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	04/23/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when:1. Three frozen packs of ham were unlabeled.2. [NAME] 1 wore a cuff bracelet (a band with an open back that slides onto the wrist without a clasp) during lunch preparation and trayline (meal assembly system).3. Food in the resident's refrigerator was not labeled properly.4. Non-Resident drinks were stored in the resident's refrigerator.These deficient practices had the potential to result in incorrect use of the unlabeled ham and placed the residents at risk for exposure to bacteria and contaminants, increasing the risk of foodborne illness, infection, and compromised health and safety.Findings:1. During a concurrent observation and interview during the initial kitchen tour on 4/20/2026 at 8:33 a.m., with the Dietary Supervisor (DS) at the freezer, three sealed packs of meat were observed on the top shelf of the freezer. The DS stated the sealed packs of meat were ham. The DS stated the three packs of ham were not labeled with the name, received date, and manufacturer's use-by date. During an interview on 4/21/2026 at 1:26 p.m., with the DS, the DS stated the three packs of ham in the freezer were supposed to have a label with the food item name, received date, and the manufacturer's use-by date. The DS stated proper labeling was important to ensure the kitchen staff knew what the food item was and did not confuse the ham for something else. The DS stated without the proper labels with the dates, there was a potential for development of foodborne illness.During a review of the facility's Policy and Procedure (P&P) titled, Labeling and Dating of Foods, undated, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.2. During an observation on 4/21/2026 at 11:34 a.m., in the kitchen, [NAME] 1 was observed wearing a cuff bracelet (a band with an open back that slides onto the wrist without a clasp) on her left wrist. [NAME] 1 removed, drained, and transferred a pot of peas from the stove to a tray, covered the tray with aluminum foil and placed the tray on the steam table. During an observation on 4/21/2026 at 11:45 a.m., in the kitchen, [NAME] 1 was observed wearing a cuff bracelet on her left wrist. [NAME] 1 removed the aluminum foil of the food trays on the steam table. During an observation on 4/21/2026 at 12:01 p.m., in the kitchen, [NAME] 1 was observed wearing a cuff bracelet on her left wrist. Trayline (meal assembly system) began and [NAME] 1 was assigned to assemble each plate. During a concurrent observation and interview on 4/21/2026 12:34 p.m., with the DS, in the kitchen, [NAME] 1 was observed wearing a cuff bracelet on her left wrist. After the trayline [NAME] 1 began clearing the food trays from the steam table. The DS stated [NAME] 1 was wearing a cuff bracelet, which did not have a backing, and could slip off her wrist and fall into the food. During a concurrent interview and record review on 4/21/2026 at 1:23 p.m., with the DS, the facility's P&P titled, Dress Code, undated, the P&P indicated, Personal hygiene and appropriate dress are a very important part of the total appearance of the Food and Nutritional Services Department. The P&P indicated proper dress included not having excessive jewelry, only weddings rings on hand, non-dangling earrings on ears, and a wristwatch. The DS stated [NAME] 1's cuff bracelet was against the dress code in the kitchen. The DS stated [NAME] 1 wearing a cuff bracelet was an infection control issue because the bracelet could harbor bacteria which could potentially transfer to the food.3. During a concurrent observation and interview on 4/21/2026 at 1:34 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	p.m., with Licensed Vocational Nurse (LVN) 3, in Station 1, the designated resident refrigerator contained:a. A bottle of green electrolyte beverage with 5C written on the cap.b. Two sealed yogurt containers with 17B written on the top, the yogurt containers did not indicate the use-by date.c. Two cola bottles with 17B written on the caps.d. A bottle of mineral water with 17B written on the bottle.LVN 3 stated the items observed belonged to residents in the facility. LVN 3 stated when a food or beverage item were placed in the refrigerator, the food or beverage item was supposed to be labeled with the resident's name, the date placed in the refrigerator, and the use-by date, when applicable. LVN 3 stated labeling with the resident's room number was not appropriate because residents may change rooms and the room number labeled food items would not match the current resident in that room. LVN 3 stated labeling the food or beverage items with the date ensured the food item were still edible and not beyond its use-by date.During an interview on 4/23/2026 at 9:10 a.m., with the Director of Nursing (DON), the DON stated unopened food and beverage items stored in the resident's refrigerator should have the resident's name, the date placed in the refrigerator, and the use-by date, when applicable. The DON stated there were room changes at times, therefore labeling the food and beverage items with the room number was inappropriate. The DON stated the yogurt in the refrigerator probably came from a box that had the use-by date and should have been transferred to the individual yogurt cups to ensure the yogurt was not ingested past the use-by date. 4. During a concurrent observation and interview on 4/21/2026 at 1:38 p.m., with LVN 3, in Station 1, the designated resident refrigerator contained a reusable bottle with a green beverage. LVN 3 stated the beverage did not belong to a resident. LVN 3 stated the beverage belonged to the psychologist visiting the facility. LVN 3 stated the refrigerator was strictly used to store food and beverages belonging to the residents. LVN 3 stated mixing resident's food and beverage items with those of the staff increased the risk of cross contamination.During an interview on 4/23/2026 at 9:12 a.m., with the DON, the DON stated the refrigerator in Station 1 was used to store the residents' food and beverages. The DON stated staff and visiting clinicians should not store their items in there. The DON stated having staff and resident food and beverage items mingling in the refrigerator was an infection control issue. During a review of the facility's P&P titled, Food Prepared Outside Facility, revised 12/2018, the P&P indicated, Food that can be safely stored shall be placed in the refrigerator on station 1 with the name and 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents' (Resident 70) clothing protector (garment worn over clothing during meals to protect against spills) was not referred to as a bib. This deficient practice had the potential for Resident 70 to feel embarrassed and to feel as if being treated as a baby.Findings:During a review of Resident 70's admission Record, the admission Record indicated Resident 70 was admitted to the facility on [DATE]. Resident 70's diagnoses included dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD- a chronic digestive condition where the stomach acid frequently flows back up the esophagus [tube connecting the mouth to the stomach]), and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 70's Minimum Data Set (MDS- a resident assessment tool), dated 2/13/2026, the MDS indicated Resident 70's cognition (process of thinking) was intact. The MDS indicated Resident 70 required substantial assistance (helper does more than half the effort) with eating and was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene. During a review of Resident 70's History and Physical (H&P), dated 2/9/2026, the H&P indicated Resident 70 had the capacity to understand and make medical decisions. During an observation on 4/20/2026 at 12:24 p.m., in Resident 70's room, Resident 70 was observed sitting in his wheelchair waiting for his lunch tray to arrive. Certified Nursing Assistant (CNA) 2 entered the room and while placing a towel over Resident 70's chest. CNA 2 stated to Resident 70, I'll put your bib on.During an interview on 4/21/2026 at 10:17 a.m., with Resident 70, Resident 70 stated he always wore a towel or a bib when he ate his meals to ensure food did not spill on his clothing. Resident 70 stated the staff always called the clothing protector (garment worn over clothing during meals to protect against spills), a bib. During an interview on 4/22/2026 at 12:30 p.m., with the Director of Staff Development (DSD), the DSD stated every resident was supposed to have a dignified dining experience during every meal. The DSD stated Resident 70 requested a clothing protector with every meal because he did not want any food spilling on his clothing. The DSD stated the clothing protector should not be called a bib because we do not want them to feel less than or as a child.During an interview on 4/23/2026 at 9:47 a.m., with the Director of Nursing (DON), the DON stated any item used as a clothing protector during meals should never be referred to as a bib. The DON stated calling a clothing protector as a bib was not appropriate for the residents because they were adults and bibs were typically reserved for babies. The DON stated calling the clothing protector as a bib had the potential for Resident 70 to feel as if he were being treated as a baby instead of an adult. During a review of the facility's Policy and Procedure (P&P) titled, Quality of Life- Dignity, dated 4/2018, the P&P indicated, Residents shall be treated with dignity and respect at all times. Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit a referral to the Office of the Long-Term Care Patient Representative (OLTCPR- office that provides a trained public representative for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized decision-maker) for one of eight sampled residents (Resident 28). This deficient practice resulted in delaying the process of obtaining a representative for Resident 28, who did not have the capacity to understand and make decisions. Cross Reference F552 and F578.Findings:During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE]. Resident 28's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (a mental condition characterized by excessive, persistent, and uncontrollable fear or worry), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 28's cognition (process of thinking) was intact. The MDS indicated Resident 28 had delusions (misconceptions or beliefs that are firmly held, contrary to belief). The MDS indicated Resident 28 required setup or clean-up assistance with eating, oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene.During a review of Resident 28's History and Physical (H&P), dated [DATE], the H&P indicated Resident 28 did not have the capacity to understand and make decisions.During an interview on [DATE] at 9:09 a.m., with the Social Services Director (SSD), the SSD stated when the physician assessed the resident as not having the capacity to understand and make decisions, the facility would attempt to find the resident's next of kin (family) who could make decisions on the resident's behalf. The SSD stated if the resident did not have any family or a designated decision-maker, the facility would send a referral to the Office of the Long-Term Care Patient Representative (OLTCPR- office that provides a trained public representative for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized decision-maker). The SSD stated while the facility waited for a representative from the OLTCPR to assess the resident, the resident would be placed under the bio-ethics committee (a multidisciplinary team designed to address, guide, and resolve resident-care issues). The SSD stated the purpose of sending in the referral and placing the resident under the bio-ethics committee was to ensure an individual or group assisted in making decisions regarding procedures, medications, and anything else concerning the resident's care. During a concurrent interview and record review on [DATE] at 9:13 a.m., with the SSD, Resident 28's admission Record was reviewed. The admission Record indicated Resident 28 was self-responsible (capable of managing own healthcare and personal decisions). The SSD stated Resident 28 was self-responsible and consented to his medications and plan of care since his admission to the facility.During a concurrent interview and record review on [DATE] at 9:14 a.m., with the SSD, Resident 28's H&P, dated [DATE], was reviewed. The H&P indicated Resident 28 did not have the capacity to understand and make decisions. The SSD stated Resident 28 did not have the capacity to make medical decisions when Resident 28 was admitted to the facility and was never referred to the OLTCPR. The SSD stated Resident 28 should have been referred to the OLTCPR once his H&P indicated his lack of mental capacity to make decisions. The SSD stated Resident 28 lacked the mental capacity to understand and make decisions and therefore would not understand the risks and benefits of medications or his plan of care. During an interview on [DATE] at 9:15 a.m., with the Director of Nursing (DON), the DON stated when a resident did not have the capacity to understand or make decisions, the facility was responsible for ensuring the resident had a representative. The DON stated the representative could be the resident's family member, friend, or an appointed representative from the OLTCPR. The DON stated Resident 28 did not have a representative to make (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his medical decisions. The DON stated it was important for Resident 28 to have someone as his decision maker or the bio-ethics committee to overlook Resident 28's care and be involved to advocate for Resident 28's best interests. During a review of the facility's policy and procedure (P&P) titled, Lack of Capacity Process (Epple Ruling), dated 1/2023, the P&P indicated, Upon admission, the social services or designee will conduct a due diligence search for residents with no legal representative. The P&P indicated, If after 72 hours, the facility cannot find a patient representative, the facility will notify the Office of Patient Representative (OPR) to assign a patient representative during interdisciplinary meetings and Bioethics meetings for the resident.During a review of the California Department of Aging's webpage topic, link https://aging.ca.gov/providers_and_partners/office_of_the_long-term_care_patient_representative/, titled, The Office of the Long-Term Care Patient Representative, undated, the webpage indicated, The Office of the Long-Term Care Patient Representative (OLTCPR) provides trained public representatives for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized surrogate. The webpage indicated, Skilled nursing and intermediate care facilities may convene an interdisciplinary team (IDT, group of different disciplines working together for a common goal of a resident) to make medical decisions for these residents. Facilities are required to include patient representatives on the IDT. If the facility cannot find a suitable person-such as a friend or family member-OLTCPR provides a trained public patient representative to help ensure the resident's rights, preferences, and dignity are supported in medical decision-making. The webpage indicated the facility should request a public patient representative if the facility received an order for medical treatment for the resident, the medical treatment required informed consent, the physician determined the resident lacked capacity to provide informed consent, and the resident lacked a legal decision maker or family/friend who could participate in the IDT review.

