) titled, Medication - Administration, by failing to ensure the same nurse that prepared Resident 4's Tylenol (Acetaminophen [APAP], treat mild to moderate pain) Extra Strength Oral Tablet 500 milligrams (mg, unit of measurement by weight) administered the medication, and documented the administration of the medication to ensure the correct resident was administered the correct dose. 2. Ensure for Resident 28, Losartan (a blood pressure medication) was administered to the resident prior to checking the resident's blood pressure. Resident 28's physician's order indicated to hold (not administer) if systolic blood pressure ([SBP] top number in blood pressure; pressure during active contraction of the heart) is less than 110 millimeters of mercury ([mm Hg] unit used to measure BP) or heart rate (HR, beats per minute [BPM]) is less than 60 BPM. 3. Ensure for Resident 28, LVN 2 failed to follow facility's P&P titled, Feeding Tube - Administration of Medication, by failing to check gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition and/or medication directly to the stomach) placement by aspiration (assessing the contents withdrawn from the GT to help confirm its location in the stomach rather than the lungs or other unintended locations) and failing to flush the GT with 15 milliliters (ml, unit of measurement by volume) of water before administering and/or attempting to administer two medications, Losartan and Oxcarbazepine (a medication to treat and prevent seizures) to Resident 28. These deficient practices of failing to administer medications in accordance with the physician orders and the facility's P&Ps, titled, Medication - Administration, and Feeding Tube - Administration of Medication, increased the risk for Resident 4 and Resident 28 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) related to their medication therapy. (Cross Reference F726, F760)Findings:A. During a review of an admission Record (face sheet), the admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dysphagia (difficulty swallowing), Type 2 diabetes mellitus (DM II, when the body cannot use insulin correctly and sugar/glucose builds up in the blood), contractures (the abnormal shortening of muscles, tendons, ligaments, or skin, which restricts the normal range of motion of a joint or body part) of right and both elbows, both knees, and both ankles. During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 7/2/2025, the MDS indicated Resident 4's cognitive skills for daily decisions making were severely impaired (ability to think and reason). The MDS indicated Resident 4 was dependent and required two or more staff physical assistance for all activities of daily living (ADL, include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). During a review of Resident 4's History and Physical (H&P) dated 5/19/2025, the resident does not have the capacity to understand and make decisions. During a review of Resident 4's Order Summary with active orders as of 7/16/2025 included the following orders for:-Tylenol (Acetaminophen, treat mild to moderate pain) Extra Strength Oral Tablet 500 mg, give two tablets (1000 mg) by mouth every day shift for pain give prior to treatment, order date 5/28/2025-May crush all crushable medications, order date 7/12/2025-Sacral Pressure Injury, monitor for pain using scale 0-10 before, during and after treatment every day shift for 14 days, order date 7/12/2025, with an end date of 7/26/2025.During a review of Resident 4's Care Plan (CP) titled, High Risk for Pain/Discomfort, dated 8/9/2024 and revised 7/16/2025, the CP goals and interventions indicated the following: Tylenol Extra Strength Oral Tablet 500 mg (Acetaminophen) instruction indicated, give 2 (two) tablets by mouth every 6 (six) hours as needed for moderate pain 5-7/10 (pain scale zero to 10, 0 indicates no pain, while 10 represents the worst pain imaginable) not to exceed 3 (three) grams (g, unit of measurement by weight) of APAP in 24 hours from all sources and give 1 (one) tablet by mouth every day shift for pain, give prior to treatment, revision on 7/16/2025.During a concurrent medication pass observation and interview, on 7/16/2025 at 9:12 a.m., with LVN 2, at the East Station Medication Cart, LVN 2 stated Resident 4 needed pain medication before the resident's wound treatment. LVN 2 prepared for Resident 4 - two, 500 mg tablets of Acetaminophen, crushed the tablets, placed the crushed powder into a medication cup and added applesauce to the crushed tablets and mixed them together. LVN 2 stated that Resident 4 has an order to

