STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel Vista Healthcare Center	5001 East Anaheim Street Long Beach, CA 90804

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was safely discharged to a lower level of care by failing to:1.Ensure Resident 1 was discharged to a Board and Care (a small, residential care setting providing housing, meals, and personal care assistance for adults and seniors who cannot live alone but do not require skilled nursing care) and not discharged to a Recuperative Care facility (provides a temporary, post-hospital care setting who are recovering from an illness and experiencing homelessness) according to physician's order and resident's preference.This failure put Resident 1 at risk for avoidable physical and psychosocial harm and resulted in an inappropriate discharge. Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses including hypertension (HTN-high blood Pressure), glaucoma(eye condition that damages the optic nerve which can lead to vision loss or blindness), lack of coordination and protein-calorie malnutrition(condition that occurs when a person does not consume enough protein and calories to meet body's needs).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 8/28/2025, the MDS indicated the resident had an intact cognition (thought process) and required supervision or touching assistance (helper provides verbal cues as resident completes the activity) with bathing, dressing, transferring to and from a bed to a chair , toilet transfer(ability to on and off a toilet or commode) and bed mobility.During a review of Resident 1's Order Summary Report dated 8/27/2025, the Order Summary Report indicated to discharge Resident 1 to a Board and Care, with Home Health for Physical Therapy (PT-treatment that restores movement, reduces pain, and improve quality of life) , Occupational Therapy (OT- provides services to increase and/or maintain a person's capability to participate in everyday life activities) for safety and a Registered Nurse (RN) for medication compliance on 8/28/2025.During a review of Resident 1's Quarterly Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Conference Notes dated 7/21/2025, the IDT Conference Notes indicated the facility would look for a board and care versus assisted living (residential senior that provides housing and personal care) for discharge planning(a coordinated effort by healthcare staff, the resident and their family to create a personalized plan for a safe and smooth transition when the resident leaves the facility).During a review of Resident 1's Care Plan titled Discharge/Transfer Planning Preference: Resident indicated a preference to be discharged to an assisted living or Board and Care, initiated 4/24/2025. The Care Plan goal indicated the facility would honor resident's preference for discharge. The Care Plan interventions indicated to assess resident needs for discharge, assisting resident ‘s preference regarding discharge preferences and appropriate post-acute care.During a review of Resident 1's Progress Notes dated 8/28/2025 at 10:01 a.m., the Progress Notes indicated Resident 1 was discharged to a Board and Care in a stable condition.During a telephone interview on 9/12/2025 at 1:51 p.m. with Resident 1, Resident 1 stated the Board and Care where he was discharged looked unsafe and the facility personnel looked suspicious. During a telephone interview on 9/16/2025, at 11:59 a.m. with the Director of Patient Care (DOPC- third party collaborating with facility's social worker to find a place for a resident who is going to get discharged), the DOPC stated the facility where the resident was discharged was not a Board and Care. The DOPC stated it was a recuperative care facility which was transitional housing for homeless people, and people who came from jail. The DPOC stated residents should be independent and should not require medical services. The DOPC stated they received an online referral from the facility's social worker and had spoken to Resident 1 over the phone about the place. The DOPC stated Resident 1 agreed but she did not know if the resident knew the facility was not a board and care. The DOPC stated Resident 1 refused to stay as soon as he got to the facility because of his fear of gangs and the facility's location. The DOPC stated Resident 1 left the recuperative care facility on his own and went back to an undisclosed place at Long Beach.During a concurrent interview and record review on 9/15/2025, at 2:34 p.m. with Case Manager (CM) 1 of Resident 1's electronic medical, CM 1 stated Resident 1 was discharged to a board and care on 8/28/2025. CM 1 stated the Social Worker (SW) arranged for the board and care facility.During an interview on 9/16/2025, at 10:32 p.m. with CM1, CM 1 stated Resident 1 was discharged to a Recuperative Care Facility and not to a Board and Care. CM1 stated Recuperative Care Facility is a home for homeless people and not a licensed facility. CM1 stated a Board and Care are for residents that need more help with activities of daily living (ADL - routine

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the proper notice for discharge for one of two sample residents (Resident 1) by failing to:1. Provide a written discharge notice (30-day notice of proposed discharge) at least 30 days prior to the transfer or discharge of the resident from the facility.This failure had the potential to put Resident 1 at risk for inappropriate and unsafe discharge.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses including hypertension (HTN-high blood Pressure), glaucoma(eye condition that damages the optic nerve which can lead to vision loss or blindness), lack of coordination and protein-calorie malnutrition(condition that occurs when a person does not consume enough protein and calories to meet body's needs). