

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER Cerritos Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown injury for one sampled resident (Resident 1) when Certified Nursing Assistant (CNA) 1 identified an area of discoloration on Resident 1's left lower jaw. This deficit practice resulted in a delayed investigation by the California Department of Public Health (CDPH) into Resident 1's injury of unknown origin and had the potential for information/facts to be lost and/or forgotten. Findings During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 10/15/2025, the MDS indicated Resident 1's cognition was severely impaired, and Resident 1 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Change of Condition (COC) form dated 10/24/2025, the COC form indicated Resident 1 had an area of discoloration on her left jaw measuring 3 centimeters ([cm] a unit of measurement) x 2 cm. The COC form indicated that the Administrator (ADM) and Director of Nursing (DON) were notified. During an interview on 11/12/2025 at 9:57 a.m., CNA 1 stated on 10/24/2025 around 1:30 p.m., she was changing Resident 1's incontinence brief, when she noticed a small discoloration on the left side of Resident 1's face, which she reported to the charge nurse (Registered Nurse 1 [RN1]). During an interview on 11/12/2025 at 12:30 p.m., the DON stated she was aware of the discoloration to Resident 1's face, she stated, she investigated Resident 1's injury and believed it was related to Resident 1's agitated behavior and that was why she did not report the injury to CDPH. During an interview on 11/12/2025 at 2:30 p.m., the ADM stated the discoloration to Resident 1's face was not reported to CDPH because the facility staff assumed the discoloration was due to Resident 1's behavior. During a review of the facility's Policy and Procedure (P/P) titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, the P/P indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation or resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056405
		If continuation sheet Page 1 of 1