STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056405	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerritos Vista Healthcare Center	17836 Woodruff Avenue Bellflower, CA 90706

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 resident who was unable to carry out activities of daily living received care services to maintain good personal hygiene for one of three sampled residents (Resident 1) who was left with soiled gown and dry blood on her right nostril for long hours. This deficient practice had the potential to result in a negative impact on Resident 1's quality of life and self-esteem. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, muscle wasting (weakening, shrinking, and loss of muscle), multiple fractures of the pelvis (hip bone), contracture of muscle, right lower leg (condition characterized by the shortening and tightening of muscles in the lower leg, specifically on the right side). During a review of Resident 1's Minimum Data Set (a resident assessment tool) dated 04/06/25, the MDS indicated Resident 1had memory problem. The MDS indicated Resident 1 was dependent (helper does all the effort) with bed mobility, eating, oral hygiene and personal hygiene. During a concurrent observation and interview on 05/29//25 at 11:02 a.m., with Resident 1, Residents 1's was observed in bed with soiled gown, face unclean with dry blood on her right nostril. Resident 1's appeared to be uncomfortable and was contracted on both lower extremities. Resident 1's stated she was waiting to be clean up and was also in pain. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 05/29/25 at 11:13 a.m., with Certified Nursing Assistance (CNA 1) in Resident 1's room. CNA 1's stated she was the assign CNA for Resident 1 on 5/29/2025. CNA 1q stated today (5/29/2025) was Resident 1's shower day, CNA 1 stated she has four residents assigned to receive a shower and one resident going home, that was the reason why Resident 1 was not clean until 11:13 a.m., CNA 1's stated Resident 1 received a shower on 5/28/2025 but needs to clean her up because Resident 1 looks dirty. CNA 1 stated she noticed the dry blood on Resident 1's right nostril but was expecting the charge nurse to check it during her assessment thinking it was not under her scope of practice but however she should have notified the charge nurse to look at Resident 1 right nostril. CNA 1 stated she did not tell the charge nurse right away because she was busy. CNA 1 stated staff have a lot of work, and they cannot help each other on time because they still have their own work. CNA 1's stated her workload was heavy that was the reason she was not able to perform ADLs on time to Resident's 1. During an interview on 05/29/25 at 11:26 a.m., with Licensed Vocational Nurse (LVN1). LVN 1 stated she saw the dry blood on Resident 1's right nostrils, but she did not clean it because it was Resident 1's shower day. LVN 1's stated she was aware that Resident'1was on anticoagulated (blood thinner) that might be the reason of Resident 1's bruising and bleeding from her nose. LVN 1 stated she should have clean Resident 1's nostril when she saw it during her initial rounds. LVN 1 stated she could have cleaned Resident 1's nostril and not to wait for the CNAs to shower Resident 1. LVN 1 stated Resident 1 and family member can be uncomfortable and not happy if Resident 1 was not well groomed. During an interview on 05/29/25 at 4:40 p.m., with the Director of Nursing (DON). The DON stated all CNAs supposed to perform their duties, to avoid skin break down when residents was not clean or change for long period of time. The DON stated residents will feel uncomfortable and needs to be treated like family and if they refuse care, it should be document and notify the charge nurse. The DON stated license nurse needs to make the resident clean as well for respect and dignity. The DON stated license staff can assist with cleaning and changing the resident during rounds. The DON stated facility was well staff on 5/29/2025, it happens that some residents need more care and takes longer during ADLs that cause delay in ADLs for Resident 1. During a review of the facility's P&P titled, Activities of Daily living(ADLs) Supporting revised March 2023, the P&P indicated Residents should be treated with appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a Hygiene (bathing, dressing, grooming, and oral care).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management 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 effectively manage residents ' pain before wound treatment for one of four sampled residents (Resident 1) by: 1. Administer Tramadol (medication used to relieve moderate to moderately severe pain) prior to wound care treatment on 5/28/2025 per physician order. 