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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 obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of Zyprexa (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]) from an individual with decision-making capabilities for one of four sampled residents' (Resident 28), who did not have the capacity to consent.This deficient practice resulted in Resident 28 making uninformed decisions about his care and unable to understand the use, side effects, and risks of taking Zyprexa.Cross Reference F551.Findings:During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE]. Resident 28's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (a mental condition characterized by excessive, persistent, and uncontrollable fear or worry), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated 4/14/2026, the MDS indicated Resident 28's cognition (process of thinking) was intact. The MDS indicated Resident 28 had delusions (misconceptions or beliefs that are firmly held, contrary to belief). The MDS indicated Resident 28 required setup or clean-up assistance with eating, oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene.During a review of Resident 28's History and Physical (H&P), dated 4/7/2026, the H&P indicated Resident 28 did not have the capacity to understand and make decisions.During a review of Resident 28's Physician Order, dated 4/15/2026, the Physician Order indicated to administer Zyprexa (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]) 5 milligrams (mg, a unit of measurement), by mouth at bedtime for schizoaffective disorder manifested by paranoid delusions. During a review of Resident 28's Medication Administration Records (MAR), dated April 2025 through July 2025, the MAR indicated, on 7/22/2025, Resident 28 received his first dose of Zyprexa 5mg. During an interview on 4/23/2026 at 8:23 a.m., with Registered Nurse (RN) 1, RN 1 stated when a resident has an order for a psychotropic medication (a medication that affects the mind, emotions, and behavior), their physician would explain the reason for the medication and the risks and benefits before obtaining informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). RN 1 stated if the resident could not understand and make decisions, informed consent was obtained from the resident's responsible party (decision maker when an individual does not have the mental capacity to do so). RN 1 stated after the physician obtains informed consent, the licensed nurse was responsible for verifying informed consent was obtained. RN 1 stated the licensed nurse was responsible for reviewing the resident's H&P, which indicated the resident's decision-making capability. During an interview on 4/23/2026 at 8:25 a.m., with RN 1, Resident 28's admission Record was reviewed. The admission Record indicated Resident 28 was self-responsible (capable of managing own healthcare and personal decisions). RN 1 stated since Resident 28's admission to the facility, Resident 28 was self-responsible and informed consent for medication were obtained from Resident 28. During a concurrent interview and record review on 4/23/2026 at 8:26 a.m., with RN 1, Resident 28's H&P, dated 1/8/2025, was reviewed. The H&P indicated Resident 28 did not have the capacity to understand and make decisions. RN 1 stated Resident 28 did not have the capacity to make his medical decisions when Resident 28 was admitted to the facility and should not consent to any procedures or medications.During a concurrent interview and record review on 4/23/2026 at 8:27 a.m., with RN 1, Resident 28's Consent for Zyprexa, dated 4/15/2025, was reviewed. The Consent indicated, on 4/15/2025, informed consent was obtained from Resident 28 for the use of Zyprexa 5mg. RN 1 stated Resident 28 gave consent for the use of Zyprexa even though he did not have the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental capacity to understand and make decisions for himself. RN 1 stated having Resident 28 consent to the use of Zyprexa was an issue because Resident 28 was unable to weigh the risks and benefits of taking Zyprexa. During an interview on 4/23/2026 at 9:25 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for verifying the physician obtained informed consent from the resident or their responsible party. The DON stated Resident 28 did not have the capacity to understand and make decisions and therefore did not have the ability to consent to the use of Zyprexa. The DON stated obtaining informed consent for the use of Zyprexa from Resident 28 meant Resident 28 did not have the ability to fully understand the use, side effects, and risks.During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Medication Management, revised 10/30/2025, the P&P indicated, The facility must obtain a resident's written informed consent for treatment using psychoactive drugs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of six sampled residents' (Resident 28) Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was reviewed and completed by an individual with decision-making capacity.This deficient practice had the potential to result in Resident 28, who did not have the capacity to make medical decisions, not understanding his decision of Do Not Resuscitate (DNR- a medical order written by a doctor to instruct health care providers not to do cardiopulmonary resuscitation [CPR- lifesaving procedure performed when the heart stops beating]) if breathing stops or the heart stops beating).Cross Reference F551.Findings:During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (a mental condition characterized by excessive, persistent, and uncontrollable fear or worry), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated Resident 28's cognition (process of thinking) was intact. The MDS indicated Resident 28 had delusions (misconceptions or beliefs that are firmly held, contrary to belief). The MDS indicated Resident 28 required setup or clean-up assistance with eating, oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene.During a review of Resident 28's History & Physical (H&P), dated [DATE], the H&P indicated Resident 28 did not have the capacity to understand and make decisions.During an interview on [DATE] at 9:16 a.m., with the Social Services Director (SSD), the SSD stated the Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was explained and reviewed upon a resident's admission to the facility. The SSD stated the POLST indicated the resident's wishes for end-of-life care whether the resident wanted life saving measures or to allow natural death. The SSD stated the resident's physician would explain the difference between Full Code (a medical order indicating that all life-saving measures, such as cardiopulmonary resuscitation [CPR- lifesaving procedure performed when the heart stops beating], should be done if the heart stops) and Do Not Resuscitate (DNR- a medical order written by a doctor to instruct health care providers not to do CPR). The SSD stated the residents, if they had the capacity to understand and make decisions, or their responsible party (decision maker when an individual does not have the mental capacity to do so) would complete the POLST. During a concurrent interview and record review on [DATE] at 9:17 a.m., with the SSD, Resident 28's POLST, dated [DATE] and H&P, dated [DATE], were reviewed. The POLST indicated Resident 28 signed for a DNR order. The H&P indicated Resident 28 did not have the capacity to understand and make decisions. The SSD stated Resident 28 did not have the capacity to understand the DNR order and it was inappropriate to have Resident 28 complete the POLST. During an interview on [DATE] at 9:21 a.m., with the Director of Nursing (DON), the DON stated the POLST gave the directive on what the facility would do if a resident's heart were to stop beating, whether CPR was initiated or comfort care was provided. The DON stated the POLST had to be completed by an individual with the mental capacity to understand and make medical decisions. The DON stated Resident 28 completed his POLST even though he did not have the capacity to make his own medical decisions. The DON stated Resident 28 had a DNR order, which was inappropriate because Resident 28 did not have the capacity to understand what DNR meant. During a review of the facility's policy and procedure (P&P) titled, Physician's Order on Life Sustaining Treatment (POLST) Policy, dated (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/2016, the P&P indicated, A qualified health care provider, preferably a registered nurse or social worker, will conduct an initial review of the POLST with the resident, or if the resident lacks decision making capacity the legally recognized health care decision maker.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely physician and resident representative party notification following a change of condition for one of six sampled residents (Resident 5). This deficient practice resulted in a delay in medical evaluation and intervention and had the potential to result in worsening neurological status, permanent deficits, or death for Resident 5.Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition characterized by weakness, reduced strength, or impaired movement on one side of the body) following cerebral infarction (CVA- stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, dysphagia (difficulty swallowing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and sepsis (a blood stream infection). During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated [DATE], the MDS indicated Resident 5's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 5 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 5's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated [DATE], the POLST indicated Resident 5 elected DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) with Comfort-Focused Treatment and a request to transfer to the hospital only if comfort needs could not be met at the current location. During a review of Resident 5's General Acute Care Hospital (GACH) History and Physical (H&P), dated [DATE], timed at 12:34 a.m. the H&P indicated, on [DATE], during dinner at the facility, Resident 5's Representative Party (RP) 1, observed drooling from the left side of the resident's mouth and noted that Resident 5 was not using her left arm. The H&P indicated facility nursing staff also observed left-sided weakness, prompting transport to the GACH. The H&P indicated upon evaluation, Resident 5 demonstrated decreased movement on the left upper and lower extremities (arms and legs). During a review of Resident 5's GACH Physician Progress Note, dated [DATE], the note indicated Resident 5's Magnetic Resonance Imaging (MRI, medical imaging technique) results confirmed Resident 5 suffered an acute (sudden) right pontine infarct (a serious ischemic stroke in the brainstem, often causing left-sided weakness, facial paralysis, vertigo [dizziness], or speech issues due to blocked blood flow). During a concurrent record review and interview on [DATE] at 10:11 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 5's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated [DATE], and Resident 5's Nursing Progress Notes, dated 3/2026, were reviewed. The SBAR Note indicated, on [DATE], at 4:30 p.m., Resident 5 was transferred from bed to her wheelchair for dinner. The note indicated at approximately 5:55 p.m., Resident 5 was observed with left-sided weakness and facial drooping. The note indicated RP 1 was notified and stated she would come after work to evaluate Resident 5. The note indicated at 6:30 p.m., RP 1 arrived and Resident 5 continued to exhibit left-sided facial drooping, drooling, and weakness. The note indicated RP 1 then requested Resident 5 to be transferred to the GACH. The note indicated the physician was not notified until approximately 7:00 p.m. and, at 7:20 p.m., the physician ordered the GACH transfer. The note indicated Resident 5 was transported to GACH via 911 at approximately 7:30 p.m. The SBAR Note and the Nursing Progress (continued on next page)

