

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Bay Vista Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Downey Ave Long Beach, CA 90805	
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure its Payroll Based Journal (a mandated reporting system used by the Centers for Medicare & Medicaid Services (CMS) to collect auditable employee-level staffing data from long-term care facilities) was submitted for the first fiscal year quarter. This deficient practice resulted in the facility's failure to provide required information regarding staffing levels necessary to ensure the provision of safe and comprehensive care for all residents in accordance with federal regulations. Findings: During a review of the facility's PBJ Staffing Data Report for Fiscal Year Quarter 1 2026 (October 1 through December 31), the PBJ report indicated the facility failed to submit data for the fiscal year one quarter. During a concurrent interview and record review on 7/14/2026 at 10:10 a.m., with the Administrator (ADMIN), CMS Submission Report for the PBJ validation report, dated 2/13/2026, was reviewed. The ADMIN stated the PBJ validation report indicated fiscal year quarter 2 was submitted instead of fiscal year 1 which covers October 2025 through December 2025. The ADMIN stated the PBJ was required to be submitted quarterly, and the facility's consulting group was responsible for submitting the PBJ fiscal year information timely. The Admin stated the risk of not submitting the facility's PBJ in a timely manner could result in submitting not accurate data and not being able to prove care services are being provided to the residents in the facility. During a record review of the State Operations Manual (SOM), dated 7/23/2025, the SOM indicates the facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system. The facility's failure to submit PBJ data, as required, will be reflected on their CASPER report and result in a deficiency citation.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of 12 sampled residents (Resident 5, 30 and 46) had completed Advance Directives ([AD]-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) correctly in the medical records when:a. Failing to ensure Resident 5 had an AD acknowledgement form.b. Failing to ensure Resident 30 had an AD acknowledgement form.c. Failing to ensure Resident 46 had an advance directive acknowledgement form.These failures had the potential to result in care being provided that was inconsistent with the residents' wishes and could compromise the residents' rights to make decisions regarding their medical care during emergencies, end of life, and changes in condition.Findings: a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 4/3/2023 and readmitted on [DATE] with diagnoses including rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), and sepsis (a life-threatening blood infection) and Alzheimer's disease(a disease characterized by a progressive decline in mental abilities) During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 6/23/2026, the MDS indicated Resident 30's cognition (ability to make decisions of daily living) was severely impaired. The MDS indicated Resident 5 was dependent (helper does all the effort) on staff with eating, oral hygiene, toileting hygiene. During a concurrent interview and record review on 7/14/2026 at 11:19 a.m., with the admission Coordinator (AC), Resident 5's medical record was reviewed. The AC stated Resident 5's acknowledgement for Advance Directives was not completed. b. During a review of Resident 30's admission Record, the admission Record indicated the facility admitted the resident on 6/9/2026 with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and centrilobular emphysema (a type of lung disease that mainly affects the center of small lung units in the upper parts of the lungs). During a review of Resident 30's History and Physical (H&P), dated 6/11/2026, the H&P indicated Resident 30 did not have the ability to understand and make decisions. During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30's cognition was moderately impaired. The MDS indicated Resident 30 required supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, personal hygiene, and moderate assistance (helper does less than half the effort to complete the task) with showering. During a concurrent interview and record review on 7/15/2026 at 12:31 p.m., with the Social Service (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director (SSD), Resident 30's Social Services Assessment, dated 6/16/2026 was reviewed. The SSD stated she did not verify Resident 30's decision-making capacity before discussing the AD with Resident 30. The SSC stated Resident 30 lacked decision-making capacity. The SSD stated she should have discussed Resident 30's AD with the resident's Public Guardian (court-appointed individuals responsible for managing the affairs of people who do not have the capacity to make decisions for themselves). During an interview on 7/16/2026, 11:35 a.m., with the DON, the DON stated only a physician, or another qualified licensed practitioner could determine a resident's decision-making capacity. The DON stated if the resident lacked the capacity to make sound decisions, the SSD should have discussed the AD with the resident's legally authorized representative to honor resident's wishes regarding their care when they are no longer able to make decisions for themselves. c. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (group of thinking and social symptoms that interfere with daily functioning), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (constantly feeling worried and nervous). During a review of Resident 46's H&P dated 3/17/2026, the H&P indicated Resident 46 did not have the capacity to make decisions. During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46 had moderate cognitive impairment. The MDS indicated Resident 46 was dependent on facility staff for toileting hygiene, bathing, upper body (above waist) and lower body (below waist) dressing, personal hygiene, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and required substantial assistance (helper does more than half) for eating, oral hygiene, and rolling left to right. During a review of Resident 46's Social Service Progress Note dated 4/22/2026 at 10:35 a.m., the social service progress note indicated Resident 46 had a public guardian and education was provided to the resident/representative on their right to formulate an Advance Directive (brochure provided). The social service progress note indicated Resident 46 did not have an Advance Directive due to impaired cognition. During an interview on 7/14/2026 at 11:32 a.m., with the SSD, the SSD stated advance directives are offered upon admission and indicated a brochure was provided whether the resident wishes to formulate or decline an advance directive. The SSD stated when the resident was unable to make decisions independently, their representatives are notified regarding the option to formulate an advance directive. During a concurrent interview and record review on 7/14/2026 at 11:36 a.m., with the SSD, the SSD Resident 46's Social Service Progress Note dated 4/22/2026 indicated Resident 46 was under conservatorship as she was unable to formulate an advance directive. The SSD stated advance (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directives are offered as it was the residents' rights to formulate what their wishes and indicated without an advance directive, the facility would not be able to honor the residents' wishes. The SSD stated they do not have any documentation that indicated Resident 46 or their public guardian had declined to formulate an advance directive. The SSD stated the policy titled Advance Directives does not cover what happens if a resident refuses to formulate an advance directive. During an interview on 7/16/2026 at 1:07 p.m. with the DON, the DON stated advance directives are offered so the facility was aware of the residents' wishes regarding their care when they are no longer able to make decisions for themselves. The DON stated that without an advance directive, the facility may not be able to honor the residents' preferences regarding their care. During a review of the facility's policy and procedures (P&P) titled, Advance Directive, revised date 7/25/2024, the P&P indicated upon admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care; including the right to accept of refuse medical or surgical treatment, and the right to formulate advance directives. The Interdisciplinary Team will periodically review the Advance Directive, if applicable, with the resident or resident representative, to ensure that it still reflects the resident's wishes.		