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	07/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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	07/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policies and procedures (P&P) titled, Medication - Administration, to prevent significant medication errors (medication errors that causes the resident discomfort or jeopardizes the resident health and safety) for two of five sampled residents (Residents 28 and Resident 4), by failing to: (Cross Reference F759) 1. Ensure LVN 2, LVN 3 and RN 1 followed facility's P&P titled, Medication - Administration, to ensure accurate administration of medications by making sure the same nurse preparing Resident 4's Tylenol medication for pretreatment for wound care was the same nurse that administered the medication and documented the administration. 2. Ensure LVN 2 followed Resident 28's Physician/Medical Doctor (MD) 1's orders to check the resident's blood pressure (BP) and heart rate (HR) prior to the administration of Losartan (a medication used to treat high blood pressure), as an ordered parameter (used to assess, monitor, and guide treatment decisions) to determine whether to give or not give the medication. These deficient practices resulted in Residents 28 and 4 not receiving medications in accordance with the physicians' orders, and the facility's P&Ps. These failures placed Residents 28 and 4 at risk for significant medical complications including pain, delayed wound healing, uncontrolled blood pressure creating a change of condition, discomfort, and hospitalization.Findings:1. During a review of an admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dysphagia (difficulty swallowing), and contractures (the abnormal shortening of muscles, tendons, ligaments, or skin, which restricts the normal range of motion of a joint or body part) of right and both elbows, both knees, and both ankles.During a review of a Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 7/2/2025, the MDS indicated Resident 4's cognitive skills for daily decisions making was severely impaired (ability to think and reason). The MDS indicated Resident 4 was dependent and required two or more staff physical assistance for all activities of daily living (ADL, include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). During a review of Resident 4's History and Physical (H&P) dated 5/19/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of an Order Summary with active orders as of 7/16/2025 included the following orders for:Tylenol (Acetaminophen, treat mild to moderate pain) Extra Strength Oral Tablet 500 mg, give two tablets (1000 mg) by mouth everyday shift for pain give prior to treatment, order date 5/28/2025During a review of Resident 4's Care Plan titled, High risk for pain/discomfort, dated 8/9/2024 and revised on 7/16/2025, the CP interventions indicated, Tylenol Extra Strength Oral Tablet 500 mg (Acetaminophen) instruction indicated, give 2 (two) tablets by mouth every 6 (six) hours as needed for moderate pain 5-7/10 (pain scale zero to 10, 0 indicates no pain, while 10 represents the worst pain imaginable) not to exceed 3 (three) grams (g, unit of measurement by weight) of APAP in 24 hours from all sources and give 1 (one) tablet by mouth every day shift for pain, give prior to treatment, revision on 7/16/2025.During a concurrent medication pass observation and interview, on 7/16/2025 at 9:12 a.m., with LVN 2, at the East Station Medication Cart, LVN 2 stated Resident 4 needed pain medication before the resident's wound treatment. LVN 2 prepared for Resident 4 - two, 500 mg tablets of Acetaminophen, crushed the tablets, placed the crushed powder into a medication cup and added applesauce to the crushed tablets and mixed them together. LVN 2 handed the cup of medication to LVN 3 as LVN 3 walked up to the East Station Medication Cart after the medication had been prepared by LVN 2. LVN 3 asked LVN 2 which room the resident was in. LVN 2 stated the resident's room number and LVN 3 left with the medication cup to administer the medication to Resident 4.During an interview on 7/16/2025 at 2:38 p.m. with LVN 3, LVN 3 stated he administered to Resident 4 two tablets of Acetaminophen 325 mg (650 mg), that was given to him crushed and mixed in applesauce by LVN 2. LVN 3 stated, he administered the crushed Acetaminophen medication to the resident (Resident 4), on 7/16/2025 during the 9 a.m., morning medication pass.During a concurrent interview and record review on 7/16/2025 at 2:56 p.m., with LVN 3, at the [NAME] Station, Resident 4's MAR for 7/16/2025 was reviewed. LVN 3 stated Resident 4 was documented to have been administered two tablets of Acetaminophen 500 mg (1000 mg) and not two tablets of Acetaminophen 325 mg (650 mg) on 7/16/2025 at 9:08 a.m., and Resident 4's MAR was initialed to indicate a Registered Nurse (RN) 2 had administered the medication to the resident. LVN 3 stated RN 2 did not administer the Acetaminophen to Resident 4, he did (LVN 3).During an interview on 7/16/2025 with LVN 2 and RN 2, RN 2 stated, she was going to be the one nurse to administer