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	04/23/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notes did not indicate the physician was made aware of Resident 5's symptoms immediately after the onset of symptoms at 5:55 p.m. LVN 1 stated Resident 5's symptoms at 5:55 p.m. were consistent with a possible stroke, and acknowledged stroke symptoms were time-critical, requiring immediate physician notification, initiation of neurological assessments and prompt activation of emergency medical services. LVN 1 stated delays in physician notification could result in delayed treatment and potential harm to Resident 5. During a phone interview on [DATE] at 10:33 a.m. with Registered Nurse (RN) 2, RN 2 stated that when a resident exhibited signs and symptoms consistent with a stroke, the physician should be notified immediately, and emergency services should be activated without delay due to the limited time frame for treatment. RN 2 stated Emergency Medical Services (EMS, a system that responds to emergencies in need of highly skilled pre-hospital clinicians) were indicated even when a resident received comfort-focused care as documented on a POLST, as the facility did not have the resources to manage an acute stroke. RN 2 further stated, upon assessment, Resident 5 exhibited left hand weakness and facial drooping on the left side. RN 2 stated that if these symptoms had been identified at approximately 5:55 p.m., he would not have delayed notification of the physician or activation of EMS pending the arrival of the resident's representative. RN 2 confirmed that if symptoms were identified at 5:55 p.m. and the physician was not notified until 7:00 p.m., this would constitute a delay in physician notification. RN 2 stated that the delay in physician notification and emergency response could have resulted in worsening condition, permanent deficits or death for Resident 5. During a phone interview on [DATE] at 12:09 p.m. with RP 1, RP 1 stated that changes were observed in Resident 5's condition during dinner on [DATE] (the day prior to Resident 5's GACH transfer). RP 1 stated Resident 5 typically sat in a wheelchair during meals; however, Certified Nursing Assistant (CNA) 5 placed Resident 5 in bed, reporting that Resident 5 had been falling forward while seated. RP 1 stated that Resident 5 appeared more sleepy than usual and exhibited left-sided weakness and drooling on the left side of her mouth. RP 1 stated that CNA 5 expressed concern that Resident 5 was not using her left hand and left leg. RP 1 stated RN 2 was notified and conducted an assessment. RP 1 stated RN 2 checked Resident 5's eyes and stated, This is not a stroke. RP 1 stated, based on the nurses' assessment and lack of concern, she was not worried about transferring the resident to the hospital and deferred to the nursing staff's clinical judgement. During an interview on [DATE] at 12:51p.m. with CNA 5, CNA 5 stated she was very familiar with Resident 5 and stated that Resident 5 was able to move both her legs and upper extremities prior to her change of condition on [DATE]. CNA 5 stated she noticed Resident 5 had weakness on her left hand on [DATE] and she had notified LVN 2, who notified RN 2. During a phone interview on [DATE] at 1:57 p.m. with Physician Assistant 1, PA 1 confirmed that she was the Physician Assistant assigned to Resident 5's care. PA 1 stated when a resident exhibited signs and symptoms consistent with a possible stroke, licensed nursing staff were expected to notify the physician immediately and initiate emergency medical services without delay. PA 1 stated the facility had communicated Resident 5's change of condition via group message on [DATE] at approximately 6:40 p.m. PA 1 stated delays in notification and treatment for stroke could result in long-term disabilities. PA 1 indicated that if she and Physician 1 had been notified earlier, they would have had the opportunity to initiate treatment and orders and arrange for immediate transfer. PA 1 stated that earlier interventions may have resulted in a different outcome for Resident 5, including less severe deficits. During a concurrent record review and interview on [DATE] at 4:01 p.m. with the Director of Nursing (DON), Resident 5's SBAR Note, dated [DATE], was reviewed. The DON stated the physician should have been notified when the change of condition was identified at 5:55 p.m. The DON stated timely physician notification would have allowed prompt medical orders and initiation of treatment, as well as communication of clinical findings and recommendations to RP 1. The DON stated that without timely notification, treatment could not be initiated, resulting in a delay in Resident 5's transfer to the hospital. The DON stated that the delay had the potential to negatively impact neurological outcomes, including brain injury and functional decline. During a concurrent record review and interview on [DATE] at 10:06 a.m. with RN 1, Resident (continued on next page)

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	555112	A. Building B. Wing	04/23/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5's SBAR Note, dated [DATE], was reviewed. RN 1 stated there was no documentation to indicate RP 1 was informed of the risks associated with delaying or declining a hospital transfer. RN 1 stated licensed nursing staff should have notified the physician immediately upon identification of Resident 5's change of condition and should have provided RP 1 with a complete clinical update, including the seriousness of Resident 5's condition. RN 1 stated staff should have explained the potential risks associated with delaying or declining transfer to the GACH to ensure RP 1 was given the opportunity to make an informed decision regarding Resident 5's care. During a phone interview on [DATE] at 10:50 a.m. with RP 1, RP 1 stated she was not contacted prior to her arrival at the facility on [DATE]. RP 1 stated that facility nursing staff did not educate her on the risks related to delaying or declining a hospital transfer. RP 1 stated she was not provided with information regarding a stroke, including the signs and symptoms, or potential seriousness of the condition. RP 1 stated she would have wanted to receive this information at the time Resident 5 exhibited signs and symptoms consistent with a possible stroke so that she could make an informed decision. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, revised [DATE], the P&P indicated the facility would ensure prompt consultation with the resident's Attending Physician, and notification the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by a significant change in the resident's physical, mental or psychosocial status, and/or a significant change in treatment. The P&P indicated a Change of Condition related to Attending Physician notification was defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident's condition which was manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Attending Physician and a change in the treatment plan.

