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	07/23/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) physician progress notes were readily accessible.This deficient practice had the potential to result in a delay in the delivery of care and necessary services for Resident 1.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/30/2025, the MDS indicated Resident 1's cognition was moderately impaired cognition and was dependent (helper does all the effort) on facility staff to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a concurrent interview and record review on 7/23/2025 at 1:40 p.m., with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON stated Resident 1's physician and nurse practitioner (NP) did see Resident 1 in the facility, however, she could not find the completed copies of the physician or NP visit notes in Resident 1's medical record. The DON stated usually the physician and/or NP will come to the facility, see the residents, and either document their visit in the electronic medical record or complete a progress note on paper. The DON stated physician or NP visit notes should be in the medical record because it provides the residents' prognosis and the plan of care and treatment for the residents.During a review of the facility's policy and procedure (P&P) titled Physician Services, dated 2/2021, the P&P indicated physician orders and progress notes are maintained in accordance with current Omnibus Budget Reconciliation Act (OBRA- minimum standards for nursing home care and residents' rights) regulations and facility policy.

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