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	04/06/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician's orders for an orthopedic surgeon (specialist in bones, joints, and muscles) and vascular specialist (specialist in blood vessels and circulation) was carried out and/or follow-up was made for one of four sampled residents (Resident 1) who had dry gangrene (tissue death caused by loss of blood supply) of the left finger. These failures resulted in a two-week delay in obtaining Resident 1's ordered consultations and placed Resident 1 at risk for worsening gangrene, auto-amputation (dead portion may fall of on its own due to lack of blood supply) of the left finger, and infection. 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] and readmitted on [DATE]. Resident 1 was admitted with diagnoses including open wound of the left index finger without damage to nail, type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and epilepsy (a brain disorder that causes repeated seizures [uncontrolled movement]).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 2/21/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and Resident 1 required moderate assistance (helper does less than half the effort) from staff for eating and was dependent (helper does all the effort) on staff for toileting and bathing. The MDS further indicated Resident 1 had a total of four venous (related to veins) and arterial (related to arteries) ulcers (a small open sore or wound generally found in the stomach or on the skin).During a review of Resident 1's History and Physical (H&P), dated 3/18/2026, the H&P indicated Resident 1 was not able to make medical decisions. The H&P indicated Resident 1 was readmitted to the facility from a General Acute Care Hospital (GACH) with gangrene of the left finger and required an outpatient follow-up with an orthopedic specialist to determine the need for amputation (the surgical removal of f body part, such as a finger, toe, hand, foot, or limb). During a review of Resident 1's Order Summary Report (Physician's Orders) dated 4/1/2026, the Physician's Orders indicated the facility was to obtain an authorization for Resident 1 to be seen by an orthopedic surgeon, ordered on 3/13/2026 and by a vascular specialist, ordered on 3/16/2026.During an observation on 4/2/2026 at 8:30 a.m., in Resident 1's room, the Treatment Nurse (TXN) 1 was observed performing wound care and a dressing change to Resident 1's left index finger. Resident 1's left index finger appeared darkened with blackened areas at the tip with discoloration extending along the finger. Resident 1's fingertip appeared larger compared to the adjacent fingers. During a review of the Social Service Note dated 3/17/2026, the Social Service Note indicated the Case Manager (CM) notified the Power of Attorney ([POA] the person who is legally allowed to receive information about the resident, make care decisions, and handle insurance or financial matters on the resident's behalf) to make her aware that the orthopedic surgeon did not accept Resident 1's secondary insurance and would refer Resident 1 to another orthopedic provider that accepted his secondary insurance. During a review of [NAME] Healthcare's Prior Authorization ([PA] insurance approval before certain medical services can be provided or paid for) determination, dated 3/18/2026, the insurance determination indicated the PA (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	request for outpatient consultation services for Resident 1's gangrene left index finger was returned. The insurance determination indicated Resident 1's primary insurance was Medicare, and that Resident 1 had secondary insurance. The insurance determination instructed the facility to contact the Resident 1's primary insurance for coverage of the outpatient consultation services.During an interview on 4/2/2026 at 2:48 p.m. with the SSD, the SSD stated when nurses authorize a specialist referral, they write a physician's order then give it to Social Services. Social Services then faxes the authorization request form to the resident's insurance. If the authorization is denied, then they (nursing staff) need to find other options. The SSD stated she was not aware of Resident 1's referral because she believed the CM was handling the authorization.During a review of Resident 1's Medical Records dated 3/13/2026 through 4/2/2026, there was no documentation indicating the SSD coordinated, scheduled, or followed up on these referrals after the authorization issue was identified.During an interview on 4/2/2026 at 2:58 p.m., with the CM, the CM stated Resident 1 required vascular and orthopedic referrals and stated the resident's insurance did not cover the referrals. The CM stated she submitted an authorization request to Resident 1's secondary insurance on 3/18/2026 and stated the authorization response indicated the resident's primary insurance was Medicare. The CM stated the authorization for Medicare was not the facility's responsibility and stated the secondary insurance was responsible for obtaining Medicare authorization and did not follow up after the insurance denial. During an interview on 4/2/2026 at 3:19 p.m., with Registered Nurse (RN 1), RN 1 stated she attempted to make an appointment for Resident 1, but the surgeon's office informed her they did not accept the resident's insurance. RN 1 stated the facility attempted to offer private pay, but the surgeon's office stated the resident could not be seen as a private pay because the resident had active insurance coverage. RN 1 stated she requested assistance from the SSD and informed the CM of the insurance issue. RN 1 stated she was responsible for scheduling the specialist appointments, but when the insurance authorization was denied, she referred the issue to the CM. RN 1 stated she made several attempts to locate a specialist who accepted Resident 1's insurance and notified the CM; however, did not document those attempts. During an interview on 4/6/2026 at 11:10 a.m., with the Director of Nursing (DON), the DON stated when a resident required a referral, nursing receives the physician's order, carries out the order, and notifies the SSD and CM. The DON stated nursing located the specialists listed in the order and initiated calls. If a specialist required insurance information or did not accept the resident's insurance, nursing would notify CM. The DON stated CM was responsible for obtaining insurance authorizations and communicating ongoing issues to SSD and the BO. The DON stated the SSD was responsible for tracking referrals, coordinating outside appointments, handling insurance appeals, and monitoring CM activity related to the resident's care. The DON stated the SSD should have coordinated referrals under Medicare once Resident 1's secondary insurance indicated Medicare was the primary payer. The DON stated the CM and SSD should have worked together and the SSD should have overseen CM's activity when referrals impacted the resident's care. The DON stated missed communication and missed coordination in the referral process resulted in a delay of resident care. During a review of the facility's Job Description titled Social Services Designee, dated 1/27/2022, the job description indicated the Social Service Designee responsibilities include: 1. Assisting in the provision of medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.2. Assisting residents or responsible parties in processing forms or applications in the effort to obtain outside services, including but not limited to Social Security, Medicaid, SSI or any other service to which the resident may be entitled; and3. Implements social service interventions that achieve treatment goals, address resident needs, and link social supports, physical care and physical environment to enhance quality of life.During a review of the facility's policy and procedure (P&P) titled Social Services, revised September 2021, the P&P indicated:1. Social services staff are responsible for making referrals and obtaining needed services from outside entities.2. The facility is responsible for ensuring that all residents are provided with (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medically related social services whether by a staff member or through referrals to an outside agency.3. Obtaining or attempting to obtain medically related social services on behalf of a resident are not contingent upon Medicaid coverage of needed services.