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	555112	A. Building B. Wing	04/23/2026

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Advance Beneficiary Notice (a notice notifying that Medicare may deny payment for specific treatments, and provides residents the opportunity to accept or refuse services if Medicare denies payment) forms were provided when Medicare Part A (insurance that primarily covers inpatient skilled nursing facility stays) coverage ended for two of three sampled residents (Resident 53 and Resident 58). This deficient practice had the potential to result in residents not being informed of items and services not covered under Medicare, and the transfer of financial responsibility to the resident.Findings: a. During a review of Resident 53's admission Record, the admission Record indicated Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 53's History and Physical (H&P) dated 11/25/2025, the H&P indicated Resident 53 had profound cognitive (ability to think and understand) impairment. During a review of Resident 53's Minimum Data Set (MDS- a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 53 had severe cognitive impairment. The MDS indicated Resident 53 was dependent on staff for eating, toileting, hygiene and bathing. During a review of Resident 53's Skilled Nursing Facility (SNF) Beneficiary Notification Review form, indicated Resident 53's last covered date for Medicare Part A skilled services was 2/6/2026. Resident 53's SNF Beneficiary Notification Review form indicated a SNF ABN form was not provided to the resident. b. During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 58's diagnoses included hypertension (HTN- high blood pressure), asthma (condition that causes airway to swell, narrow and fill with mucus), and dysphagia (difficulty swallowing). During a review of Resident 58's H&P dated 11/21/2025, the H&P indicated Resident 58 could make needs known but could not make medical decisions. During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58 had severe cognitive impairment. The MDS indicated Resident 58 required substantial assistance from staff for dressing, bathing and toileting. During a review of Resident 58's SNF Beneficiary Notification Review form, indicated Resident 58's last covered date for Medicare Part A skilled services was 1/23/2026. Resident 53's SNF Beneficiary Notification Review form indicated a SNF ABN form was not provided to the resident. During an interview on 4/22/2026 at 10:36 a.m. with Resident 53's Responsible Party (RP) 2, RP 2 stated the Business Office Manager (BOM) discussed Resident 53's Medicare coverage ending, but did not explain that Resident 53 could be financially responsible for items and services not covered by Medicare. RP 2 stated he would have wanted a more in-depth explanation of financial responsibility, including which specific services would not be covered by Medicare. During an interview on 4/22/2026 at 10:21 a.m. with the BOM, the BOM stated Resident 53 and Resident 58 both remained in the facility after their last covered day of Medicare part A services. The BOM stated Resident 53 and Resident 58 were provided a Notice of Medicare Non-Coverage [(NOMNC), a form that notifies Medicare residents that their covered services are going to end) form, but were not provided an ABN form. The BOM stated ABN forms should have been provided to Resident 53 and Resident 58 because it was the residents' right to know which specific services would be covered by Medicare, and which services they would be financially responsible. During an interview on 4/23/2026 at 2:36 p.m. with the Administrator (ADM), the ADM stated ABN forms should be completed for Resident 53 and Resident 58 because it was the residents right to be informed of costs of services. The ADM stated ABN forms ensure residents were able to make informed decisions regarding their stay at the facility and the services they receive. During a review of the facility's policy and procedure (P&P) titled, Advance Beneficiary Notice of Non-coverage (ABN) undated, the P&P indicated, When Medicare is not likely to (continued on next page)

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	555112	A. Building B. Wing	04/23/2026