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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 ensure to store and handle food in a sanitary manner to prevent growth of microorganisms that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins) for 61 out of the 70 residents in the facility by failing to ensure: 1. There were no pests in the storage room. 2. The dry storage room temperature was not above the appropriate range of 50 Fahrenheit (F, temperature scale) - 70 F 3. Frozen food items were dated and ensure and accurately labeled. 4. Food items in the residents' refrigerator were dated, had resident identifiers, and a log of when the refrigerator was cleaned. 5. The kitchen staff performed proper hand hygiene in-between tasks. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for 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 a concurrent observation and interview on 7/13/2026 at 8:29 a.m., with the Dietary Services Supervisor (DSS), in the dry storage room, there was a fly sitting on top of an opened plastic bag with an opened box of sugar. The dry storage room temperature also read 'danger' with a temperature of 78 F. The thermometer in the room indicated to maintain the temperature of a dry storage to between 50 F - 70 F or 60 percent (%) relative humidity (RH, measures the amount of moisture in the air compared to the maximum amount the air can hold at that specific temperature, expressed as a percentage). The RH% on the thermometer in the dry storage room read 82%, and per DSS, they go based off of the RH% for the dry storage room temperature. During an observation on 7/13/2026 at 8:36 a.m., in the kitchen side door freezer, there was a bag of unlabeled frozen items stored. During an observation on 7/13/2026 at 8:38 a.m., in the dining room freezer, there were four bags of undated broccoli florets stored. During a concurrent observation and interview on 7/13/2026 at 8:43 a.m., with the Dietary Services Supervisor (DSS), the DSS stated the freezer named chest wall on left side in the basement storage did not have a thermometer in it. During an observation on 7/13/2026 at 8:46 a.m. in the basement storage, the chest middle freezer had a box of Tony's Cheese Pizza that had a prepared date of 9/11/2026. A box written peaches unopened had a prepared date of 9/11/2026. During an observation on 7/13/2026 at 1:03 p.m., in the resident's refrigerator, there were two bags labeled pasta for chicken noodle soup with no date, room number, and resident identifier. During an interview on 7/14/2026 at 8:16 a.m., with the DSS, the DSS stated food items should be dated to ensure staff knew when the items need to be used by to prevent illnesses and to prevent keeping items that are potentially expired. The DSS stated without a date, they would not know when the food item expired. The DSS stated they would not know if the food items were spoiled without an accurate date label on the food items. The DSS stated the storage room was supposed to be 70-80% and indicated the storage room should be kept at the recommended temperature as the room can get hot and produce needs to be kept at a certain temperature to avoid spoilage. During a concurrent observation and interview on 7/14/2026 at 9:19 a.m., with the DSS, the DSS stated facility staff did not keep a log of when the resident's refrigerator was cleaned. The DSS stated there were two bags of items that were labeled pasta for chicken noodle soup in the resident's refrigerator with no date and resident identifier. The DSS stated there was supposed to be a name and date on the bags of pasta. The DSS stated items should be labeled with owner's name to know who the items belong to so they would not give it to the wrong resident and each item should be dated (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to prevent giving expired food to the residents. During a concurrent observation and interview on 7/14/2026 at 12:05 p.m. with DA 1, DA 1 was observed getting gloves and started plating the food with no hand hygiene observed. DA 1 stated hand washing was performed in between tasks and when coming in and out of the kitchen for infection control. DA 1 stated she did not perform hand hygiene when performing the tasks of taking the temperatures of the food, emptying out the water of the peas, and putting on gloves to start plating the food. DA 1 stated she was supposed to wash hands before wearing gloves. During an interview on 7/14/2026 at 12:42 p.m., with the DSS, the DSS stated hand hygiene should be performed after every task, when coming in and out of the kitchen. The DSS stated gloves should be worn when touching food, when mixing seasoning, dishwashing, and when serving food. The DSS stated hand hygiene was performed to prevent cross contamination. The DSS stated there was a thermometer in the freezer to ensure the food was stored at the appropriate temperature and indicated if the temperature was not within range, the food items have to be discarded as it can cause food borne illness and residents can get sick. During an interview on 7/14/2026 at 2:43 p.m., with the DSS, the DSS stated ants, roaches, or fruit flies are considered pests. The DSS stated it was not acceptable for a fly to be sitting on top of an open bag that contains an open box of sugar. The DSS stated the sugar box had to be discarded as flies have germs that can cause infectious diseases harmful to the residents. During a review of the facility's policy and procedures (P&P) titled, Food Storage and Handling, effective date 6/4/2024, the P&P indicated Frozen Meat, Poultry, and Food: store items promptly at 0 F or below. Foods should be labeled, dated, and in their original contained if designed for freezing. Dry Storage Area: place opened products in storage contained with tight fitting lids, monitor area routinely for pest activity. During a review of the facility's P&P titled, Food Brought in by Visitors, effective date 5/22/2025, the P&P indicated place the food in a food container that is clearly labeled with the resident's name and date received and stored in a refrigerator designated for this purpose. When refrigerated, it will be labeled, dated, and discarded after 48 hours if not consumed. During a review of the facility's P&P titled, Dietary Department Infection Control for Dietary Employees, effective date 3/25/2026, the P&P indicated proper hand hygiene: immediately before engaging in food preparation, including working with non-prepackaged food, clean equipment and utensils. After handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination, and to prevent cross-contamination when changing tasks, before initially donning gloves for working with food, before dispensing or serving food and handling clean tableware and serving utensils in the food service area, after engaging in any other activities that contaminate the hands.