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	07/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of infectious organisms that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food) for 81 of the facility's residents who eat food prepared in the kitchen by failing to: 1. Ensure the store prepared 18 cups of juice with a prepared-on date.2. Ensure to place an open-date on a Residents juice that was placed in the fridge. These deficient practices had the potential to result in residents developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization. Findings: During an initial visit to the kitchen on 7/15/2025 at 8:15 a.m., with the Dietary supervisor (DS) , there were six glasses of cranberry juice, 5 glasses of apple juice, 3 glasses of milk, and 3 glasses of orange juice without a prepare-on date inside the walk-in refrigerator. During an observation on 7/15/2025 at 08:30 a.m., with the DS, there was 1 large container of juice in the resident's refrigerator with no opened-on date. During an interview on 7/16/2025 at 8:47 a.m., with the DS, the DS stated it is the dietary staff's responsibility to label foods and drinks with prepared-on and opened-on dates. The DS stated it was important to label and date foods and drinks so that we can know when to throw them out. The DS stated juices last for 72 hours then you must throw it out. The DS stated if the juice is kept beyond the 72 hours the juice can be hazardous, and the resident can become sick if they drink it. During a review of the facility's P&P titled Food Storage and Handling revised on 2/9/2024, the P&P indicated label and date all food items.

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	07/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensureA. Licensed Vocational Nurse (LVN) 2 failed to perform hand hygiene (hand washing using soap and water, and cleaning hands with waterless or alcohol-based hand sanitizers) for one of five sampled resident (Resident 28) during medication administration observation. This failure placed Resident 28 at risk for the spread of infection between residents and staff and had potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another). B. One of three residents (Resident 62)'s peripheral intravenous catheter IV ([IV] a flexible tube inserted into a vein for medication administration) was labeled and dated . This deficient practice had the potential to result in the sterility infection at the IV site. Add to Based on: Findings: A. During a review of Resident 28’s admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), DM II, epilepsy (is a neurological condition that causes unprovoked, recurrent seizures [is a sudden rush of abnormal electrical activity in the brain]), hypertension (HTN, high blood pressure), blindness, right eye, and gastrotomy status (GT) During a review of Resident 28's Minimum Data Set (MDS a resident assessment tool) dated 6/2/2025, the MDS indicated Resident 28’s cognitive (ability to make decisions of daily living [ADL]) skills were severely impaired (ability to think and reason). The MDS indicated Resident 28 was dependent and required assistance from two or more staff physical for all ADLs. During a review of Resident 28’s History and Physical (H&P) dated 6/6/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a concurrent medication pass observation and interview, on 7/16/2025 between at 9:32 a.m. through 10:01 a.m., with LVN 2, at the East Station Medication Cart, On 7/16/2025 at 9:32 a.m., LVN 2 stated she had prepared a total of seven morning medications for Resident 28. LVN 2 crushed each tablet individually and placed the following medications into separate medication cups: a. Clopidogrel (used to prevent blood clots) 75 mg, one tablet b. Gabapentin (treat nerve pain) 300 mg, one capsule c. Losartan (treat high blood pressure) 50 mg, one tablet d. Oxcarbazepine (used to treat or prevent seizures) 300 mg/ 5 ml, 15 ml (900 mg) e. Aspirin 81 (preventative treatment) mg chewable, one tablet f. Levetiracetam (used to treat or prevent seizures) Oral Solution 100 mg/ml, 15 ml (1500 mg) (continued on next page)

