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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F000	INITIAL COMMENTS AMENDED 6.2.2025 The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 5/17/2025 to 5/18/2025. The resident census at the time of survey was 35. The sample size was 14. Highest Scope and Severity: E	F000		
F684 SS=E	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 observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with physician orders for two of eight sampled residents (Resident 2 and 28) by: 1.Failing to follow up dermatology (branch of medicine that diagnosis and treats skin disorders) consult for Resident 2. 2.Failing to follow physician orders for dressing change for Resident 28's right above the knee amputation (AKA) These deficient practices resulted in Resident 2 not being seen by a dermatologist and had the potential for Resident 28's wound to become infected.	F684	**This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.** **F-tag 684** **I: Corrective Action for residents found to have been affected:** • Resident 2 lesion was reassessed by the RN on 5/18/2025. The attending physician was made aware of the dermatology follow-up appointment and orders was given by the physician on 5/20/2025 for a Dermatology consult on June 18, 2025, at 0930. • Resident 28's treatment for right AKA was completed by the RN on 5/18/25. • Resident 28 was reassessed by RN on duty for any signs or symptoms of infection such as • No other residents have been affected.	06/12/2025

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

ADMINISTRATOR 06/12/2025

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F684	Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on 9/17/2023 and was readmitted on 5/13/2024 with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and chronic kidney (bean shaped organ responsible for filtering blood and removing waste) disease (progressive condition where the kidneys become damaged and are unable to filter blood effectively). During a review of Resident 2's History and Physical (H&P), dated 5/17/2025, the H&P indicated Resident 2 was able to make her own medical decisions. During a review of Resident 2's Minimum Data Set [MDS] a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 2's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 2 required moderate assistance (provide less than half the effort) in bathing, toileting hygiene, and shower transfer, required supervision for chair/bed-to-chair transfer, lower body (waist below) dressing, putting/taking shoes off, and is independent in eating, oral hygiene, upper body (waist above) dressing, and personal hygiene. The MDS indicated Resident 2 utilizes a wheelchair and walker and has bilateral (both sides) impairments on the lower (hips/legs) extremities.	F684	drainage, pain, foul smelling odors, etc. Resident 28 wound remains stable at this time. **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • On 06/06/2025, the MRD completed an audit of residents' specialist consult orders in the past 30 days to ensure that residents with orders are seen per physician orders. • The DON/designee performed an audit on 5/18/25 on residents' treatments and verified that treatment orders were followed per physician. **III: Facility measures and systemic changes to ensure the deficient practice does not recur:** • DON/designee conducted an in service to facility licensed nurses regarding following physician orders for treatment, including follow-up of needed consult orders of resident as ordered by the physician. The goal is to ensure that residents receive treatment and needed services per the physician's order. • MRD will conduct audits that resident's consult orders are followed per physician orders weekly x 1 month then bi-monthly for 2 months. • DON/designee will conduct random audits of 5 resident residents' treatment weekly for orders to ensure that each order is followed by physician orders X 90 days. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance;**	