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cover a specific item or service, healthcare providers and suppliers must use this ABN to let the patient know they may be financially liable before they get the items or services. The P&P indicated, Notifiers must: Deliver the ABN far enough in advance that the patient or representative has time to consider the options and make an informed choice.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment for one of six sampled residents (Resident 2), when they failed to ensure Resident 2's closet was organized and the closet doors were able to close. This deficient practice had the potential to place Resident 2 at risk of an unsafe and unclean environment. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included cerebral palsy (disorder that affects movement, muscle tone and posture), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (mental health condition characterized by persistent sadness, or loss of interest in activities), and hypertension (HTN- high blood pressure). During a review of Resident 2's History and Physical (H&P) dated 3/10/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 1/20/2026, the MDS indicated Resident 2's cognitive skills for daily decision making (ability to think and understand) was intact. The MDS indicated Resident 2 required substantial assistance from staff for personal hygiene, toileting and bathing. During a concurrent observation and interview on 4/21/2026 at 11:02 a.m. with Resident 2, in Resident 2's room, Resident 2's closet door was observed open. The door was unable to close which limited the available space to move freely in and out of Resident 2's room. Resident 2 stated his belongings in his closet were not organized and his closet door could not fully close. Resident 2 stated he used a wheelchair and had hit his hand on the closet door multiple times while trying to wheel out of his room. Resident 2 stated the closet doors inability to close made him feel frustrated and unsafe when entering and exiting his room. During a concurrent observation and interview on 4/21/2026 at 1:01 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 2's room, observed Resident 2's closet door open and unable to close due to the residents' belongings. LVN 1 stated Resident 2's belongings should be organized and the closet door should be able to close. LVN 2 stated an opened closet door placed Resident 2 at risk for safety, and staff should keep rooms clean to ensure a homelike environment. During an interview on 4/23/2026 at 9:10 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated staff were responsible for organizing residents closets to ensure closest doors closed. CNA 1 stated a clean environment was important to ensure residents were safe and accidents did not occur. During an interview on 4/23/2026 at 10:40 a.m. with the Director of Nursing (DON), the DON stated residents had the right to a clean and safe environment. During a review of the facility's policy and procedure (P&P) titled, Resident's Homelike Environment dated December 2017, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment. The P&P indicated, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: cleanliness and order.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise one of five sampled residents' (Resident 4) care plan to reflect Resident 4's use of Mirtazapine (medication to treat major depressive disorder [disorder that causes a persistent feeling of sadness and loss of interest]).This deficient practice had the potential to result in a delay in the delivery of Resident 4's necessary care and services.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 4's cognition (process of thinking) was moderately impaired. The MDS indicated, in a two-week period, Resident 4 had little interest or pleasure in doing things and felt down, depressed, or hopeless for about seven to 11 days. The MDS indicated Resident 4 was dependent on staff's assistance with toileting, bathing, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 4 received antidepressant medication (medication to treat major depressive disorder [disorder that causes a persistent feeling of sadness and loss of interest]).During a review of Resident 4's History and Physical (H&P), dated 2/15/2026, the H&P indicated Resident 4 did not have the capacity to understand and make medical decisions. The H&P indicated Resident 4 had a diagnosis of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 4's Physician Order, dated 4/14/2026, the Order indicated to administer Mirtazapine (an antidepressant medication) 15 milligrams (mg, a unit of measurement), by mouth at bedtime for depression manifested by consuming less than half of her meals.During an interview on 4/22/2026 at 9:55 a.m., with the MDS Nurse (MDSN), the MDSN stated care plans were the road map on how to care for each individual resident to ensure their goals are met. The MDSN stated resident's diagnoses, medications, and risk for or actual problem areas should be care planned to ensure all staff knew how to provide the best care for the residents.During a concurrent interview and record review on 4/22/2026 at 9:58 a.m., with the MDSN, Resident 4's Care Plan titled, Uses Antidepressant Medication, dated 1/1/2026, was reviewed. The care plan indicated Resident 4 was receiving Lexapro (an antidepressant medication) related to depression manifested by self-expression of sadness. The MDSN stated Resident 4 was not taking Lexapro anymore and instead was prescribed Mirtazapine related to a decrease in oral intake during meals. The MDSN stated the focus of the care plan should have been revised to reflect the discontinued Lexapro and the new Mirtazapine order. The MDSN stated the entire care plan should have been reviewed and revised, as needed, to ensure the proper monitoring for the behavior and side effects were in place. The MDSN stated without a revised care plan, there would be confusion about what antidepressant medication Resident 4 was currently taking. The MDSN stated the wrong care plan could result in incorrect interventions being implemented.During an interview on 4/23/2026 at 10:07 a.m., with the Director of Nursing (DON), the DON stated care plans dictated the treatment plan for each resident. The DON stated any diagnosis, change in condition, and medications were care planned. The DON stated Resident 4's Lexapro was discontinued and was ordered Mirtazapine. The DON stated Resident 4's care plan should have been revised to reflect that change, and the behavior Mirtazapine was treating. The DON stated the care plans should always match the active orders to ensure the staff were not confused regarding the care to be provided.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 11/2018, the P&P indicated, Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed nursing staff followed professional standards of practice by failing to obtain an accurate and timely blood pressure assessment prior to the administration of a blood pressure medication for one of five sampled residents (Resident 24) This deficient practice had the potential to result in a hypotensive (low blood pressure) episode for Resident 24.Findings: During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was initially admitted to the facility on [DATE]. Resident 24's diagnoses included chronic subdural hemorrhage (severe brain bleeding), hypertension (high blood pressure), and compression of the brain. During a review of Resident 24's Minimum Data Set ([MDS], a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 24's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 24 required maximal assistance (helper does more than half the effort) for dressing, putting on footwear, and personal hygiene. During a record review of Resident 24's care plan, titled Hypertension, dated 1/31/2026, the care plan interventions indicated to administer anti-hypertensive medications (used to treat high blood pressure) as ordered. During a record review of Resident 24's Physician Order, dated 1/31/2026, the orders indicated to administer amlodipine (used to treat high blood pressure) oral tablet 10 milligrams (mg, unit of measurement), give one tablet by mouth, one time a day for hypertension and to hold for systolic blood pressure (SBP, the top number for a blood pressure reading, normal reading below 120) less than 110. During an observation on 4/21/2026 at 8:43 a.m. with Licensed Vocational Nurse (LVN) 4, observed LVN 4 prepare and administer amlodipine 10 mg to Resident 24. During a concurrent interview and record review on 4/21/2026 at 8:51 a.m., Resident 24's Medication Administration Record (MAR) for the month of April 2026, the MAR indicated on 4/21/2026, LVN 4 documented a blood pressure reading of 140/90 millimeters of mercury (mmHg, a unit of measurement; normal range SBP below 120 and a diastolic pressure [DBP, bottom number] below 80). LVN 4 stated Resident 24's blood pressure reading of 140/90 mmHg was obtained at approximately 7:50 a.m., nearly one hour prior to medication administration. LVN 4 stated Resident 24's blood pressure should have been measured closer to the time of administration to ensure safe administration. LVN 4 stated this placed Resident 24 at risk for a hypotensive episode. During an interview on 4/22/2026 at 3:42 p.m. with the Director of Nursing (DON), the DON stated that it was best practice to measure the blood pressure of a resident five minutes prior to blood pressure medication administration because blood pressure could quickly fluctuate based on the resident's activity and medical condition. The DON stated that there was a potential for a resident's blood pressure to change significantly if blood pressure measurements were taken greater than five minutes prior to administration. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 6/26/2025, the P&P indicated the facility would ensure all medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform weekly weights for one of two sampled residents' (Resident 70), after Resident 70 experienced a three-pound (lb, unit of weight measurement) weight loss in one week.This deficient practice resulted in the uncertainty whether Resident 70's 4 lb weight loss in a month period was gradual or sudden.Findings:During a review of Resident 70's admission Record, the admission Record indicated Resident 70 was admitted to the facility on [DATE]. Resident 70's diagnoses included dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD- a chronic digestive condition where the stomach acid frequently flows back up the esophagus [tube connecting the mouth to the stomach]), and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 70's Minimum Data Set (MDS- a resident assessment tool), dated 2/13/2026, the MDS indicated Resident 70's cognition (process of thinking) was intact. The MDS indicated Resident 70 required substantial assistance (helper does more than half the effort) with eating. The MDS indicated Resident 70 was dependent on staff's assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene. During a review of Resident 70's History and Physical (H&P), dated 2/9/2026, the H&P indicated Resident 70 had the capacity to understand and make medical decisions.During a review of Resident 70's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Weight and Nutrition Review, dated 2/26/2026, the record indicated Resident 70 had a 3 pound (lb., a unit of weight measurement) weight loss over a one week period. The record indicated Resident 70 remained at a high nutritional risk and required close monitoring to prevent further decline. The record indicated to monitor Resident 70's weekly weights closely. During a review of Resident 70's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/27/2026, the SBAR indicated Resident 70 had a 3 lb. weight loss, a decrease from 119 lbs. to 116 lbs., in one week. The SBAR indicated to consult the Registered Dietician (RD).During a review of Resident 70's Care Plan titled, Weight Loss, dated 2/27/2026, the care plan indicated to weigh Resident 70 as indicated. During an interview on 4/22/2026 at 11:17 a.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated when a resident was admitted to the facility, the resident was weighed weekly for four weeks and then monthly thereafter. RNA 1 stated if a resident lost weight, the Director of Nursing (DON) or other licensed nurse would place a physician's order to continue with weekly weights. RNA 1 stated the RNAs would only know to continue with weekly weights if there was an order for it. During an interview on 4/23/2026 at 9:48 a.m., with the Director of Nursing (DON), the DON stated the RNAs weighed the residents according to their orders. The DON stated after a newly admitted resident completed their four weekly weights, the resident would be weighed monthly. The DON stated if the resident experienced any weight loss, the physician would be notified and weekly weights would continue, if indicated.During a concurrent interview and record review on 4/23/2026 at 9:54 a.m., with the DON, Resident 70's weights, dated 2/7/2026 through 4/9/2026, were reviewed. The Weights indicated Resident 70's weights on the following days:a. 2/7/2026 - 118 lbs.b. 2/13/2026 - 118 lbs.c. 2/19/2026 - 119 lbs.d. 2/26/2026 - 116 lbs.e. 3/3/2026 - 116 lbs.f. 4/9/2026 - 112 lbs.The DON stated Resident 70 was weighed for weekly for four weeks and Resident 70's monthly weights began on 4/9/2026. During a concurrent interview and record review on 4/23/2026 at 10:45 a.m., with the DON, the facility's policy and procedure (P&P) titled, Evaluation of Weight and Nutritional Status, revised 1/2019, was reviewed. The P&P indicated, Weekly weights will be continued when the resident's weight has been within a stable range for a period of four weeks. Monthly Evaluation will continue for all residents. The DON stated after Resident 70 lost 3lbs in one-week, weekly weights should have continued for at least another four weeks. The DON stated the purpose of weekly weights (continued on next page)

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	04/23/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to closely monitor Resident 70's weight and to intervene quickly to ensure no further weight loss occurred. The DON stated Resident 70 had a 4 lb weight loss in a month and they were unable to determine if the weight loss was gradual or sudden.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure licensed nursing staff demonstrated competency to prioritize and respond to signs and symptoms consistent with a possible cerebrovascular accident (CVA- stroke, loss of blood flow to a part of the brain), including left-sided weakness and facial drooping for one of one sampled residents (Resident 5). This deficient practice had the potential to result in delayed medical evaluation and interventions for time-sensitive conditions, which could lead to worsening neurological status, permanent deficits, or death.Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition characterized by weakness, reduced strength, or impaired movement on one side of the body) following cerebral infarction (CVA- stroke, loss of blood flow to a part of the brain) affecting the left non-dominant side, dysphagia (difficulty swallowing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and sepsis (a blood stream infection). During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 5's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 5 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 5's General Acute Care Hospital (GACH) History and Physical (H&P), dated 3/11/2026, timed at 12:34 a.m. the H&P indicated, on 3/10/2026, during dinner, Resident 5's Representative Party (RP) 1 observed drooling from the left side of Resident 5's mouth. The H&P indicated Resident 5 was noted to not be using her left arm. The H&P indicated nursing staff also observed left-sided weakness, prompting transport to the GACH. The H&P indicated upon evaluation, Resident 5 demonstrated decreased movement on the left upper and left lower extremities (arms and legs). During a review of Resident 5's GACH Physician Progress Note, dated 3/12/2026, the note indicated Resident 5's Magnetic Resonance Imaging (MRI, medical imaging technique) results confirmed Resident 5 suffered an acute (sudden) right pontine infarct (a serious ischemic stroke in the brainstem, often causing left-sided weakness, facial paralysis, vertigo [dizziness], or speech issues due to blocked blood flow). During a review of the facility's Change of Condition In-Services, dated in 2025 and 2026, the in-services did not indicate the licensed nurses were provided in-services on possible stroke identification and treatment. During a concurrent interview and record review on 4/22/2026 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 5's situation, background, assessment, recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/10/2026, and Resident 5's Nursing Progress Notes, dated 3/2026, were reviewed. The SBAR indicated, on 3/10/2026, at approximately 5:55 p.m., Resident 5 was observed with left-sided weakness and facial drooping. The SBAR indicated RP 1 was notified and informed the facility she would come after work to evaluate Resident 5. The SBAR indicated at 6:30 p.m., RP 1 arrived to the facility and Resident 5 continued to exhibit left-sided facial drooping, drooling, and weakness. The SBAR indicated RP 1 then requested Resident 5 to be transferred to the GACH. The SBAR indicated the physician was not notified until approximately 7:00 p.m. and, at 7:20 p.m., and ordered the GACH transfer. The note indicated Resident 5 was transported to GACH via 911 at approximately 7:30 p.m. The SBAR and the Nursing Progress Notes did not indicate neurological checks were initiated after the onset of Resident 5's symptoms. LVN 1 stated Resident 5's symptoms at 5:55 p.m. were consistent with a possible stroke, and acknowledged stroke symptoms were time-critical, requiring initiation of neurological assessments. LVN 1 stated she did (continued on next page)