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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:Ensure the padded bed side rails that were wrapped with porous foam were effectively disinfected for two of six sampled residents (Resident 1 and Resident 50).Complete the Infection Screening Evaluation form for one of five sampled residents (Resident 57), who was on the facility's Infection Prevention Surveillance Program for [DATE].These failures had the potential to increase the risk of cross-contamination (the transfer of bacteria, viruses, microorganisms or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spreading infection for Resident 1 and Resident 50, and negatively impact the treatment for Resident 57. Findings: 1.During a review of Resident 1's admission Record, the admission Record indicated the facility readmitted the resident on [DATE] with diagnoses including hemiplegia a (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (inability to move one side of the body) following cerebral infarction (stroke-blockage of the flow of blood brain, causing or resulting in brain tissue death) and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated the resident had the ability to make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated the resident's cognitive (ability think and reason) skills for daily decision making were moderately impaired. The MDS indicated Resident 1 required set up assistance (helper sets up or cleans up; resident completes activity) with eating, supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with oral hygiene, toileting hygiene, moderate assistance (helper does less than half the effort to complete the task) with showering, and personal hygiene. During a review of Resident 50's admission Record, the admission Record indicated the facility readmitted the resident on [DATE] with diagnoses including hemiplegia, hemiparesis following cerebral infarction (stroke-blockage of the flow of blood brain, causing or resulting in brain tissue death) and epilepsy (disorder that causes episodes of seizures or altered consciousness). During a review of Resident 50's H&P, dated [DATE], the H&P indicated the resident had fluctuating ability to understand and make decisions. During a review of Resident 50's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 50 required supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene, showering, and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal hygiene. During an interview on [DATE] at 09:50 a.m., with Housekeeping (HK) 1, HK 1 stated she cleaned the residents' room daily, including the foam-padded side rails, with a disinfectant identified as Hydrogen Peroxide (disinfectant). During an observation on [DATE] at 10:00 a.m., in Resident 50's room, Resident 50's upper side rails were observed padded with black foam. During an observation on [DATE] at 10:52 a.m., in Resident 1's room, Resident 1's upper side rails were observed padded with black foam wrapped with black electrical tape. During a concurrent interview and record review on [DATE] with the Infection Preventionist Nurse (IPN), manufacturer's instructions on the label of hydrogen Peroxide, undated was reviewed. The IPN stated the Hydrogen Peroxide should not be used on porous (material with tiny holes so liquid and air passes through it) materials such as the foam wrapped around Resident 1 and Resident 50's bed rails. The IPN stated, the hydrogen peroxide was intended for use on nonporous surfaces. During a concurrent observation and interview on [DATE] at 9:26 am with the Infection Preventionist Nurse (IPN) in Resident 1 & 50's room, the residents' side rails were observed with padded black foam. The IPN stated the disinfectant identified Hydrogen Peroxide was intended for nonporous surfaces and was not appropriate for use on the porous foam. The IPN stated the porous surface might not be adequately disinfected, place vulnerable residents including Resident 1 and Resident 50 at risk of infection. During an interview on [DATE] at 11:35 a.m., with the Director of Nursing (DON), the DON stated the facility should clean and disinfect reusable medical equipment, including padded side rails, in accordance with the manufacturer's instructions to prevent the spread of infection. During a review of the facility 's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Equipment, dated [DATE], the P&P indicated, staff should verify the disinfectant is compatible with the equipment and follow manufacturer recommendations for cleaning equipment. During a review of the manufacturer's product label for Hydrogen Peroxide, undated, the label indicated the disinfectant is designed for hard and non-porous surfaces. 2.During a review of Resident 57's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of muscle weakness, dementia (decline in memory, thinking, or reasoning skills) and anxiety (a feeling of intense worry, nervousness). During a review of Resident 57's Minimum Data Set (MDS &ndash; a resident assessment tool), dated [DATE], the MDS indicated the resident has severe cognitive impairment (inability to think and make decisions for themselves). The MDS also indicated the resident requires full assistance with every aspect of daily living. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 57's Order Summary Report (OSR) dated [DATE], the OSR indicated Resident 57's moisture associated skin damage (MASD-skin breakdown, irritation, or rashes caused by your skin being wet for too long) be treated with Nystatin External Powder, bilaterally to the breast folds, every day and evening shifts, for 30 days with an initiated date of [DATE] and target date of [DATE]. During a review of Resident 57's Care Plan Report (CPR), (undated), the CPR indicated Resident 57's bilateral breast folds were to be monitored for spreading or signs of infection with an initiated date of [DATE] and target date of [DATE]. During a concurrent interview and record review on [DATE] at 11:15 a.m. with Infection Preventionist (IPN), Infection Control Line Listing Log (IPCLLL), (undated) was reviewed. The IPCLLL indicated Resident 57 has a MASD, with an onset date of [DATE] and stop date of [DATE]. IPN stated the log is to keep track of residents with ongoing infections. During a concurrent interview and record review on [DATE] at 12:10 p.m. with IPN, Resident 57's Infection Screening Evaluation (ISE), dated [DATE] was reviewed. The ISE indicated, the Infection Analysis portion was not completed. IPN stated that it was her responsibility to determine which criteria applied, or to indicate if none were met—based on the Infection Analysis options. The IPN also stated it is essential to thoroughly complete the ISE form before informing the physician about any infections. As his process helps ensure residents are not prescribed incorrect medications or antibiotics, which could result in unnecessary or inappropriate treatment. Such errors may contribute to the spread of infection and foster antibiotic resistance, where bacteria adapt to survive drugs intended to eliminate them. During concurrent interview and record review on [DATE] at 2:01 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Infection Control Surveillance, dated [DATE] was reviewed. The P&P indicated, a license nurse is to initiate the gathering of surveillance data for each resident being monitored for infection. The DON stated her expectation was for IPN to follow the facility's P&P and to report any issues related to infections within the facility. The DON added, all assessments outlined in the Infection Screening Evaluation must be completed, as they enable the IPN to verify whether the correct treatment has been ordered. Neglecting these preventative assessments could lead to residents spreading infections within the facility and developing antibiotic resistance.