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 8/28/2025, the MDS indicated the resident had an intact cognition (thought process) and required supervision or touching assistance (helper provides verbal cues as resident completes the activity) with bathing, dressing, transferring to and from a bed to a chair , toilet transfer (ability to on and off a toilet or commode) bed mobility.During a review of Resident 1's Order Summary Report dated 8/27/2025, the Order Summary Report indicated to discharge the resident to Board and Care on 8/28/2025. During a review of Resident 1's Notice of Proposed Transfer/Discharge (formal, written notification from long term care facility to a resident and their representative about a planned move from the facility and must be provided at least 30 days in advance under federal law) dated 8/28/2025, the Notice of Proposed Transfer/ Discharge indicated the resident received and signed the form on 8/28/2025. The Notice of Proposed Transfer indicated the resident was discharged to a Board and Care (a small residential care setting providing housing, meals, and personal care assistance for adults and seniors who cannot live alone but do not require skilled nursing care) on 8/28/2025.During a review of Resident 1's Progress Notes dated 8/28/2025 at 10:01 a.m., the Progress Notes indicated the resident was discharged to a board and care in stable condition.During a concurrent interview and record review on 9/15/2025, at 3:06 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 1's Notice of Proposed Transfer/ Discharge was reviewed. LVN 2 stated the Notice of Proposed Transfer/Discharge was provided to Resident 1 on the day of discharge. LVN2 stated the Notice of Proposed Transfer/ Discharge is provided to residents upon their discharge.During an interview on 9/16/2025, at 2:58 p. m. with the Director of Nursing (DON), the DON stated the facility provides a Notice of Proposed Transfer /Discharge to the residents on the day that they are leaving the facility or the day they get discharged . The DON stated she was not aware the written notice for discharge should be provided to the residents at least 30 days before the discharge as indicated in the facility policy. The DON agreed that the Notice of Proposed Transfer/ Discharge should be given at least 30 days prior to the discharge of the residents to give ample time to decide and be informed about their discharge.During a review of facility's policy and procedure (P&P) titled, Transfer or Discharge Notices, revised 3/2025, the P&P indicated residents or resident representative are notified of an impending discharge at least 30 days prior to transfer or discharge. The P&P indicated the written notice should be in a language or manner that the residents can understand.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and service for one of three sampled residents (Resident 2) by failing to:1.Monitor Resident 2 for constipation (a condition in which stool becomes hard, dry, difficult to pass) daily.2.Provide necessary medications for constipation when the resident had no bowel movement for three days as ordered by the physician.These failures had the potential to put Resident 2 at risk for fecal impaction (hardened stool that's stuck in the rectum or lower colon) that could lead to a bowel obstruction (partial or complete blockage of small or large intestines which is life threatening), nausea or pain.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy(condition where the brain is unable to function properly due to an imbalance of chemicals in the blood), atrial fibrillation(irregular heartbeat), hypertension(HTN- high blood pressure), and acute osteomyelitis of left ankle and foot(inflammation of bone or bone marrow, usually due to infection).During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 8/7/2025, the MDS indicated the resident had moderately impaired cognitive skills (a person is having trouble with thinking, remembering, and making decisions) and required substantial assistance (helper does more than half the effort to complete an activity) with dressing, bathing and bed mobility.During a review of Resident 2's Care Plan titled, At risk for complications with bowel regimen/constipation due to immobility, side effects of medication initiated on 9/11/2025, the Care Plan's interventions included to administer medications for constipation per physician order.During a review of Resident 2's Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) Task for Bowel Continence (ability to control the passage of stool from the rectum), the ADL Bowel Continence Task indicated Resident 2 did not have a bowel movement on 8/20/2025, 8/21/2025, and 8/22/2025.During a review of Resident 2's Order Summary Report dated 8/2/2025, the Order Summary Report indicated a physician order to give Milk of Magnesia ([MOM]-laxative) oral suspension 400 milligrams ([mg]- unit of measurement) to give 30 milliliters ([ml]- unit of measurement) by mouth prn (as needed) every 24 hours for constipation daily.During a review of Resident 2's Order Summary Report dated 8/2/2025, the Order Summary Report indicated a physician order to give Dulcolax (laxative Suppository 10 mg rectally (per rectum) prn for constipation daily if MOM is ineffective. During a review of Resident 2's Order Summary Report dated 8/2/2025 indicated a physician order to give Fleet Saline Enema (a liquid laxative rectally to relieve occasional constipation) rectally prn for constipation every three days if Dulcolax is ineffective.During a concurrent interview and record review of Resident 2 ‘s ADL Task for Bowel Continence on 9/16/2025 at 9:34 a.m. with Certified Nursing Assistant (CNA)2, CNA 2 stated Resident 1 had no bowel movement on 8/20/2025, 8/21/2025 and 8/22/2025. CNA 2 stated she should have notified the charge nurse when Resident 2 did not have a bowel movement so the resident could receive medication for constipation. CNA 2 stated Resident 2 could get sick and increase his chance of hospitalization due to infection.During a concurrent interview and record review on 9/16/2025 at 11:30 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's ADL Task for Bowel Continence and Medication Administration (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) were reviewed. LVN 1 stated Resident 2 did not have bowel movement on 8/20/2025, 8/21/2025, and 8/22/2025. LVN 1 stated the electronic chart would alert the LVNs if a resident had no bowel movement within 24 to 48 hours. LVN 1 stated she could not recall if she received an alert for Resident 2 in the electronic chart and was not notified by the CNA regarding Resident 2's constipation. LVN 1 stated Resident 2 did not receive any medication for constipation, and she should have administered the prn laxatives to relieve constipation. LVN 1 stated if all the prn laxatives are ineffective, the physician will be notified because the resident could be at risk for fecal impaction. During a concurrent interview and record review on 9/16/2025, at 10:49 a.m. with the Director of Staff Development (DSD), Resident 2's MAR was reviewed. The DSD stated CNAs report to the charge nurse when a resident has no bowel movement and if a resident has no bowel movement for two days, the licensed nurse should administer medications for constipation. The DSD stated the staff should have monitored the frequency of Resident 2's bowel movement on the MAR and the CNAs should have notified the licensed nurse about Resident 2's constipation.During an interview on 9/16/2025, at 3:54 p.m. with the Director of Nursing (DON), the DON stated the charge nurse should have checked to see if Resident 2 had a bowel movement