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	555112	A. Building B. Wing	04/23/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not perform the neurological assessments because she thought RN 2 would conduct the assessments and recalled being busy at the time because she had to pass medications and conduct blood sugar checks. LVN 1 stated neurological assessments were critical for a thorough assessment to be relayed to the physician, identification of affected extremities, severity determination of the stroke, and subsequent worsening of symptoms. During an interview on 4/22/2026 at 4:01 p.m. with the Director of Nursing (DON), the DON stated the licensed nursing staff were expected to conduct a thorough neurological assessment after the identification of neurological deficits to assess the progression of the condition and severity of deficits. The DON stated the lack of neurological checks increased the potential for the development neurological deficits. During a review of the facility policies and procedures (P&P), the facility did not have a policy related to the initiation of neurological assessments for residents exhibiting signs and symptoms of a possible stroke. During a review of the facility's Licensed Vocational Nurse (LVN) Job Description (undated), the Job Description indicated the licensed nurse was to ensure the following:1. Complete initial and ongoing assessments by gathering data in a timely manner, incorporating functional/development age factors into the assessment process.2. Correctly differentiate between normal and abnormal clinical findings and intervenes in accordance with clinical standards of practice and per physician orders.3. Demonstrates sound clinical judgment in the implementation, and evaluation of the nursing aspects of interdisciplinary resident care plan of care.4. Proficiently and accurately monitors and reports resident condition changes to the Registered Nurse, attending physician, family, and interdisciplinary team members.

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	555112	A. Building B. Wing	04/23/2026

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure annual evaluations were completed for two of five employees (Certified Nursing Assistant's [(CNA) CNA 3 and CNA 4]).This deficient practice had the potential to place residents at risk of not receiving quality care.Findings:During a review of five (5) employees' files, on 4/22/2026 at 11:07 a.m., a randomized annual evaluation audit was conducted for Certified Nursing Assistant (CNA) 3 and CNA 4. CNA 3's date of hire was 6/29/2015. CNA 4's date of hire was 3/15/2023. The audit did not indicate CNA 3 had an annual evaluation completed for the year of 2025-2026. The audit did not indicate CNA 4 had an annual evaluation completed for the year of 2025-2026.During an interview on 4/22/2026 at 12:51 a.m. with the Director of Staff Development (DSD), the DSD stated CNA 3 and CNA 4 did not have annual evaluations completed for the year of 2025-2026. The DSD stated annual evaluations should have been completed because its ensures staff are compliant with facility policies and expectations. The DSD stated failure to complete annual evaluations for CNA's placed staff at risk of unaddressed area's of care that require improvement and placed residents at risk of not receiving quality care.During an interview on 4/23/2026 at 10:19 a.m. with the Administrator (ADM), the ADM stated annual evaluations were important because it gave management the opportunity to address any identified issues staff needed to improve on, or issues that required additional training.During a review of the facility's Policy and Procedure (P&P), titled, Annual Performance Evaluation dated 7/2019, the P&P indicated, Annually, each employee will receive a performance evaluation review.

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	555112	A. Building B. Wing	04/23/2026

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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 observation, interview, and record review, the facility failed to ensure pharmaceutical services were provided in accordance with accepted professional standards and facility policies to meet the needs of residents when the facility failed to ensure the following for two out of six sampled residents (Resident 16 and Resident 46):1. Ensure controlled medications (medications that the use and possession of are controlled by the federal government) were securely maintained and effectively destroyed.2. Ensure Resident 46's lisinopril (blood pressure medication) was available for timely administration.3. Ensure Resident 46's dose of lisinopril was accurately documented. 4. Ensure Resident 16's famotidine (a medication that treats conditions where the stomach produces too much acid) was administered at the correct time, per the physician's order. These deficient practices had the potential to result in diversion (the illegal, unauthorized, or improper transfer of prescription drugs) and unauthorized access to controlled substances, as well as adverse outcomes to Resident 16 and Resident 46 due to delayed, missed, or inaccurately administered medications, including uncontrolled blood pressure and ineffective treatment.Findings: 1. During observations made on 4/21/2026 at 2:45 p.m. and on 4/22/2026 at 11:08 a.m., of the Director of Nursing's (DON) office, observed the office door open. The DON not in her office. The controlled medication (medications that the use and possession of are controlled by the federal government) destruction bin located within the office was unsecured and accessible. During a concurrent observation on 4/21/2026 at 2:41 p.m. with the Director of Nursing (DON), in the DON's office, a controlled medication destruction collection bin was observed under the desk next to a trash can. The bin contained multiple medications mixed with a minimal amount of pink to red chemical solution applied. The bin contained several whole, undissolved white tablets scattered on top of the bin contents. During a concurrent observation and interview on 4/21/2026 at 3:29 p.m. with the DON, in the DON's office, observed the controlled medication destruction collection bin contained five whole, white, oblong-shaped pills identifiable by imprint code IP 109. The pills were intact and retrievable from the bin. The DON stated that controlled medications were typically destroyed in the presence of Pharmacist 1. The DON stated that medications should be secured under double lock to prevent access. The DON stated if the controlled medication destruction bin was left unsecured, there was potential for unauthorized access and mishandling. During a phone interview on 4/22/2026 at 8:39 a.m. with Pharmacist 1, Pharmacist 1 stated a chemical solution used was intended to dissolve the controlled medications in the controlled destruction collection bin and the application of the solution completed the destruction process. Pharmacist 1 stated it was not the facility's practice was to ensure all tablets were submerged or dissolved and confirmed that the bin should be kept locked to ensure security. During an interview on 4/22/2026 at 11:14 a.m. with the Maintenance Director, the Maintenance Director stated he had a master key and access to the DON's office. During an interview on 4/22/2026 at 3:32 p.m., the DON stated the purpose of the chemical solution was to dissolve and render disposed controlled medications non-retrievable. The DON stated it was not the facility's practice to ensure all medications made contact with the chemical solution. The DON stated the controlled medication disposal bin should be double locked to prevent access. The DON stated that if the bin was unsecured, there was potential for unauthorized access by staff, or individuals within the facility. During a review of the facility's policy and procedure (P&P) titled, Schedule II Controlled Substance Medication, dated 2023, the P&P indicated the facility would ensure 1) all controlled drug substances (CDS) would be stored under double lock, separate from al other medications, 2) keys to locked areas that store CDS medications must always be in the possession of licensed nurse that meets criteria for handling CDS medications, and 3) controlled medications, which have been discontinued due to physician order, customer discharge or customer death, must be destroyed per facility policy. During a (continued on next page)

