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	12/08/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 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 (Resident 1) was protected when Resident 1 reported to Certified Nursing Assistant (CNA) 4 that she had been struck/hit, after CNA 4 found Resident 1 with bruising to the right side of her chin. On 9/14/2025 during the 11 a.m. to 7 a.m. shift, while receiving care, Resident 1 told CNA 1 the guy had two fist towards her cheek. CNA 1 later that evening, observed Registered Nurse (RN) 1 rough handling Resident 1, while providing care, and later observed redness to Resident 1's left and right cheeks. These deficient practices resulted in Resident 1 being left unprotected after making an allegation of abuse and placed her at risk for continued abuse. Findings: During a review of Resident 1's admission Record (Face Sheet) the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of generalized muscle weakness, and depression (a persistent feeling of sadness, hopelessness and loss of interest in activities previously enjoyed). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 1 required substantial/maximal assistant (helper dose more than half the effort) with eating, personal hygiene and chair to bed/bed to chair transfers. During a review of Resident 1's History and Physical (H&P), the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Change of Condition (COC)/Interact Assessment form (SBAR), dated 9/14/2025 and timed at 9:14 a.m., the COC/SBAR indicated upon initial rounds at approximately 9:14 a.m., CNA 4 reported that Resident 1 had multiple facial discolorations on her right and left jaw, left cheek, left temple (side of the head) and left orbital (around the eye) area. During an observation on 9/25/2025 at 10 a.m., Resident 1 was observed in bed with large purplish/black bruises on the right and left side of her jawline. During an Interview on 9/25/2025 at 4:15 p.m., CNA 4 stated on 9/14/2025 at approximately 9 a.m., she went to Resident 1's room to provide care. CNA 4 stated she turned on the light, pulled the sheet from Resident 1's head and noticed red- and purple-colored bruises to Resident 1's right chin. CNA 4 stated, she asked Resident 1 what happened, and Resident 1 replied in Spanish Golpes (blow, hit, strike). CNA 4 stated she reported what Resident 1 told her to Registered Nurse (RN) 3. During a telephone interview on 9/26/2025 at 10 a.m., CNA 1 stated on 9/13/2025 at approximately 3 a.m., RN 2 asked her to assist RN 1 with cleaning Resident 1. CNA 1 stated when she went to Resident 1's room, Resident 1 was screaming the guy had two fists towards my cheek, I swear to GOD that he was hurting me. CNA 1 stated every time RN 1 entered Resident 1's room, Resident 1 would begin to shake. CNA 1 stated she reported what Resident 1 said to RN 2 and RN 2 told her (CNA 1) she (RN 2) would ask RN 1 if he was being rough with Resident 1. CNA 1 stated, later during the shift, RN 2 told her (CNA 1) that RN 1 said he did not do anything to Resident 1. CNA 1 stated at approximately 4 a.m. (9/14/2025), RN 1 asked her to hold Resident 1's hand while he fixed her Resident 1's gastrostomy tube ([GT] a thin tube inserted into the stomach it provides a direct route for delivering nutrition and medication), while assisting RN 1, she observed RN 1 shoving Resident 1 roughly and then threw a sheet over resident 1's face. CNA 1 stated Resident 1 was shaking and insulting RN 1 in Spanish. CNA 1 stated she checked on Resident 1 at the end of her shift and observed Resident 1's right and left cheeks were red. CNA 1 stated she did not know what to do because when she reported Resident 1's allegation of abuse to RN 2 earlier in the shift nothing was done. CNA 1 stated she felt bad because she should have reported Resident 1's allegation of abuse to someone else. During a telephone interview on 9/29/2025 at 9 a.m., RN 2 stated she worked on 9/13/2025 during the 11 p.m. to 7 a.m. shift and CNA 1 never told her about RN 1. RN 2 stated she saw Resident 1 between 3 a.m. and 4 a.m., the resident was agitated, confused and speaking Spanish. RN 2 stated she did not think Resident 1's behavior was a concern, so she did not get anyone to translate because Resident 1 always acted like that. RN 2 stated if she had suspected abuse she would have removed RN 1 from Resident 1's care and notified their abuse coordinator. During an interview on 9/29/2025 at 10:30 a.m., the Director of Nursing (DON) stated it was important to report suspected abuse so an investigation could begin to prevent further abuse. During a review of the facility's undated Policy and Procedure (P&P) titled, Abuse & Mistreatment of Residents the P&P indicated to uphold a resident's right to be free from verbal, sexual and mental abuse, corporal punishment and involuntary seclusion. As part of the daily and routine inspection Director of Nurses, Director of Staff Development, Nursing Supervisors, and/or designee shall monitor resident staff interaction to ensure the residents are treated in an environment that

