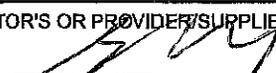


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056405	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER CERRITOS VISTA HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17836 WOODRUFF AVENUE , BELLFLOWER, California, 90706	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint Number: 2569001 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the complaint number: 2569001 (Refer to F842).	F0000	Disclaimer: The signing of this plan of correction is not an admission or agreement by this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all	F0842	F 842 Immediate Corrective Action The Medical Records Director immediately contacted the physician's office to request the progress notes for Resident 1. Identification of Others at Risk The Medical Records designee audited all resident charts on 7/24/25 to ensure the physicians progress notes were in the chart. No other residents were identified with the same deficient. Process to Prevent Recurrence On 8/1/25 the Medical Records Consultant gave an in-service to the Medical Records staff regarding the policy for physicians visits specifically ensuring that the physicians progress notes are readily accessible to prevent a delay in the delivery of care and necessary services.	8/2/25

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 reverse for further 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 Administrator	(X6) DATE 8/15/25
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F0842 SS = D	Continued from page 1 information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F0842	The Medical Records Designee will audit physicians progress notes several times a week for six weeks to ensure they are readily available and monthly thereafter for 3 months. All findings will be reported to the Administrator. Monitoring Performance The Medical Records consultant will visit monthly for three months and quarterly thereafter for six months to ensure physicians progress notes are readily accessible. All findings will be reported to the Administrator. Findings will be reported to the QA committee for further review and recommendations, monthly, for 3 months or until substantial compliance is achieved.	

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F0842 SS = D	<p>Continued from page 2 professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) physician progress notes were readily accessible.</p> <p>This deficient practice had the potential to result in a delay in the delivery of care and necessary services for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted on 6/1/2025 with diagnoses including pneumonia (an infection/inflammation in the lungs).</p> <p>During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool) dated 4/30/2025, the MDS indicated Resident 1's cognition was moderately impaired cognition and was dependent (helper does all the effort) on facility staff to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a concurrent interview and record review on 7/23/2025 at 1:40 p.m., with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON stated Resident 1's physician and nurse practitioner (NP) did see Resident 1 in the facility, however, she could not find the completed copies of the physician or NP visit notes in Resident 1's medical record. The DON stated usually the physician and/or NP will come to the facility, see the residents, and either document their visit in the electronic medical record or complete a progress note on paper. The DON stated physician or NP visit notes should be in the medical record because it provides the residents' prognosis and the plan of care and treatment for the residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled "Physician Services," dated 2/2021, the P&P indicated physician orders and progress notes are maintained in accordance with current Omnibus Budget Reconciliation Act (OBRA- minimum standards for nursing home care and residents' rights) regulations and facility policy.</p>	F0842					

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