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	555112	A. Building B. Wing	04/23/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's policy and procedure (P&P) titled, Medication Storage , dated 2023, the P&P indicated the facility would ensure medications would be stored in a manner that maintained the safety of the customers, and in accordance with state Department of Health guidelines, and were accessible only to licensed nursing and pharmacy personnel. The facility did not provide any other policies regarding controlled substance waste or destruction. 2. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 46's diagnoses included cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain) and hyperlipidemia (high cholesterol). During a review of Resident 46's Minimum Data Set ([MDS], a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 46's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 46 required maximal assistance (helper does more than half the effort) for toileting, showering, lower body dressing and personal hygiene. During a record review of Resident 46's Physician Order, dated 4/17/2026, the order indicated lisinopril (a blood pressure medication) oral tablet five milligram (mg, a unit of measurement) one time a day for hypertension (high blood pressure). During a concurrent interview and record review on 4/21/2026 at 9:01 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 46's Medication Administration Record, dated 4/2026, was reviewed. The MAR indicated Resident 46's dose of lisinopril oral tablet 5 mg was due at 9 a.m. LVN 4 stated Resident 46's supply of lisinopril had not been delivered after the order had been placed on 4/17/2026 (four days prior). LVN 4 confirmed that the dose was not available in the facility's emergency supply kit and stated that it was important to have the medication readily available for timely medication administration. LVN 4 stated this placed Resident 46 at risk for uncontrolled blood pressure. 3. During a concurrent interview and record review on 4/21/2026 at 9:20 a.m. with LVN 4, Resident 46's MAR, dated 4/2026, was reviewed. The MAR indicated Resident 46 was administered lisinopril 5 mg on 4/20/2026. LVN 4 stated she documented in error and Resident 46 did not receive her ordered dose of lisinopril 5 mg on 4/20/2026 because the medication was not available. LVN 4 stated medication administration documentation should be completed accurately to ensure that Resident 46 had taken the medication. During a concurrent interview and record review on 4/21/2026 at 9:39 a.m. with LVN 3, Resident 46's MAR, dated 4/2026, was reviewed. The MAR indicated Resident 46 was administered lisinopril 5mg on 4/18/2026. LVN 3 stated she informed Resident 46 her ordered dose of lisinopril was not available on 4/18/2026. LVN 3 stated she documented the administration in error. LVN 3 stated medication administration documentation should be completed accurately to ensure that Resident 46 had taken the medication. During a review of the facility's P&P titled, Medication Administration, dated 6/26/2025, the P&P indicated the facility would ensure all medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner. 4. During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's diagnoses included gastrointestinal hemorrhage (severe stomach bleeding), gastrostomy (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status, and gastro-esophageal reflux disease (GERD, a chronic condition where stomach acid frequently flows back into the esophagus, causing persistent heartburn, regurgitation, chest pain, and potential esophageal damage). During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 16 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation of Resident 16's medication administration on 4/21/2026 at 7:59 a.m. with LVN 4, observed LVN 4 crush and administer famotidine (a medication that treats conditions where the stomach produces too much acid) 20 mg via g-tube. During a concurrent interview and (continued on next page)

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	555112	A. Building B. Wing	04/23/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review on 4/21/2026 at 8:05 a.m., Resident 16's MAR, dated 4/2026, was reviewed. Resident 16's MAR indicated famotidine 20 mg was to be administered via g-tube at 11:00 a.m. LVN 4 admitted she mistakenly gave the dose early, putting Resident 16 at risk for gastrointestinal (stomach) issues since Resident 16's feeding was scheduled to stop shortly. During a review of the facility's P&P titled, Medication Administration, dated 6/26/2025, the P&P indicated the facility would ensure all medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner. The P&P also indicated 1) medications must be administered within one hour before or one hour after the scheduled time, 2) the licensed nurse would verify the resident's identity before administering the medication using the 6 rights of medication administration:i. Right Resident: Confirm with two identifiers.ii. Right Medication: Verify against the MAR and pharmacy label.iii. Right Dose: Ensure accurately based on provider order.iv. Right Route: Confirm oral, topical, injection, etc.v. Right Time: Administer within ordered time window.vi. Right Documentation: Immediately document after administration.

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	555112	A. Building B. Wing	04/23/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered in accordance with physician orders for one of six sampled residents (Resident 73).This deficient practice had the potential to result in hypotension (low blood pressure), decreased cardiac perfusion (blood oxygenation), and potential cardiac complications for Resident 73. Findings: During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 73's diagnoses included atrial fibrillation (ineffective pumping of the heart), hypertensive chronic kidney disease (progressive kidney damage caused by chronic, poorly controlled high blood pressure), chronic ischemic heart disease (tissue damage to the heart muscles due to a lack of oxygen), and bradycardia (slow heart rate). During a review of Resident 73's Minimum Data Set ([MDS], a resident assessment tool), dated 4/8/2026, the MDS indicated Resident 73's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 73 required maximal assistance (helper does more than half the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 73's care plan titled, Hypertension (high blood pressure), revised on 3/23/2025, the care plan indicated to give anti-hypertensive medications (used to lower blood pressure) as ordered. During a record review of Resident 73's Physician Order, dated 11/22/2025, the order indicated to administer amiodarone (a medication used to treat heart rhythm issues and lowers blood pressure) oral tablet 200 milligrams (mg, a unit of measurement) one tablet by mouth two times a day for abnormal heart rhythm. The order indicated to hold if systolic blood pressure (SBP, the top number for a blood pressure reading, normal reading below 120) was less than 110 or the heart rate was less than 60 beats per minute (normal range 60 to 100 beats per minute). During a record review of Resident 73's Medication Administration Record (MAR), dated 4/2026, the MAR indicated Resident 73 received amiodarone on the following dates for the following blood pressure readings: a. 4/6/2026: 108/68 millimeters of mercury (mmHg, a unit of measurement).b. 4/10/2026: 102/76 mmHg.c. 4/17/2026: 106/68 mmHg.d. 4/19/2027: 106/70 mmHg. During an interview on 4/21/2026 at 9:30 a.m. with LVN 3, LVN 3 stated she documented the administration of Resident 73's dose of amiodarone on 4/10/2026 and 4/17/2026. LVN 3 stated the documented SBP values were below the physician-ordered parameters. LVN 3 stated administering the medication under these conditions placed Resident 73 at risk for hypotension (low blood pressure) and cardiac complications. During an interview on 4/21/2026 at 2:30 p.m. with LVN 4, LVN 4 stated she administered amiodarone on 4/6/2026 and 4/19/2026. LVN 4 stated the SBP values were below the ordered parameters and stated the medication should have been held. LVN 4 stated there was potential for Resident 73 to exhibit a hypotensive episode. During a review of the facility's P&P titled, Medication Administration, dated 6/26/2025, the P&P indicated the facility would ensure all medications would be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner.

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	04/23/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an unused and unopened NovoLog Flex Pen (a medication device that contains insulin aspart [a medication used to control blood sugar]) was stored in accordance with manufacturer's specifications and per facility policy for one of six sampled residents (Resident 37). This deficient practice had the potential to compromise the medication effectiveness, which could result in uncontrolled blood sugar levels and serious complications for Resident 37.Findings: During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was initially admitted to the facility on [DATE]. Resident 37's diagnoses included diabetes (poor blood sugar control) and end stage renal disease (irreversible kidney failure). During a review of Resident 37's Minimum Data Set ([MDS], a resident assessment tool), dated 3/2/2026, the MDS indicated Resident 37's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 37 required maximal assistance (helper does more than half the effort) for toileting, lower body dressing and taking off footwear. During a record review of Resident 37's Physician Orders, dated 2/25/2026, the orders indicated the administration of insulin aspart injection solution 100 unit per milliliter (ml, a unit of measurement) per sliding scale (a personalized diabetes management scale). During a concurrent observation and interview on 4/21/2026 at 12:54 p.m. with Licensed Vocational Nurse (LVN) 4, observed a single, unopened NovoLog Flex Pen (a medication device that contains insulin aspart), labeled for Resident 37 was located inside the medication cart. LVN 4 stated the medication had not been used. LVN 4 stated the medication had been delivered earlier that morning and was kept in the medication cart for convenience for the 3 p.m. to 11 p.m. (evening) shift. LVN 4 stated unopened insulin medications were typically stored in the refrigerator until first use. LVN 4 stated the lack of refrigeration had the potential to compromise the medication effectiveness for Resident 37. During a record review of the manufacturer guidelines for insulin apart (NovoLog) (undated), the guidelines indicated unopened insulin must be stored under refrigeration until initial use. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 2023, the P&P indicated the facility would ensure medications would be stored in a manner that maintained the integrity of the product, safety of the customers, and in accordance with state Department of Health guidelines.