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 report suspected abuse for one of three sampled residents (Resident 1) when Resident 1 was found with a bruise to her right and left cheek. This deficient practice resulted in the inability of the California Department of Public Health (CDPH) to conduct an effective investigation due to the potential for information 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 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including anemia (a condition where the body does not have enough healthy red blood cells), generalized muscle weakness, and depression (a persistent feeling of sadness, hopeless and loss of interest in activities previously enjoyed). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 1 required substantial/maximal assistant (helper does more than half the effort) with eating, personal hygiene and chair to bed/bed to chair transfer. During a review of Resident 1's History and Physical (H&P), the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Change of Condition (COC)/Interact Assessment form (SBAR), dated 9/14/2025 and timed at 9:14 a.m., the COC/SBAR indicated upon initial rounds at approximately 9:14 a.m., Certified Nursing Assistant (CNA) 4 reported that Resident 1 had multiple facial discolorations on her right and left jaw, left cheek, left temple (side of the head) and left orbital (around the eye) area. During an observation on 9/25/2025 at 10 a.m., Resident 1 was observed in bed with large purplish/black bruises on the right and left side of her jawline. During an interview on 9/25/2025 at 4:15 p.m., CNA 4 stated on 9/14/2025 she went to Resident 1's room to provide care at approximately 9 a.m., she turned on the light, pulled the sheet from Resident 1's head and noticed red and purple colored bruises to Resident 1's right chin. CNA 4 stated she asked Resident 1 what happened, and Resident 1 replied in Spanish Golpes (blow, hit, strike). CNA 4 stated she reported what Resident 1 told her to Registered Nurse (RN) 3. During a telephone interview on 9/26/2025 at 10 a.m., CNA 1 stated on 9/13/2025 at approximately 3 a.m., RN 2 asked her to assist RN 1 with cleaning Resident 1. CNA 1 stated when she went to Resident 1's room, Resident 1 was screaming the guy had two fists towards my cheek I swear to GOD that he was hurting me. CNA 1 stated every time RN 1 entered Resident 1's room Resident 1 would shake. CNA 1 stated she reported this to RN 2 and RN 2 told her (CNA 1) she would ask RN 1 if he was being rough with Resident 1. CNA 1 stated later RN 2 told her (CNA 1) that RN 1 said he did not do anything to Resident 1. CNA 1 stated at approximately 4 a.m. (9/14/2025) RN 1 asked her to hold Resident 1's hand while he fixed Resident 1's gastrostomy tube ([GT] a thin tube inserted into the stomach it provides a direct route for delivering nutrition and medication). CNA 1 stated, while assisting RN 1, she observed RN 1 shove Resident 1 roughly and then he threw a sheet over her face. CNA 1 stated Resident 1 was shaking and insulting RN 1 in Spanish. CNA 1 stated she checked on Resident 1 at the end of her shift and observed Resident 1's right and left cheeks were red. CNA 1 stated she did not know what to do because when she reported Resident 1's allegation of abuse to RN 2 earlier in the shift nothing was done. CNA 1 stated she felt bad because she should have reported the alleged abuse to someone else. During a telephone interview on 9/29/2025 at 9 a.m., RN 2 stated she worked on 9/13/2025 during the 11 p.m. to 7 a.m. shift and CNA 1 never told her about RN 1. RN 2 stated she saw Resident 1 between 3 and 4 a.m., the resident was agitated, confused and speaking Spanish. RN 2 stated she did not think to get a translator for Resident 1 because Resident 1 always behaved that way. RN 2 stated if she suspected abuse had occurred, she would have removed RN 1 and got another nurse to care for Resident 1. During an interview on 9/26/2025 at 10:24 a.m., the Director of Staff Developer (DSD), stated suspected abuse should be reported immediately. During an interview on 9/29/2025 at 10:30 a.m., the Director of Nursing (DON) stated as mandated reporters' staff should report suspected abuse immediately so the allegation of abuse could be investigated and the resident protected. During a review of the facility's undated Policy and Procedure (P&P) titled, Abuse allegation Reporting the P&P indicated: 1. All allegations involving abuse of any type will be reported by the charge nurse and or/supervisor immediately to the Director of Nursing. 2. As a mandated reporter, an employee who identifies suspected abuse committed against an individual who is a resident must also report the incident to one local law enforcement entity by phone within 24 hours and provide a written report to the local ombudsman, the L&C Program, and local law enforcement within 24 hours for non-serious bodily injury. For serious bodily injury, the requirement requires a phone call

