STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555112	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Rancho Vista Health Care Center	8925 Mines Avenue Pico Rivera, CA 90660

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure complete and accurate medical record was maintained in accordance with accepted professional standards, for one of three sampled residents (Resident 1), who received rehabilitative services from Certified Occupational Therapy Assistant (COTA) and Physical Therapist Assistant (PTA). This deficient practice resulted in incomplete treatment encounter notes and the potential for inappropriate clinical reasoning for PT and OT services provided to the resident. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including joint replacement surgery (involves removing a damaged joint and replacing it with an artificial prosthesis to relieve pain and restore function), muscle weakness (muscles cannot generate the expected force during contraction, making it difficult to perform normal activities) and difficulty in walking (gait abnormality) refers to any change in normal walking pattern that can be due to injury, disease, or neurological issues). During a review of Resident 1's History and Physical examination (H&P) dated 5/9/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 required substantial/ maximal assistance on staff with activity of daily living (ADLs) such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, taking on taking off footwear, personal hygiene. During a review of Resident's 1 orders summary report dated 4/14/2025, the order summary indicated OT services every day five (5) times a week for four (4) weeks for therapeutic exercises, therapeutic activities, neuromuscular reeducation, and difficult walking. During a review of Resident 1's order summary report dated 4/16/2026, the order summary indicated PT treatment, for diagnosis of weakness, difficult in walking, daily 5 times a week for 4 weeks for gait training, safety awareness. During a review of Resident 1's OT treatment encounter notes dated 4/24/2026, the OT Treatment encounter notes dated 5/11/2026, 6/3/2026, 6/4/2026, 6/8/2026 had no original cosignatures. The Treatment encounter notes dated 5/18/2026 were not fully completed and had missing original and cosignatures. During a review of Resident 1's PT treatment encounter notes dated 4/24/2026, the Treatment encounter notes dated 5/11/2026 and 5/21/2026 had missing cosignatures. During an interview on 6/10/2026 at 10:39 a.m., with Certified Occupational Assistance (COTA), COTA stated COTA will need to be cosigned by a licensed OT. The COTA stated the OT will cosign the encounter notes the same day or next day after treatment. The COTA stated all encounter notes must be completed after each treatment. During an interview on 6/10/2026 at 11:22 a.m., with PT, the PT stated, PTA need to be cosigned per state law. The PT stated, PT will cosign PTA's notes the same day after treating residents or at the end of the day. The PT stated the Treatment encounter notes are important documentation on how Resident 1 performed on the day-to-day PT/ OT therapies. During an interview on 6/10/2026 at 10:39 a.m. with the COTA, the COTA stated that all COTA documentation must be cosigned by a licensed OT. The COTA stated the OT should cosign the encounter notes the same day or the next day after treatment. The COTA (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also stated that all encounter notes must be completed after each treatment session. During an interview on 6/10/2026 at 11:22 a.m. with the Physical Therapist (PT), the PT stated, We cosign PTA signatures per state law. The PT stated they would sign the same day after treating residents at the end of the day. The PT also stated it is important to document in the encounter notes how Resident 1 performed during the treatment on that day. During an interview on 6/10/2026 at 1:16 p.m., with the Director of Rehabilitation (DOR), the DOR stated that all COTA and PTA treatment encounter notes must be cosigned. The DOR explained that cosigning the notes indicate oversight of the level of therapy provided by the COTA and PTA. The DOR stated that notes are documented throughout the day or at the end of the day and emphasized that it is essential to document how residents progress with daily therapy. The DOR further stated that if treatment is provided on weekends, they will sign the notes on Monday morning. During an interview on 6/17/2026 at 2:45 p.m., with the DOR, the DOR that treatment encounter notes should be finished before staff leave the facility. The DOR explained that the rehabilitation department has its own policies and procedures (P&P) but follows facility policies when necessary. The DOR stated it is very important to ensure treatment encounter notes are completed and cosigned before being sent, to verify that the clinical reasoning for Resident 1 is appropriate for the level of PT and OT services provided. During a review of facility's P&P titled, Documentation Guidelines, dated 11/2021, the P&P indicated documentation in the legal health record should include date and time as appropriate and signed.