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	04/23/2026

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

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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	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 the medical record for one of six sampled residents (Resident 5) was complete and accurately reflected care provided after a change of condition. This deficient practice had the potential to result in incomplete communication among healthcare providers, delayed or inappropriate clinical decision-making, and inability to verify that appropriate assessment and interventions were performed for Resident 5. Cross Reference F580 and F726.Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition characterized by weakness, reduced strength, or impaired movement on one side of the body) following cerebral infarction (CVA- stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, dysphagia (difficulty swallowing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and sepsis (a blood stream infection). During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 5's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 5 was dependent on staff for activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 5's General Acute Care Hospital (GACH) History and Physical (H&P), dated 3/11/2026, timed at 12:34 a.m., the H&P indicated, on 3/10/2026, during dinner, Resident 5's Responsible Party (RP) 1, observed drooling from the left side of her mouth and noted that Resident 5 was not using her left arm. The H&P indicated nursing staff also observed left-sided weakness, prompting transport to the GACH. The H&P indicated upon evaluation, Resident 5 demonstrated decreased movement on the left upper and left lower extremities (arms and legs). During a review of Resident 5's GACH Physician Progress Note, dated 3/12/2026, the note indicated Resident 5's Magnetic Resonance Imaging (MRI, medical imaging technique) results confirmed Resident 5 suffered an acute (sudden) right pontine infarct (a serious ischemic stroke in the brainstem, often causing left-sided weakness, facial paralysis, vertigo [dizziness], or speech issues due to blocked blood flow). During a concurrent record review and interview on 4/22/2026 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 5's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 3/10/2026, and Resident 5's Nursing Progress Notes, dated 3/2026, were reviewed. The SBAR Note indicated, on 3/10/2026, at 4:30 p.m., Resident 5 was transferred from bed to her wheelchair for dinner. The note indicated at approximately 5:55 p.m., Resident 5 was observed with left-sided weakness and facial drooping. The note indicated RP 1 was notified and informed staff she would come after work to evaluate Resident 5. The note indicated at 6:30 p.m., RP 1 arrived and Resident 5 continued to exhibit left-sided facial drooping, drooling, and weakness. The note indicated RP 1 then requested Resident 5 to be transferred to the GACH. The note indicated the physician was not notified until approximately 7:00 p.m. and, at 7:20 p.m., the physician ordered the transfer to the GACH. The note indicated Resident 5 was transported to the GACH via 911 at approximately 7:30 p.m. The SBAR Note and the Nursing Progress Notes did not indicate the Registered Nurse (RN) 2 was made aware of Resident 5's change of condition, nor did the note indicate RN 2 assessed Resident 5. LVN 1 stated Resident 5's symptoms at 5:55 p.m. were consistent with a possible stroke, and acknowledged stroke symptoms were time-critical, requiring immediate physician notification, initiation of neurological assessments and prompt activations of emergency medical services. LVN 1 stated that she made RN 2 aware of Resident 5's change of (continued on next page)

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	555112	A. Building B. Wing	04/23/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition but did not document. LVN 1 stated that it was important to ensure documentation was complete and accurately reflected the care of Resident 5. During a phone interview on 4/22/2026 at 10:33 a.m. with RN 2, RN 2 stated it was important to ensure accurate documentation was maintained in the medical record to reflect interventions performed and care provided to the residents. RN 2 stated upon being made aware of Resident 5's change of condition, he assessed the resident; however, he did not complete documentation reflecting his assessment or any interventions performed. RN 2 stated documentation should reflect the care provided. RN 2 stated that if care was not documented, it could not be verified. During a review of the facility's policy and procedure (P&P) titled, Documentation Guidelines, dated 11/20/2021, the P&P indicated the facility staff would 1) record applicable observations, psychosocial and physical manifestations, incidents, unusual occurrences, and abnormal behavior and 2) promptly record as the events or observations occur; complete, concise, descriptive, factual and accurately describe services provided to/for the resident. During a review of the facility's Registered Nurse Supervisor Job Description, dated 5/2017, the job description indicated the RN was to perform the following:1. Supervise and administer direct nursing care when more than routine care is indicated. Evaluate all residents with COC to assure residents' needs are being met. Provide support/ education to staff, residents and families.2. Proficiently and accurately evaluate, assist with treatments, and report resident condition changes to the attending physician, family, interdisciplinary team members and nursing personnel.3. Assure accuracy and completeness of medical records.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely replacement and sanitation of water pitchers for two of six sampled residents (Resident 10 and Resident 53). This deficient practice had the potential to result in bacterial growth and contamination of the water pitchers, and subsequent infection for Resident 10 and Resident 53, who were both diagnosed with dysphagia (difficulty swallowing) and impaired cognition (ability to think and reason).Findings: a. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 10's Minimum Data Set ([MDS], a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 10's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 10 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 4/20/2026 at 9:30 a.m. in Resident 10's Room, observed Resident 10's water pitcher labeled with a prepared date of 4/18/2026 and a use by date of 4/19/2026. b. During a review of Resident 53's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 53's diagnoses included dysphagia and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 53 was dependent on staff for ADLs. During an observation on 4/20/2026 at 9:43 a.m. in Resident 53's room, observed Resident 53's water pitcher labeled with a prepared date of 4/18/2026 and a use by date of 4/19/2026. During a concurrent observation and interview on 4/22/2026 at 2:39 p.m. with Certified Nursing Assistant (CNA) 6, photographs of Resident 10 and Resident 53's water pitchers, dated 4/20/2026, were reviewed. The photographs showed each residents' water pitcher labeled with a prepared date of 4/18/2026 and a use by date of 4/19/2026. CNA 6 stated the water pitchers contained thickened water and acknowledged the pitchers should be changed daily. CNA 6 stated the water pitchers for Resident 10 and Resident 53 should have been changed on 4/19/2026. CNA 6 stated there was potential for bacterial growth or infection for Resident 10 and Resident 53 if not replaced timely. During an interview on 4/22/2026 at 3:02 p.m. with the Dietary Supervisor (DS), the DS stated nursing staff was responsible for changing the water pitchers each day. The DS stated Resident 10 and Resident 53's water pitchers should have been changed on 4/19/2026 at the end of the day. The DS stated there was a potential for infection if the water pitchers were not changed and sanitized timely. During a review of the facility's policy and procedure (P&P) titled, Water Pitcher, dated 2023, the P&P indicated the facility would ensure sanitation of the residents' water pitchers at least once a day.

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	555112	A. Building B. Wing	04/23/2026

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents' (Resident 52) responsible party's (RP- decision maker when an individual does not have the mental capacity to do so) refusal of the coronavirus (COVID-19- a highly contagious respiratory illness) vaccine (a medical treatment to help the body's immune system to recognize and fight disease) was documented. This deficient practice had the potential to result in RP 3 being unaware of the risks involved in refusing the COVID-19 vaccine and potential for the facility to not track Resident 52's vaccination status and reoffer at another time. Findings: During a review of Resident 52's admission Record, the admission Record indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and hypertension (high blood pressure). Responsible Party (RP) 3 was Resident 52's assigned responsible party (RP- decision maker when an individual does not have the mental capacity to do so).During a review of Resident 52's Census, dated 12/14/2023 through 3/24/2026, the Census indicated Resident 52 was discharged from the facility on 1/16/2024 and readmitted on [DATE].During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool), dated 3/6/2026, the MDS indicated Resident 52's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 52 required moderate assistance (helper does less than half the effort) with oral hygiene, toileting, and putting on/taking off footwear. The MDS indicated Resident 52 was not updated on her COVID-19 vaccine.During a review of Resident 52's History and Physical (H&P), dated 3/2/2026, the H&P indicated Resident 52 did not have the capacity to understand and make decisions.During an interview on 4/22/2026 at 9:32 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated upon a resident's admission to the facility, she was responsible for reviewing the resident's vaccines and offering the resident or their RP vaccines within five days of admission.During a concurrent interview and record review on 4/22/2026 at 9:35 a.m., with the IPN, Resident 52's Immunization Report, dated 4/1/2018 through 4/30/2026, was reviewed. The Immunization Report indicated Resident 52 last received the COVID-19 vaccine on 12/22/2023. The IPN stated when Resident 52 was admitted to the facility, she spoke to RP 3 and offered to administer the COVID-19 vaccine to Resident 52. The IPN stated RP 3 refused. The IPN stated she did not document RP 3's refusal in Resident 52's health record. The IPN stated documenting the refusal was important to prove the risks and benefits were explained and other information was provided to RP 3. The IPN stated after a vaccine refusal, the vaccine should be reoffered a second time just in case the resident and/or RP changed their mind. The IPN stated she should have documented RP 3's refusal and reoffered the COVID-19 vaccine to protect Resident 52 and others from COVID-19. During an interview on 4/23/2026 at 9 a.m., with the Director of Nursing (DON), the DON stated upon admission, the licensed nurse was responsible for inquiring about the Resident 52's vaccines, including the COVID-19 vaccine, and the following day, the IPN would reevaluate and ask RP 3 whether they would like to receive the vaccine or not. The DON stated RP 3 refused the COVID-19 vaccine and should have signed the declination form (a signed document stating an individual officially declined or refused a specific offer, service, or requirement) after providing RP 3 with additional information. The DON stated the refusal should be documented in Resident 52's health record detailing when RP 3 was offered the vaccine, the risks and benefits explained, and an estimated timeline when the vaccine would be reoffered. The DON stated without the proper documentation, the facility did not have proof the vaccine was offered or when to reoffer the vaccine. The DON stated Resident 52 was elderly and was at higher risk for infections and (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications.During a review of the facility's Policy and Procedure (P&P) titled, COVID-19 Vaccination Program, revised 2/23/2022, the P&P indicated residents are encouraged to be vaccinated against COVID-19.During a review of the facility's P&P titled, Documentation Guidelines, dated 11/2021, the P&P indicated, Promptly record as the events or observations occur; complete, concise, descriptive, factual, and accurately describe services provided to/for the resident.