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for one of three sampled residents (Resident 1) when Resident 1 was found with a bruise on her right and left cheek. This deficient practice resulted in the inability of the facility to determine how bruising on Resident 1's face occurred and placed Resident 1 at risk for continued injury/abuse. Findings: During a review of Resident 1's admission Record (Face Sheet) the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of generalized muscle weakness, and depression (a persistent feeling of sadness, hopelessness and loss of interest in activities previously enjoyed). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 1 required substantial/maximal assistant (helper dose more than half the effort) with eating, personal hygiene and chair to bed/bed to chair transfers. During a review of Resident 1's History and Physical (H&P), the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Change of Condition (COC)/Interact Assessment form (SBAR), dated 9/14/2025 and timed at 9:14 a.m., the COC/SBAR indicated upon initial rounds at approximately 9:14 a.m., CNA 4 reported that Resident 1 had multiple facial discolorations on her right and left jaw, left cheek, left temple (side of the head) and left orbital (around the eye) area. During an observation on 9/25/2025 at 10 a.m., Resident 1 was observed in bed with large purplish/black bruises on the right and left side of her jawline. During a telephone interview on 9/26/2025 at 10 a.m., Certified Nursing Assistant (CNA) 1 stated on 9/14/2025 during the 11 p.m. to 7 a.m. shift, she wrote and turned in a statement to the Director of Staff Development (DSD) regarding Resident 1's allegation that Registered Nurse (RN) 1 hurt her. During an interview on 9/26/2025 at 10:24 a.m., the DSD stated she collected written statements from the CNAs who provided care to Resident 1, including CNA 1, but stated she did not read any of the statements. The DSD stated she gave the CNAs written statements, including CNA 1's statement, to the Director of Nursing (DON). During an interview on 9/29/2025 at 10 a.m., the DON stated it was both her and the Administrator's (ADM) responsibility to conduct interviews during abuse investigations and her investigation of Resident 1's bruises was not complete. The DON stated she interviewed and received statements from all staff who were assigned to Resident 1 but stated she did not interview CNA 1, and she did not have a statement from her. During a review of the facility's undated Policy and Procedure (P&P) titled, Abuse & Mistreatment of Residents the P&P indicated extensive efforts shall be carried out in the investigation and determination of unusual occurrences and or events that may constitute abuse, including those injuries incurred by the residents for which the origin of such injury is unknown.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 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 (Resident 1), who displayed behaviors of uncontrollable singing, and was transferred to a General Acute Care Hospital (GACH) for evaluation and treatment, was allowed to return to the facility once the GACH cleared her for discharge back to the facility. This deficient practice resulted in Resident 1 remaining in the GACH for 21 days after attempts to transfer her back to the facility were made by the GACH. This deficient practice placed Resident 1 at risk for disruption in her routine, anxiety and non-continuity of care.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 diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had severe cognitive (the ability to think and reason) impairment. During a review of Resident 1's SBAR [(situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) dated [DATE], the SBAR indicated Resident 1 had uncontrollable singing of unknown words creating a disturbance amongst her roommates, and refusal to have her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) completed by staff. During a review of Resident 1's Physician's Order, dated [DATE], the Physician's order indicated to transfer Resident 1 to a GACH for further evaluation and intervention related to Dementia. During a review of Resident 1's Bed Hold Notice, dated [DATE], the Bed Hold Notice indicated Resident 1 and/or her emergency contact were notified of the bed hold. The Bed Hold Notice indicated FM was notified and gave a verbal consent. During a review of Resident 1's Notice of Proposed Transfer and discharge date d [DATE] (the same day Resident 1 was transferred to the GACH), the Notice of Proposed Transfer and discharged indicated Resident 1's discharge was necessary for Resident 1's welfare and her needs could not be met in the facility. The Notice of Proposed Transfer and Discharge was not signed by Resident 1 or Resident 1's FM, instead there was a printed name in the space designated for a signature. The Notice of Proposed Transfer and Discharge did not indicate how far in advance the notice should be given to the resident and/or the resident's representative. During a review of Resident 1's Licensed Nursing Note, dated [DATE], and timed at 6:38 p.m., the Licensed Nursing Note indicated Resident 1 was transferred to a GACH emergency room for further treatment and evaluation by ambulance at 6:30 p.m. During a review of the Facility's Census dated [DATE], the Facility Census indicated four female beds were available. During a review of the GACH's Emergency Department (ED) Record dated [DATE], the ED Record indicated Resident 1 arrived to the ED on [DATE] at 6:58 p.m. During a review of the GACH's Progress Note, dated [DATE], the Progress Note indicated on [DATE] the Social Worker (SW) received a call from the facility's Admissions Coordinator (AC) informing her the facility would not be accepting Resident 1 back to