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to provide evidence that their ice machine was being serviced routinely to be maintained in a safe operating condition. This failure had the potential to result in a widespread foodborne illness with the residents. Findings: During an interview on 7/15/2026 at 2:34 p.m. with the Central Worker (CW), the CW stated there was no log documenting previous ice machine vendor service, however, a magnet attached to the ice machine displayed the most recent service date. During a concurrent observation and interview on review on 7/15/2026 at 2:40 p.m. with the CW in the staff breakroom, a magnet on the ice machine indicated that maintenance was required every three months and showed 5/27/2025 as the next scheduled service date. The CW stated the date on the magnet was incorrect. During an interview on 7/16/2026 at 8:57 a.m. with the Dietary Supervisor (DS), the DS stated the ice machine is serviced by an external vendor once a year. During a concurrent interview and record review on 7/16/2026 at 9:14 a.m. with the CW, Vendor 1's Invoice #122013, dated 5/13/2026 was reviewed. The Invoice #122013 indicated that Vendor 1 carried out routine maintenance on the facility's ice machine on 5/13/2026. The CW stated that 5/13/2026 was the most recent service date for the ice machine. The CW also stated he will establish a log for future ice machine maintenance, as this will help ensure accurate records of when service was last performed and reduce the risk of bacterial buildup in the ice machine, which could potentially cause stomach discomfort among residents. During an interview on 7/16/2026 at 9:40 a.m. with the Maintenance Supervisor (MS), the MS stated they were unsure of the exact dates when Vendor 1 serviced the ice machine. During an interview on 7/16/2026 at 2:33 p.m. with the Administrator (Admin), the Admin stated there was no log to keep track of previous service dates by Vendor 1. The Admin added that the absence of a tracking system for previous service dates makes it challenging to determine when the ice machine was last serviced, which could result in improper use and potentially pose a risk to residents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Bay Vista Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Downey Ave Long Beach, CA 90805	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 5) was provided the opportunity to eat her meals at the same time as other residents during lunch at the dining room. This failure had the potential to diminish the resident's dignity, promote social isolation during mealtime, and result in an unsatisfactory dining experience. Findings: During a record review of Resident 5's admission Record (Face Sheet), the admission record indicated Resident 5 was admitted to the facility on [DATE] with a diagnoses including Alzheimer's disease (a progressive neurodegenerative disorder that impairs memory, thinking, and daily functioning), unspecified dementia (a decline in cognitive function affecting memory, reasoning, and the ability to perform activities of daily living), dysphagia, oropharyngeal phase (difficulty swallowing due to impaired movement of food from the mouth and throat to the esophagus), chronic kidney disease (progressive loss of kidney function over time), and protein-calorie malnutrition (inadequate intake or absorption of protein and calories resulting in poor nutritional status). During a record review of Resident 5's Minimum Data Set (MDS - a resident assessment tool) dated 6/23/2026, the MDS indicated Resident 5 had a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The MDS also indicated Resident 5 was dependent on eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and putting on and taking off footwear, and was not attempted for showering/bathing due to a medical condition or safety concerns. During a record review of Resident 5's Care Plan (Focus), revised 5/20/2026, the Care Plan indicated, Resident 5 is (dependent on staff, etc.) for meeting emotional, intellectual, physical, and social needs related to diagnosis of Alzheimer's disease, interventions indicated Resident 5 was dependent for eating, requiring staff assistance during meals. During a concurrent dining observation on 07/13/2026 at 12:50 p.m., and interview with Certified Nurse Assistant 1, Resident 5 observed her lunch tray was not in her table and had not begun eating her lunch while three other Residents got fed by the respected assigned CNAs. Resident 5 remained seated in her wheelchair awaiting meal assistance. CNA 1 stated she was assigned to feed Resident 5. During an interview on 07/13/2026 at 12:50 p.m. with CNA 1, CNA 1 stated Registered Nursing Assistants (RNAs) and CNAs are responsible for feeding residents. CNA 1 stated meal trays are delivered without a specific delivery time. CNA 1 stated LVNs, RNAs, and CNAs are responsible for ensuring residents at the same dining table are served and assisted with meals. CNA 1 stated that if unable to feed an assigned resident promptly, she notifies the LVN or another CNA to provide meal assistance. During an interview on 07/16/2026 at 9:45 a.m. with the Director of Staff Development (DSD), DSD stated the CNAs and RNAs, are responsible in making sure residents receive meal assistance. DSD stated CNAs are educated to verify the correct diet, perform hand hygiene before meal service, set up meal trays, and monitor residents during meals. DSD stated residents assigned to the same dining table should receive meal assistance at the same time to preserve residents dignity. During a record review of the facility's Policies and Procedures (P&P) titled, Resident Rights, revised 1/1/2012, the P&P indicated the facility will promote and protect the rights of all residents. The P&P indicated staffs are to treat all residents with kindness, respect, and dignity, encourage residents to participate in planning their daily care routines, including activities of daily living (ADLs), and gather and document residents' personal preferences to facilitate resident choice and participation in preferred activities.		

