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	01/06/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 resident's (Resident 1) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for a psychotropic (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication was obtained prior to administration of the medication to Resident 1.This deficient practice violated Resident 1 rights to receive information, in advance, of risks and benefits of proposed care, treatment, treatment alterative, and choose the alterative of choice which includes information for administration of psychotropic drugs.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health conditions causing intense, excessive, and persistent fear or worry that disrupts daily life, insomnia (trouble falling asleep or staying asleep), and homelessness.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 1 had moderately impaired cognition and needed set up assistance with eating, and partial assistance (helper does less than half the effort) with other Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Physician's Order Listing Report, 12/24/2025 to 12/31/2026, the Physician's Order Listing Report indicated, starting 12/25/2025, Quetiapine Fumarate (medication for depression and anxiety) tablet 50 milligrams, one tablet by mouth at bedtime for depression manifested by verbalized feeling of hopelessness and agitation.During a concurrent interview and record review on 1/6/2026 at 2:20 p.m., with Registered Nurse (RN) 1, Resident 1's physician order for Quetiapine Fumarate tablet, 50 milligrams, one tablet by mouth at bedtime was reviewed. RN 1 stated facility staff did not obtain informed consent before administering the quetiapine, and medication administration started on 12/25/2025.During an interview with the Director of Nursing (DON) on 1/6/2026 at 1:21 p.m. the DON stated that informed consent should be obtained prior to the administration of psychotropic medications.During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic drug informed consent, revised 1/2026, the P&P indicated facility will ensure residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, possible side effects and alternative approaches before initiating the administration of psychotherapeutic drugs.

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

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	01/06/2026

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

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident (Resident 1) was seen by a psychologist (medical doctor who can diagnose and treat mental health conditions) as physician ordered. The deficient practice resulted in Resident 1 not being assessed and treated (as needed) by a psychologist while in the facility, with the potential for untreated mental health decline.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health conditions causing intense, excessive, and persistent fear or worry that disrupts daily life, insomnia (trouble falling asleep or staying asleep).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 1 had moderately impaired cognition and needed set up assistance with eating, and partial assistance (helper does less than half the effort) with other activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Physician's Order Listing Report, 12/24/2025 to 12/31/2026, the Physician's Order Listing Report indicated an order for Resident 1 dated 12/24/2025, for a psychological evaluation and follow up treatment as indicated.During a review of Resident 1's Physician's Order Listing Report, 12/26/2025 3:26 p.m. the Physician's Order Listing Report indicated psych consultation for depression and anxiety.During a concurrent interview and record review on 1/6/2026 at 2:20 p.m., with Registered Nurse (RN) 1, Resident 1's physician orders were reviewed. RN 1 stated a Psych consultation was ordered for Resident 1 but it was not completed. RN 1 stated the order for a Psych consult should have been carried out as ordered. During an interview with the Director of Nursing (DON) on 1/6/2026 at 1:21 p.m. the DON stated psych consult should be completed if ordered by the physician.During a review of the facility's Policy and Procedure (P/P) titled, Behavioral Assessment, Intervention, and Monitoring revised 3/2019, the P/P indicated the facility will provide and residents will receive behavior health services as needed to attain or maintain highest practicable mental, physical, and psychosocial well-being.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident's (Resident 1) Permethrin shampoo (medication for head lice [tiny crawling insects]) ordered on 12/26/2025 was dispensed by the pharmacy and administered in a timely manner. The deficient practice resulted in a delay of care and Resident 1 was not treated for head lice until 12/29/2025, three days after head lice infestation was identified, which has the potential to cause uncomfortable itching and loss of sleep for the Resident 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health conditions causing intense, excessive, and persistent fear or worry that disrupts daily life, insomnia (trouble falling asleep or staying asleep), and homelessness.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 1 had moderately impaired cognition and needed set up assistance with eating, and partial assistance (helper does less than half the effort) with other activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Physician's Order Listing report, 12/24/2025 to 12/31/2026, the Physician's Order Listing report, indicated an order starting on 12/26/2025, for Permethrin- NLT Remover-Permeth Combination kit, apply head scalp one time only for head lice for one day then reorder after 7 days.During a concurrent interview and record review on 1/6/2026 at 1 p.m., with Registered Nurse (RN) 1, Resident 1's Medication Administration record was reviewed. RN 1 stated the lice medication for Resident 1 was ordered on 12/26/2025 but was not administered until 12/29/2025 (three days later). RN 1 stated not administering Resident 1's Permethrin as soon as it was ordered was unacceptable and should have been carried out right away.During an interview with the Director of Nursing (DON) on 1/6/2026 at 1:21 p.m. the DON stated medication orders with instructions need to be implemented within 24 hours.During a review of the facility's Policy and Procedure (P/P) titled, Administering Medications, revised 4/2019, the P/P indicated medication will be administered in a timely manner.During a review of the facility's P/P titled, Medication Ordering and Receiving from Pharmacy, revised 1/2022, the P/P indicated medication will be received in a timely manner.