2.Failing to identify and assess the resident's pain level after the administration of routine medication for Resident 1. These deficient practices resulted in Resident 1 ' s experiencing unrelieved pain during wound treatment and personal care on 5/28/2025. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, muscle wasting (weakening, shrinking, and loss of muscle), multiple fractures of the pelvis (hip bone), contracture of muscle, right lower leg (condition characterized by the shortening and tightening of muscles in the lower leg, specifically on the right side). During a review of Resident 1's Minimum Data Set (a resident assessment tool) dated 04/06/25, the MDS indicated Resident 1had memory problem. The MDS indicated Resident 1 was dependent (helper does all the effort) with bed mobility, eating, oral hygiene and personal hygiene. The MDS indicated Resident 1 received scheduled pain medication, prn (only when necessary) pain medication and non-medication intervention for pain. During an observation and interview on 05/29//25 at 11:20 a m, Residents 1 ' s was observed lying in bed, Resident 1 observed to be very uncomfortable. Resident 1 was contracted on both lower extremities. Resident 1 stated she was feeling pain all over her body, when surveyor ask if resident received pain medication this morning, Resident 1 responded, No. During an interview on 05/29/25 at 11:26 a.m. Licensed Vocational Nurse 1(LVN1). LVN 1 stated she was responsible to assess for pain every shift, even though Resident 1 ' s was lying quietly she could have asked if resident was in pain and gave pain medication as ordered. LVN 1 stated she failed to ask Resident 1 if she was in pain. LVN 1 stated Resident 1 was readmitted to the facility on [DATE] and able to verbalize if she needs pain medication, but LVN 1 failed to ask Resident 1 during morning medication administration. LVN 1 stated another reason she did not give Resident 1 her pain medication, as she was waiting to give it prior to the treatment nurses doing wound treatment to Resident 1. LVN 1 stated that it was not an excuse not to assess Resident 1 her pain level and give Resident 1 her pain medication as needed. During a review of Resident 1 ' s Administration History Report, the Administration History Report indicated the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Tramadol HCl 50 milligram (mg-unit of measurement) give one tablet by mouth every 12 hours as needed for moderate to severe pain (Pain Scale from 4 to 6- moderate pain [0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable]). 2.Tramadol 50 mg give 1 tablet by mouth in the morning prior to treatment. The Administration History Report indicated No data. 3.Tylenol 325 mg give 2 tablets by mouth every 4 hours as needed for mild pain (Pain scale 0 to 3-mild pain). The Administration History Report indicated No data. 4.Tylenol 500 mg give 2 tablets by mouth every 8 hours as needed for moderate pain (Pain scale pain 4-6.) last given on 05/28/25 at 5:23 p.m. During a review of Resident 1 ' s care plan titled Potential for alteration in comfort related to .pressure sore/wounds .and close pelvic fracture dated 4/3/2025, the care plan goal indicated to reduce episodes of pain or discomfort through appropriate interventions. The care plan interventions included to monitor signs and symptoms of pain, administer medication as ordered, monitor effect of medication and inform medical doctor if ineffective. During wound treatment observation on 05/29/25 at 1:43 p.m. with treatment nurse, observed Resident 1 screaming out loud when touch and turned. Treatment Nurse stop the wound treatment. Resident 1 requested to wait and give another medication for pain. During an interview on 05/29/25 at 4:40pm with the Director of Nursing (DON). The DON reports license staff needs to follow pain assessment, physician orders, monitor for pain and provide medication per MD orders and keep Resident 1 comfortable. During a review of the facility's P&P titled, Administrating pain medication revied March 2020, the P&P indicated -The purpose of this procedure is to provide guidelines for assessing the resident ' s level of pain prior to administrating analgesic pain medication. [NAME] medication is a multidisciplinary care process that includes the following: A.assessing the potential for pain B. Recognizing the presence of pain. C. Addressing the underlying cause of pain and identify the characteristics of pain.