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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 observation, interview and record review, the facility failed to ensure appropriate skin care plan for Resident 16 with dermatitis (inflammation of the skin, commonly causing red, itchy, and swollen skin) to address the resident's skin care needs for one of 1 sampled resident (Resident 16). This failure had the potential to result in unidentified care and delayed medical intervention. Findings: During a record review of Resident 16's admission record, the admission record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including dermatitis, unspecified (inflammation of the skin causing redness, itching, and irritation), other specified dermatitis (a specific type of skin inflammation not otherwise classified), impetigo, unspecified (a contagious bacterial skin infection characterized by sores and blisters), and non-bullous impetigo (the most common form of impetigo, causing crusted skin lesions without large fluid-filled blisters). During a record review of the Minimum Data Set (MDS - a resident assessment tool) dated 5/28/2026, Resident 16 had a Brief Interview for Mental Status (BIMS - a short, standardized test used by healthcare providers in nursing homes and rehabilitation centers to evaluate a person's memory, thinking, and orientation) score of 3, indicating severe cognitive impairment. Resident 16 was independent with mobility and most self-care activities but required supervision with showering, dressing, footwear, and personal hygiene. During a review of Resident 16's Medication Administration Record (MAR) dated 7/1/2026 to 7/31/2026, the resident had physician orders for Clobetasol Propionate (topical steroid used to treat severe skin and scalp conditions like eczema, plaque psoriasis, and lichen sclerosus) 0.05% (50 out of 100 parts, equal to one half) cream to treat a generalized body rash, Mupirocin 2% (prescription topical antibiotic containing 20 mg of mupirocin per gram of cream or ointment) ointment for open skin lesions on the bilateral arms and left leg, and Zinc Oxide 20% (topical skin protectant ointment or cream containing 20 percent active zinc oxide) cream to protect the buttocks, coccyx, and bilateral inner thighs. During a record review of Resident 16's care plan dated 7/14/2026, the care plan indicated Resident 16's dermatitis included interventions for skin care, hygiene, hydration, and prescribed treatments. The care plan did not identify the specific affected skin sites and did not include interventions to monitor the progression or resolution of Resident 16's dermatitis. During a concurrent observation and interview on 7/14/2026 at 10:28 a.m. with the TXN1, the TXN1 stated Resident 16 had dermatitis on multiple areas of the body and received prescribed treatments. TXN1 stated that Resident 16's skin is assessed during treatment, changes are reported to the physician, and the care plan is updated when Resident 16's skin condition changes. The TXN1 stated the care plan did not identify the specific affected skin site to monitor progress and care. During a record 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 will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards and ensure a comprehensive person-centered care plan is developed for each resident.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 4 received appropriate care when staff did not recognize and respond to: a) Resident 4's multiple episodes of loose stools while receiving Lactulose (a prescription laxative used to treat chronic constipation), and a physician's order to hold the medication for loose stools, for one of one sampled residents (Resident 4). b) Resident 3's change in condition following the initiation of anticoagulant therapy, without initiating a Change of Condition (COC), for one of one sampled residents (Resident 3). These failures have the potential to result in inconsistent care delivery, breakdowns in communication of resident's specific interventions among interdisciplinary staff, unmet resident needs, and a decline in physical or psychosocial well-being, ultimately reducing the quality of care. Findings: a. During a record review of Resident 4's admission record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with a diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting the right non-dominant side (weakness or partial paralysis affecting the right side of the body resulting from a stroke), chronic obstructive pulmonary disease (COPD) (a chronic progressive lung disease characterized by airflow limitation), type 2 diabetes mellitus with hyperglycemia (a chronic metabolic disorder resulting in elevated blood glucose levels due to insulin resistance or inadequate insulin production), hyperlipidemia (elevated cholesterol and lipid levels in the blood), major depressive disorder, recurrent (a mental health disorder characterized by repeated episodes of persistent sadness and loss of interest), peripheral vascular disease (reduced blood flow to the extremities due to narrowed blood vessels). During a record review of the Minimum Data Set (MDS - a resident assessment tool) dated 6/26/2026, Resident 4 had a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident 4 was cognitively intact. Resident 4 required dependent assistance with eating, oral hygiene, toileting hygiene, bathing, dressing, footwear management, bed mobility, and wheelchair mobility. Resident 4 used a manual wheelchair for mobility and demonstrated impairment in the range of motion (the full movement potential of a joint, usually measured in degrees of a circle) of one upper extremity. Resident 4 was assessed as occasionally incontinent of bowel. During a concurrent interview on 7/16/2026 at 9:36 a.m. with Licensed Vocational Nurse 2 (LVN 2), and during a record review of Resident 4's bowel movements since 7/6/2026, it indicated that Resident 4 had multiple episodes of loose stools. The LVN's continued administering Lactulose, and the physician was not notified. LVN 2 stated the medication should have been held because loose stools place the resident at risk for dehydration and there is a physician's order. During a review of Resident 4's Medication Administration Record (MAR) dated 07/05/2026, 07/06/2026, 07/08/2026, and 07/09/2026, Lactulose (a prescription laxative to treat chronic constipation) was administered on the days Resident's 4 had episodes of loose stools. b. During a record review of Resident 3's admission record, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of acute embolism and thrombosis of unspecified deep veins of the right lower extremity (a blood clot in the deep veins of the right leg), long-term (current) use of anticoagulants (ongoing treatment with blood-thinning medication to prevent or treat blood clots), Type 2 diabetes mellitus with hyperosmolar hyperglycemic state without nonketotic hyperglycemic-hyperosmolar coma (a severe complication of diabetes characterized by markedly elevated blood glucose and dehydration), During a record review of Resident 3's MDS dated [DATE], Resident 3 had a