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	07/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Phenytoin (used to treat or prevent seizures) 50 mg chewable, four tablets (200 mg) On 7/16/2025 at 9:38 a.m., before entering Resident 28's room, Licensed Vocational Nurse (LVN) 2 failed to perform hand hygiene and proceeded to donning (put on) a new glove and gown. On 7/16/2025 at 9:40 a.m., LVN 2 stated she added 15 ml of water to each cup with crushed medication and mixed. LVN 2 came into contact with Resident 28’s body when she disconnected the feeding tube line and connected a GT syringe to the GT tubing. LVN 2 placed a stethoscope on Resident 28’s stomach and using the GT syringe and a plunger inside of the GT syringe pushed air through the tube to check GT placement. On 7/16/2025 at 9:44 a.m., LVN 2 changed gloves and failed to perform hand hygiene. During an interview on 7/17/2025 at 12:23 p.m., with LVN 2, LVN 2 stated when providing care for residents with a GT, the licensed nurse must use hand sanitizer or wash hands with soap and water before entering and after leaving the resident’s room, before putting on gloves and after the removal of gloves. LVN 2 stated the licensed nurse must wear PPE, that includes gown, and gloves when caring for a resident with a GT. LVN 2 stated for Resident 28, she forgot to sanitize her hands. During an interview on 7/17/2025 at 2:30 p.m., the Infection Preventionist Nurse (IPN) stated, prior to performing any high contact activity the facility staff must perform hand hygiene and don (put on) gown and gloves for residents on Enhanced Barrier Precautions ([EBP], involving the use of gowns and gloves during high-contact resident care activities to prevent the spread of multidrug-resistant organisms [MDROs]). IPN stated high contact activity included medication administration via GT, bathing, diaper change, linen change, care for indwelling device, wound care, and lifting and caring for resident. IPN stated the licensed nurse must perform hand hygiene before starting medication pass, before donning PPE (including gowns and gloves) and after doffing (removal) of PPE. IPN stated facility staff must perform hand hygiene between residents by gel in, before entering the resident’s room and gel out upon leaving the resident’s room. IPN stated each staff must complete a PPE competency upon hire and annually. IPN stated licensed nurse must perform hand hygiene before handling and putting on PPE for infection control and to prevent cross contamination to residents and staff. During a review of the facility's policy and procedure (P&P), titled Hand Hygiene Program, revised 9/2020, the P&P indicated Facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, Residents, volunteers and visitors - Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub with 60-95% alcohol). - Wearing gloves does not replace the need for hand hygiene - The following situations require appropriate hand hygiene: · Before donning and after doffing Personal Protective Equipment (PPE) · Immediately upon entering and exiting a resident room” (continued on next page)

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	07/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P, titled Enhanced Barrier Precautions, dated 7/2024, the P&P indicated, To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Multidrug-resistant organisms (MDRO) transmission is common in long term care (LTC) facilities (i.e. , nursing homes), contributing to substantial resident morbidity and mortality and increased healthcare costs. During a review of Resident 62’s admission Record, the admission Record indicated Resident 62 was last admitted to the facility on [DATE] with diagnoses including unspecified, congestive heart failure (the isn’t pumping blood as well as it should leading to a buildup of fluid in the body), bacteriuria (bacteria in the urine), and metabolic encephalopathy (a problem in the brain it is caused by a chemical imbalance in the blood). During a review of Resident 62’s MDS dated [DATE], the MDS indicated Resident 62 ‘s cognitive skills were intact. The MDS indicated Resident 62 was dependent on staff for toilet hygiene, chair/bed to chair transfer, toilet hygiene, shower/ bathe self, upper and lower body dressing, and sit to lying . During an observation and interview on 7/17/2025 at 9:30 a.m., with Registered Nurse 2 (RN 2), RN 2 stated an IV site is changed every 7 days to prevent the site from becoming infected. RN 2 stated when inserting an IV it was important to initial, date and time the IV so that we can know when the IV was inserted and when it needs to be replaced. During an interview on 7/18/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated a Licensed Registered Nurse (RN) is responsible for, putting their initials, and the date of insertion on a new IV. The DON stated that is important to track how long the IV has been in place, and when it needs to be replaced. During a review of the facility’s P&P titled ” Peripheral Catheter Dressing Change”, dated on March 2023, the P&P indicated to label with date, time, and nurse’s initials.