

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

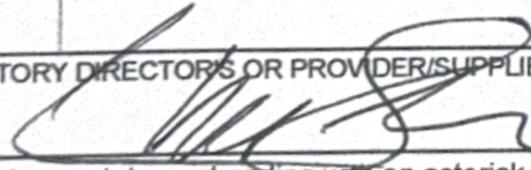
PRINTED: 05/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555805	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2025
NAME OF PROVIDER OR SUPPLIER BEL VISTA HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5001 EAST ANAHEIM STREET EAST LONG BEACH, CA 90804	
(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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one facility reported incident. Facility Reported Incident Number: CA00961588. The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for facility-reported incident number CA00961588 at F684.	F 000	Submission of this Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents or other individuals who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the status of one of three sample residents (Resident 1)'s alleged abuse allegation was assessed and monitored. These deficient practices had the potential to negatively affect the residents' physical comfort and psychosocial well-being by not receiving the needed and necessary services timely.	F 684	a) How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 1 was discharged to home on May 20, 2025. b) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents who experience a Change of Condition, to include an allegation of abuse, have the potential to be affected. On 05/23/2025, the MRD (Medical Records Director) reviewed the facilities current residents noted to have Change of Condition within the past 30 days to ensure that they were assessed timely and placed on 72-hour alert charting/documentation.	5/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



ADMINISTRATOR

05/30/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555805	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2025
NAME OF PROVIDER OR SUPPLIER BEL VISTA HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5001 EAST ANAHEIM STREET EAST LONG BEACH, CA 90804		
(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
F 684	<p>Continued From page 1 Findings:</p> <p>During a review of Resident 1's Admission record, the Admission Record indicated Resident 1 was admitted to the facility on 4/14/2025 with diagnoses including unspecified sequelae (long term effect) of cerebral infarction (stroke: blockage that disrupts blood flow to the brain leading to brain), slurred speech, and hypertension (high blood pressure).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 4/22/2025, the H&P indicated Resident 1 is not able to make medical decisions.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/18/2025, the MDS indicated Resident 1's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 1 is dependent on toileting hygiene, lower body (waist below) dressing, required maximal assistance (provide more than half the effort) for toilet transfer, chair/bed-to-chair transfer, bathing, upper body (waist above), and required supervision for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 1 has an impairment on one side of the lower (hips/legs) extremities and utilized a wheelchair.</p> <p>During a review of the Change in Condition (COC) Evaluation dated 5/9/2025, from a report reported by Social Service Director (SSD), Nurse Practitioner 1 (NP 1) reported during her visit with Resident 1, Resident 1 verbalized her breast and vagina was fondled, inappropriately touched by a</p>	F 684	<p>The audit identified other residents noted to be affected.</p> <p>Current residents identified to be affected were reassessed on 05/30/2025 by RN. In addition, the nurse who completed the COC has also been identified and has received 1:1 formal education on the Policy & Procedure titled "Change in a Resident's Condition or Status".</p> <p>c) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p> <p>On 05/27/2025, the Director of Nursing conducted an in-service with the facility's licensed nursing staff on the Policy & Procedure titled "Change in a Resident's Condition or Status".</p> <p>The Medical Records Department (MRD) will audit the medical records of residents identified to have a change in condition, including allegation of abuse, during each workday to ensure timeliness of documentation and that residents are also placed on alert charting/documentation.</p> <p>Non-compliance identified will immediately be brought to the attention of the Director of Nursing for further follow-up.</p> <p>d) How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The MRD will summarize the audit findings and present during the Quarterly QAPI meeting for further recommendation by the QA Steering Committee, until compliance has been achieved for three consecutive quarters.</p> <p>Compliance Date: 05/30/2025</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555805	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/13/2025
NAME OF PROVIDER OR SUPPLIER BEL VISTA HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5001 EAST ANAHEIM STREET EAST LONG BEACH, CA 90804		
(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	
F 684	<p>Continued From page 2 male staff.</p> <p>During a review of the progress notes for the 72-hour (hr.) charting, the progress notes indicated there was a 72-hr charting dated 5/10/2025 at 10:05 a.m., 5/10/2025 at 10:29 a.m., and 5/13/2025 at 4:04 a.m.</p> <p>During a concurrent interview and record review on 5/13/2025 at 2:09 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated a COC is something that is out of the ordinary, and once a COC is initiated, the doctor and family are notified, a care plan is created, document on the progress notes, and the resident with have a 72-hr monitoring. LVN 2 stated if there is a COC, there should be 72-hr. monitoring. LVN 2 stated the COC on 5/9/2025 indicated Resident 1 verbalized an alleged abuse by a staff and is not sure what Resident 1 should be on monitoring for. LVN 2 stated the 72-hr monitoring is documented in the progress note for every shift and Resident 1 should have been on monitoring until 5/12/2025. LVN 2 stated they monitor the residents to see if there's any development regarding the COC.</p> <p>During an interview on 5/13/2025 at 2:56p.m. with Director of Nursing Covering Consultant (DONCC), DONCC stated when there is an alleged abuse allegation, ensure the resident is safe and secure, assess the resident, notify the doctor, family, start the investigation, and report to the Administrator (ADM) since they are responsible for contacting the local police, Ombudsman, and California Department of Public Health (CDPH). DONCC stated the residents will be monitored for 72-hr, the SSD will visit the residents to ensure they feel safe and</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555805	(X2) MULTIPLE CONSTRUCTION A. RILING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 05/13/2025
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BEL VISTA HEALTHCARE CENTER	STREET ADDRESS CITY STATE ZIP CODE 5001 EAST ANAHEIM STREET EAST LONG BEACH, CA 90804
---	---

(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
F 684	Continued From page 3 there are no psychosocial issues. DONCC stated the residents will be monitored for 72-hr every shift when there is a COC, and if there's no 72-hr monitoring, how would they be able to identify the COC in a resident if there's no monitoring. During a review of the facility's policy and procedure (P&P) titled, "Change in a Resident's Condition or Status," revised date February 2021, the P&P indicated the nurse will record in the resident's medical information relative to changes in the resident's medical/mental condition or status.	F 684		