BIMS score of 9, indicating moderate cognitive impairment, with moderately impaired daily decision-making and no signs or symptoms of delirium. Resident 3 required setup assistance (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with eating; supervision or touching assistance with oral hygiene, toileting hygiene, dressing, bed mobility, transfers, and toilet transfers; and partial/moderate assistance with showering and personal hygiene. During a record review of the MAR, the MAR dated 5/01/2026-5/31/2026 documented an order for Eliquis (prescription anticoagulant) 5 milligrams(mg-unit of measurement) by mouth twice daily for Deep Vein Thrombosis (DVT - any medical or preventive measure taken to guard against a disease, infection, or health condition before it occurs) prophylaxis, initiated on 5/03/2026 and administered as ordered. The MAR dated 6/01/2026-6/30/2026 and 7/01/2026-7/15/2026 indicated continued to document Eliquis 5 mg by mouth twice daily. There was no documentation on the MAR demonstrating ongoing monitoring for signs and symptoms of bleeding following initiation of anticoagulant therapy. During a record review of the titled All Active Medications at Time of Discharge Reconciliation (formal process in which healthcare providers compare a patient's current medication orders with the medications they are actually taking) dated 5/02/2026 at 4:41 p.m., Eliquis (apixaban - a medication prescription anticoagulant) was not listed among the Resident 3's discharge medications at the time of discharge reconciliation to the skilled nursing facility. During a concurrent interview with a Licensed Vocational Nurse (LVN 2) on 7/16/2026 at 9:36 a.m. and record review of Resident 4 bowel movement, LVN 2 stated that when a resident has multiple loose bowel movements, the nurse would assess Resident 4 for abdominal pain, bowel sounds, mental status, and stool characteristics, notify the physician immediately, initiate a Change of Condition (COC) after the second or third episode, notify the Director of Nursing (DON), continue monitoring the resident, obtain a stool specimen if ordered, and develop a care plan the same day the COC is initiated. During a continued interview Licensed Vocational Nurse (LVN 2) on 7/16/2026 at 9:36 a.m. and record review of Resident 3's MAR and Resident's 3 medication reconciliation records was reviewed , LVN 2 stated Eliquis 5 mg was initiated on 5/04/2026 and no COC documentation was initiated following the start of anticoagulant therapy. During an interview with the Registered Nurse (RN 2) on 7/16/2026 at 12:41 p.m., RN 2 stated that Resident 4 experienced loose bowel movements on 7/5/2026, 7/6/2026, 7/8/2026, and 7/9/2026, and that a Change of Condition (COC) should have been initiated on 7/9/2026 and medication should have been on hold RN 2 stated that medications should be administered according to the Physician's orders, and a care plan should be developed on the same day a COC is initiated. During an interview with the Director of Nursing (DON) on 7/16/2026 at 1:11 p.m., the DON stated that residents with anticoagulant therapy, skin issues, and loose bowel movements should have individualized care plans with appropriate interventions. The DON stated that a Change of Condition (COC) should have been initiated for Resident 4's anticoagulant therapy that started in the facility and a corresponding care plan should have been developed the same day. The DON stated that lactulose be held for loose bowel movements in accordance with the Physician's order, and failure to follow physician orders could place the resident at risk for dehydration and compromise continuity of care. During a record review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, effective 8/25/2022, the facility's P&P indicated it requires staff to promptly notify the physician/advanced practice provider, resident, and resident representative of any significant change in the resident's condition. The policy defined a change of condition as any sudden or marked adverse change requiring medical assessment, physician consultation, coordination of care, and changes to the resident's treatment plan, to ensure timely communication and appropriate interventions.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of five sampled residents selected for unnecessary medications (Resident 3 and Resident 46) were free from the use of unnecessary medications by: Failing to monitor and document Resident 3 who was receiving anticoagulant therapy (blood thinners to prevent harmful blood clots from forming or getting larger). Failing to provide an actual indication for the continued use of Ativan (a psychotropic [chemical substance that alters brain function that affects mood and behavior] medication used to treat anxiety) for Resident 46. This deficient practice had the potential for licensed staff to miss signs of bleeding from anticoagulant therapy, increasing the risk for serious complications and delayed medical intervention for Resident 3 and for Resident 46 to experience a diminished quality of life due to adverse effects such as sedation, coma, and death for the continued use of Ativan when it was not indicated. Findings: 1. During a record review of Resident 3's admission record, the admission record indicated that Resident 3 was admitted to the facility on [DATE] with diagnoses of acute embolism and thrombosis of unspecified deep veins of the right lower extremity (a blood clot in the deep veins of the right leg), long-term (current) use of anticoagulants (ongoing treatment with blood-thinning medication to prevent or treat blood clots), Type 2 diabetes mellitus with hyperosmolar hyperglycemic state without nonketotic hyperglycemic-hyperosmolar coma (a severe complication of diabetes characterized by markedly elevated blood glucose and dehydration). During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 6/10/2026, Resident 3 had a Brief Interview for Mental Status (BIMS - evaluates attention, orientation, and short-term memory) score of 9, indicating moderate cognitive impairment, with moderately impaired daily decision-making and no signs or symptoms of delirium. Resident 3 required setup assistance with eating; supervision or touching assistance with oral hygiene, toileting hygiene, dressing, bed mobility, transfers, and toilet transfers; and partial/moderate assistance with showering and personal hygiene. During a record review of the Medication Administration Record (MAR), the MAR dated 5/01/2026 and 5/31/2026 documented an order for Eliquis (prescription anticoagulant) 5 milligrams (mg - a unit of measurement) by mouth twice daily for Deep Vein Thrombosis (DVT - any medical or preventive measure taken to guard against a disease, infection, or health condition before it occurs) prophylaxis, initiated on 5/03/2026 and administered as ordered. The MAR's dated 6/01/2026 and 6/30/2026 and 7/01/2026 indicated continued to document Eliquis 5 mg by mouth twice daily. There was no documentation on the MAR or associated records demonstrating ongoing monitoring for signs and symptoms of bleeding following initiation of anticoagulant