the facility after she stabilized. The Progress Note indicated the facility's psychiatrist informed her (SW) that the facility did not want Resident 1 to return to the facility.During a review of the GACH's Progress Note, dated [DATE], the Progress Note indicated the SW informed Resident 1's Family Member (FM) that another facility accepted Resident 1 for admission, but the FM requested for the SW to contact the facility Resident 1 was transferred from to see if they would accept Resident 1 back. The Progress Noted indicated the SW spoke to the facility's AC and the AC stated, per the facility's Administrator (ADM) they were not going to accept Resident 1 back because they felt she needed a placement at a facility who could handle her behaviors. The Progress Note indicated the facility did not give the patient a chance to improve before making that decision. During a review of a Text Message from the facility's Director of Nursing (DON) to the facility's psychiatrist, dated [DATE] and timed at 12:26 p.m., the Text Message indicated Resident 1 was ready for discharge from the GACH, but could he (the psychiatrist) refer her (Resident 1) to a facility with a dementia unit. The text indicated psychiatrist said OK. During a review of the GACH's Discharge Orders dated [DATE], the Discharge Orders indicated Resident 1 was transferred to another skilled nursing facility on [DATE] (21 days after Resident 1 was ready for transfer back to the facility). During an interview on [DATE] at 11:13 a.m., the GACH's SW stated on [DATE] she called the facility to make sure they were going to readmit Resident 1 to the facility. The SW stated she spoke to the facility's AC, who told her they were not going to readmit Resident 1 back because she needed a more behavioral focused facility. The SW stated the

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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 observation, interview and record review, the facility failed to ensure care provided to one of three sampled residents (Resident 1) was completed in a timely manner and under appropriate conditions. This deficient practice resulted in rounds not being completed and care not being provided to Resident 1 until approximately four hours after the 11 p.m. to 7 a.m. shift began on 9/14/2025 and when care was provided at approximately 3 a.m., (9/14/2025), it was done with the lights off/dimmed with staff unable to determine Resident 1's status. This deficient practice placed Resident 1 at risk for an unrecognized change of condition (COC).Findings: During a review of Resident 1's admission Record (Face Sheet) the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of generalized muscle weakness, and depression (a persistent feeling of sadness, hopelessness and loss of interest in activities previously enjoyed). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 1 required substantial/maximal assistant (helper dose more than half the effort) with eating, personal hygiene and chair to bed/bed to chair transfers. During a review of Resident 1's History and Physical (H&P), the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's COC/Interact Assessment form (SBAR), dated 9/14/2025 and timed at 9:14 a.m., the COC/SBAR indicated upon initial rounds at approximately a.m., Certified Nursing Assistant 4 (CNA 4) reported that Resident 1 had multiple facial discolorations on her right and left jaw, left cheek, left temple (side of the head)and left orbital (around the eye) area. During an observation on 9/25/2025 at 10a.m., Resident 1 was observed in bed with large purplish/black bruises on the right and left side of her jawline. During a telephone interview on 9/25/2025 at 3:13 p.m., Registered Nurse (RN) 1 stated on 9/13/2025 during the 11 p.m. to 7 a.m. shift he made rounds on Resident 1 at 11 p.m., 2:35 a.m., and 5 a.m., but when he entered Resident 1's room the lights were dim, and he never saw Resident 1's face. During a telephone interview on 9/26/2025 at 8:30 a.m., CNA 2 stated on 9/13/2025 during the 11 p.m. to 7 a.m. shift, Resident 1 was assigned to her but stated she never saw Resident 1 and was told later by CNA 1 that Resident 1 had already been cleaned at 3 a.m. During an interview on 9/26/2025 at 10:24 a.m., the Director of Staff Development (DSD) stated CNAs are instructed to attend a huddle (a short meeting) at the beginning of the shift, and after they receive their assignment, to make rounds in order to make sure the residents are there, their call lights are in reach, and they are safe. The DSD stated if the room was dark when a CNA or other staff entered the room to give care, they should turn the lights on. The DON stated staff cannot perform effective care or determine if injuries are present if the lights are out. During an interview on 9/29/2025 at 10 a.m., the Director of Nursing (DON) stated staff should make rounds at the beginning of the shift to make sure residents are clean, comfortable and safe. During a review of the facility's undated Policy and Procedure (P&P) titled, Abuse & Mistreatment of Residents the P&P indicated department supervisors shall ensure that adequate supervision is being given, and appropriate assistance extended to residents in need when performing their daily activities monitoring and rounds.