

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 6) who had behaviors of getting up unassisted, was not restrained in a Trendelenburg (a specific body position where the patient lies flat on their back with their feet elevated higher than their head) like position, while seated in a Geri-chair. This deficient practice resulted in Resident 6's inability to get out of the Geri-chair unassisted and frustration when he wanted to get up but could not do so himself. This deficient practice had the potential for Resident 6 to act out and move in ways that could cause him injury. Findings: During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was admitted to the facility on [DATE]. Resident 6 had diagnoses including encephalopathy (a condition in which there is disturbance in brain function that causes confusion, memory loss and coma), dementia (a progressive state of decline in mental abilities) and depression (a mood that causes ongoing sadness and loss of interest in normal daily activities of life). During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool) dated 6/29/2026, the MDS indicated Resident 6 was forgetful and unable to make decisions. Resident 6 required a one person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 6's Medical Record, the Medical Record indicated there was no written documentation of Resident 6's need or evaluation for a restraint, no physician's order for a restraint, and no alternative measures used before restraining Resident 6 in a Geri-chair. During an observation on 7/29/2026 at 10:14 a.m., Resident 6 was seen sitting in a Geri-chair, in a Trendelenburg like position. The Activity Director (AD) pushed Resident 6 in the Geri-chair to the facility's patio. Resident 6's jaw was tightened and her was frowning and attempted to turn from side to side while in the Geri-chair. Resident 6 was heard telling the AD that he did not want to go outside, and he wanted to get out of the Geri-chair. Resident 6 continued to frown and glare while talking loudly to the AD. During an interview on 7/29/2026 at 10:18 a.m., the Social Services Director (SSD) stated she was on the patio with Resident 6 when Resident 6 verbalized he was unhappy and wanted to get out of the Geri-chair but could not get up on his own. The SSD stated Resident 6 was confused and the Geri-chair had been recommended for use by the rehabilitation department for Resident 6's safety. During an interview on 7/29/2026 at 12:35 p.m., the Director of Rehabilitation (DOR) Services stated Resident 6 had good trunk control while sitting in a wheelchair and only needed assistance when moving from place to place in the wheelchair. The DOR stated a Geri-chair was not recommended for use by Resident 6 because Resident 6 could sit well in a regular wheelchair. During an interview on 7/29/2026 at 1:03 p.m., Certified Nursing Assistant (CNA) 1 stated she positioned Resident 6 with his head lower than his legs while sitting in a Geri-chair so Resident 6 would not try to get up and fall. During an interview on (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/29/2026 at 1:14 p.m., the AD stated Resident 6 should be positioned with his head lower than his legs and his legs elevated over his head for his safety because he was a fall risk. During an interview on 7/29/2026 at 1:35 p.m., Resident 6's Responsible Party (RP) stated the nursing staff told her they place Resident 6 in a Geri-chair because he tries to get up unassisted. During an interview on 7/29/2026 at 1:56 p.m., Licensed Vocational Nurse (LVN) 1 stated Resident 6 had a behavior of getting up unassisted and to prevent him from falling, the CNAs would position him in a Geri-chair with his feet elevated over his head for his safety. During an interview on 7/29/2026 at 2:36 p.m., the Director of Nursing (DON) stated the nursing staff should not have placed Resident 6 in a Geri-chair to prevent him from getting up even if he was a fall risk. The DON stated positioning Resident 6 in the Geri-chair with his head lower than his lower extremities restricted his movements and they should have monitored and redirected him when he attempted to get up unassisted. During a review of the facility's P/P titled, Use of Restraints revised 4/2017, the P/P indicated the facility shall only use restraints such as a Geri-chair, to: a. Ensure the safety and well-being of the resident and only after alternatives have been tried unsuccessfully, b. Implement and perform a pre-restraining assessment and review to determine the need for restraints and to determine if there are least restrictive interventions., c. Use the restraints only upon the written order of the physician and after obtaining consent from the resident and/or responsible party d. Inform the residents and their responsible parties about the potential risks and benefits of all options under in consideration, including the use of restraints, not using restraints, and the alternatives to restraint use; and e. Use the restraints to treat the residents' medical symptoms and never for discipline or staff convenience, of the prevention of falls.		