therapy. During a record review of the titled All Active Medications at Time of Discharge Reconciliation (formal process in which healthcare providers compare a patient's current medication orders with the medications they are actually taking) dated 5/02/2026 at 4:41 p.m., Eliquis (apixaban - a medication prescription anticoagulant) was not listed among the Resident 3's discharge medications at the time of discharge reconciliation to the skilled nursing facility. During a concurrent interview on 7/15/2026 at 9:50 a.m. with Licensed Vocational Nurse 2 (LVN 2) and record review of medication reconciliation from General Acute Care Hospital (GACH) was reviewed. LVN 2 stated the facility performs medication reconciliation upon admission using hospital transfer records, physician orders, and diagnoses. LVN 2 stated residents receiving anticoagulants require monitoring for signs and symptoms of bleeding and that licensed nurses initiate Change of Condition (COC) (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation for significant changes in treatment or condition or why starting the prescribed medication. LVN 2 stated Eliquis 5 mg was initiated on 5/04/2026 and no COC documentation was initiated following the start of anticoagulant therapy. LVN 2 stated Eliquis is not at the medication reconciliation. During a concurrent interview on 7/15/2026 at 10:00 a.m. with the Registered Nurse 1 (RN 1), RN 1 stated that prophylaxis refers to preventing a medical condition rather than treating an existing diagnosis. RN 1 stated Resident 3's diagnosis of acute embolism and thrombosis supported the use of Eliquis (apixaban) to prevent recurrent thrombosis. RN 1 stated staff are instructed to monitor for signs and symptoms of bleeding every shift, including discolored urine, black tarry stools (a warning sign of bleeding in the upper gastrointestinal (GI) tract), sudden severe headache, nausea, vomiting, diarrhea, muscle or joint pain, lethargy, bruising, changes in mental status or vital signs, shortness of breath, and nosebleeds. RN 1 stated that medications should have a documented diagnosis, pharmacists perform monthly medication reviews to ensure appropriate dosing and reduce the risk of bleeding, and medication reconciliation is completed using hospital transfer documents and physician orders. During a concurrent interview on 7/16/2026 at 1:44 p.m. with the Director of Nursing (DON), the DON stated Resident 3 was prescribed Eliquis 5 mg on 5/03/2026 and stated no Change of Condition (COC) documentation was initiated following the start of anticoagulant therapy. The DON stated licensed nurses should initiate COC documentation for changes in condition, abnormal laboratory results, new diagnoses, and new skin issues. The DON stated Resident 3 was receiving anticoagulants requires monitoring for signs and symptoms of bleeding because anticoagulant therapy places residents at risk for bleeding and other adverse effects. The DON stated the resident's care plan addressed anticoagulant therapy and there was no documentation demonstrating ongoing monitoring for signs and symptoms of bleeding. During a record review of the facility's Policy and Procedure (P&P) titled Change of Condition Notification, effective 8/25/2022 and reviewed 8/25/2022, the P&P indicated the facility to notify the physician/Advanced Practice Provider (APP) and initiate a Change of Condition (COC) when a resident experienced a significant change in treatment or condition requiring medical assessment and a change in the treatment plan. 2. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (group of thinking and social symptoms that interfere with daily functioning), bipolar disorder (irregular mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (constantly feeling worried and nervous). During a review of Resident 46's H&P dated 3/17/2026, the H&P indicated Resident 46 did not have the capacity to make decisions. During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46 had moderate cognitive (ability to think and make decisions) impairment. The MDS indicated Resident 46 was dependent on toileting hygiene, bathing, upper body (above waist) and lower body (below waist) dressing, personal hygiene, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and required substantial assistance (helper does more than half) for eating, oral hygiene, and rolling left to right. During a review of Resident 46's order summary report dated 6/10/2026, the order summary report indicated a physician's order for Ativan Oral Tablet 0.5 milligram (mg, unit of mass) (generic name (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam): give 1 tablet by gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every 12 hours as needed for anxiety manifested by (m/b) attempting to get out of bed. During a review of Resident 46's Medication Administration Record (MAR) dated 6/1/2026 - 6/20/2026 the MAR indicated Resident 46 received Ativan 0.5 mg on 16 days (6/1/2026, 6/3/2026, 6/4/2026, 6/8/2026, 6/9/2026, 6/10/2026, 6/13/2026, 6/14/2026, 6/16/2026, 6/18/2026, 6/21/2026, 6/23/2026, 6/25/2026, 6/27/2026, 6/28/2026, and 6/30/2026) without any documentation indicating Resident 46 had any behaviors. During a review of Resident 46's order summary report dated 7/2026, the order summary report indicated a renewed physician's order for Ativan Oral Tablet 0.5 mg : give 1 tablet by gastrostomy every 12 hours as needed for anxiety or 27 Days m/b attempting to get out of bed placing resident at risk for injury with order date 7/8/2026 end date 7/22/2026. During a concurrent interview and record review on 7/15/2026 at 11:22 a.m., with Registered Nurse (RN) 1, Resident 46's order summary report dated 7/2026 was reviewed. RN 1 stated on Resident 46's had a renewed order for Ativan Oral Tablet 0.5 mg. : give 1 tablet by g-tube, every 12 hours as needed for anxiety or 27 Days m/b attempting to get out of bed placing resident at risk for injury with order date 7/8/2026 end date 7/22/2026. RN 1 stated if a resident does not have episodes of trying to get out of bed, Ativan should not be given. During a concurrent interview and record review on 7/15/2026 at 11:39 a.m., Resident 46's MAR with RN 1, RN 1 stated on the MAR dated 6/1/2026 &ndash; 6/30/2026 was reviewed. RN 1 stated, Resident 46 received Ativan 0.5mg on the following days: 6/10/2026, 6/12/2026 to 6/16/2026, 6/18/2026 to 6/21/2026, 6/23/2026, 6/25/2026 to 6/28/2026, and 6/30/2026. RN 1 stated the administration of Ativan was not necessary based on no documented behaviors to justify administering the Ativan. RN 1 stated possible side effects of getting a medication the resident does not need include adverse effects such as shortness of breath and respiratory depression (breathing becomes too slow or shallow). RN 1 stated it was important for the resident to be monitored for their behavior to assess how they are progressing (improving or declining) and to determine whether the resident continues to require this medication or if it can be gradually discontinued. During a concurrent interview and record review on 7/16/2026 at 1:21 p.m. with the DON, the DON stated the Behavior Management/Psychoactive Committee Meeting -Initial/Change of Condition (COC) document dated 7/8/2026 at 11:55 a.m. indicated attempting to get out of bed placing resident at risk for injury, anger outburst, sudden mood changed and renewal of Ativan 0.5mg. The DON stated they do not have specific documentation that the use of Ativan was discussed with the doctor and indicated the Ativan was renewed. The DON stated documentation was important to ensure the doctor knows the status of the resident as the renewal of Ativan 0.5mg had been ongoing. The DON stated the doctor may want to try something else or continue renewing Ativan and indicated this may have been discussed during the meeting but was not documented. The DON stated Ativan had been renewed due to the continue behavior Resident 46 exhibits (attempting to get out of bed). During a review of the facility's policy and procedures (P&P) titled, Behavior/Psychoactive Drug (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Bay Vista Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Downey Ave Long Beach, CA 90805	
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management, effective date 1/30/2026, the P&P indicated if the resident exhibits mood or behavior problems upon admission, assessments will be conducted to address the resident's mood or behavior status. Assessment will be documented on the Behavior Management/Psychoactive Committee Meeting &dash; Initial/COC Committee Noted. The Licensed Nurse will collaborate with the healthcare practitioner family, resident, resident representative, and/or Interdisciplinary (IDT, resident's healthcare team consisting of various specialties that share and combine their knowledge and information to create the best possible care plan for the resident) members, to identify the contributing factors related to the resident's mood/behavior and the non-medication interventions to be implemented. The IDT will reassess the effectiveness of the psychoactive medication at least quarterly during the IDT Care plan meeting, or psychoactive behavior management committee. Residents have the right to be free from chemical restraints. The Behavior Management/Psychoactive Review Committee will review the following and make recommendations based on resident's need: The effectiveness of non-medication interventions; Continued use of psychoactive medication; Possible nonpharmacological alternatives During a review of the facility's P&P titled, Psychotropic Medication Use, effective date 6/2021, the P&P indicated the facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social, or environmental cause of the resident's behaviors. Facility staff should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors. Staff should become familiar with the culture, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress, types and the consequences of behaviors exhibited by the resident and interventions that may be indicated for a specific behavior type. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. For psychotropic prn medications, excluding antipsychotics, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Bay Vista Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Downey Ave Long Beach, CA 90805	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure Medical Director or designee attended the Quality Assessment and Assurance Committee (QAA committee, a group of people within an organization who are responsible for reviewing identifying and addressing quality issues) meeting held on 6/26/2026 as required QAA committee meetings. This failure had the potential to adversely affect the facility's quality assessment and performance improvement process by limiting clinical oversight and guidance. Findings: During a review of the facility's QAA Steering Committee attendance sign-in sheet, dated 6/26/2026, the attendance sheet indicated the Medical Director's did not attend the meeting. During an interview on 7/16/2026 at 3:50 p.m., with the Administrator (ADMIN). The ADMIN stated, the Medical Director or designee did not attend the QAA Committee meeting held on 6/26/2026 as required, and no additional documentation was available regarding the Medical Director's absence. The ADMIN stated the Medical Director's participation is essential to provide clinical oversight, educate nursing staff, and support quality improvement activities. During a review of the facility's Policy and Procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 3/28/2024, the P&P indicated, members of the committee must include Medical Director or designee.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to offer the influenza (a highly contagious viral infection that attacks the nose, throat, and lungs) and pneumococcal (an illness caused by the Streptococcus bacteria [a common bacteria on the nose and throat] immunizations (the process of making your body immune to a specific disease) at the time of admission, for one of five sampled residents (Resident 56). This failure had the potential to result in the resident contracting influenza or pneumococcal and developing a life-threatening infection. Findings: During a review of Resident 56's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with the following but not limited to diagnoses of encephalopathy (damage or malfunction of the brain), epilepsy (a brain disorder that causes repeated, unprovoked seizures) and catatonic schizophrenia (a condition that effects one's movements and speech). During a review of Resident 56's Minimum Data Set (MDS - a resident assessment tool), dated 7/3/2026, the MDS indicated Resident 56 was unable to complete the cognitive (mental capacity) assessment due to the inability to complete brief interview for mental status. The MDS also indicated, the resident requires assistance with every aspect of daily living. During a review of Resident 56's Medical Record (MR), the MR did not indicate the resident received the influenza and/or pneumococcal immunizations for 2025-2026. During an interview on 7/15/2026 at 9:52 a.m. with the Infection Preventionist (IPN), the IPN stated Resident 56 was not offered the influenza and pneumococcal immunizations because the resident was unable to make decisions independently, and the responsible party did not respond to a phone call made on 7/10/2026 to either consent to or decline the immunizations. IPN also stated there was no follow up phone call to Residents 56's responsible party. During an interview on 7/16/2026 at 2:05 p.m. with the Director of Nursing (DON), the DON stated that an additional follow-up call should have been made to Resident 56's responsible party to confirm whether the influenza or pneumococcal immunizations were wanted. During a review of the facility's policy and procedure (P&P) titled, IPC601 Pneumococcal Vaccination, dated 10/02/2025, the P&P indicated the facility will provide all residents the opportunity to receive the pneumococcal vaccine. During a review of the facility's P&P titled, Influenza Prevention and Control, dated 9/10/2020, the P&P indicated the facility is to offer all residents an influenza immunization.		