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F684	During a review of Resident 2's Order Summary Report (physician orders) dated 5/18/2025, the order summary indicated dermatology consult and treatment as indicated for right hand lesions with an active date of 1/31/2025. During a review of Resident 2's progress notes dated 5/18/2025, the progress note dated 1/31/2025 at 11:57 a.m. indicated Dermatologist 1 (DERM 1) was called for a dermatology consult and treatment as indicated for right hand lesions. DERM 1 requested the face sheet and to take a photograph of lesions on Resident 2's right hand. During a review of Resident 2's physician order sheet from DERM 1 dated 3/26/2025, the physician order sheet indicated to fax a signed consent form to schedule a biopsy to rule out basal cell (most common type of skin cancer)/ squamous cell carcinoma (type of skin cancer that makes up the outermost layer of the skin). During a review of Resident 2's skin biopsy consent form, there are no dates and signature indicated on the consent form. During a concurrent observation and interview on 5/17/2025 at 10:43 a.m. with Resident 2, Resident 2 stated she has had this skin issue for about six months. Resident 2 stated the facility is aware, and she had not received any medication, and the facility has not done anything for her. It was observed Resident 2 had two raised bumps on her right hand. During a concurrent interview and record review on 5/18/2025 at 11:34 a.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated the order for Resident 2 indicated there was an order for a dermatology consult on 1/31/2025. RNS 1 stated when there is an order for a dermatology consult, they will schedule and make an appointment with dermatology. RNS 1 stated depending on the	F684	**Integrate the POC to QA Process.** • The Medical Record Director/designee will report on the findings and trends of weekly audits of new psychotropic medications for informed consent during the monthly QA meeting for the next 3 months to ensure compliance. • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F684	insurance the Case Manager (CM) or the Social Service Director (SSD) will get prior authorization for the referral and fax the documents to the clinic. RNS 1 stated per order, Resident 2 should have a dermatology consultation appointment. RNS 1 stated the progress note on 1/31/2025, indicated DERM 1 asked for Resident 2's face sheet to be faxed over. RNS 1 stated the DERM 1 physician order sheet indicated the informed consent to be faxed, but the informed consent was not signed. RNS 1 stated there are no notations in March, April, and May 2025 regarding the dermatology consultation and indicated it is not known if a signed consent form was faxed to the dermatology clinic. RNS 1 stated the informed consent should have been signed and sent out at that time. RNS 1 stated the nurses usually follow up with the documents and indicated this was communicated from the nurses to DERM 1 and DERM 1 requested the face sheet. RNS 1 stated it is known what happened afterwards and usually follow up within 72 hours (hr.). RNS 1 stated if the resident does not receive the intended consultation, their condition can get worse and affect the health of the resident. During an interview on 5/18/2025 at 6:57p.m. with the Administrator (ADM), the ADM stated the previous Director of Nursing (DON) was in charge of all ancillary services (services that support, or supplement primary care provided by doctors and nurses) and was aware that Resident 2 had an order summary by DERM 1 in March 2025 and was not followed up. The ADM stated at that time, it was DON's responsibility and indicated that the residents not receiving the intended consultation is a huge issue as it can potentially lead to a more serious issue, and this could have been easily preventable had they made an appointment, and they did not.	F684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F684	During an interview on 5/18/2025 at 8:38p.m. with the DON, the DON stated it was important for residents to get consultations if needed, and if there is an order, the resident should get the consultation. 2.During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was initially admitted to the facility on 3/24/2025 with diagnoses including type 2 diabetes mellitus (a condition where the body has trouble controlling blood sugar) with hyperglycemia (elevated sugar in the blood), type 2 diabetes mellitus with diabetic neuropathy arthropathy (nerve damage and joint disease), hypertension (high blood pressure) and acquired absence of right leg above knee. During a review of Resident 28's history and physical (H&P), dated 5/15/2025 the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS), a resident assessment tool dated 3/31/2025, the MDS indicated Resident 28 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity) with eating, and personal hygiene, substantial/maximal assistance (helper lifts and holds trunk or limbs, provides more than half the effort) with lower body dressing, shower/bathe self and putting on /taking off footwear. During a record review of Resident 28's Treatment Administration Record (TAR) dated 5/16/2025 . the TAR indicated right AKA (surgical incision) cleanse with normal saline (sterile water), apply xeroform (wound dressing), ABD pad (a highly absorbent medical dressing used to manage heavily draining wounds)and wrap with	F684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F684	kerlix (used to secure and protect wounds , injuries or surgical sites) every day shift x 30 days . Another order with a start date of 5/15/2025 indicated to monitor surgical incision daily every day shift. And last order dated 5/15/2025 indicated to monitor dressing integrity daily every day shift. During an observation and interview on 5/18/2025 at 11:30 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 28 was in bed with his right AKA without a dressing . LVN 3 stated she was aware resident had no dressing . LVN 3 states it was important to keep Resident 28's surgical wound covered with dressing to prevent infection. During an interview on 5/18/2025 at 12:30 p.m., with Registered Nurse 1 (RN 1), RN 1 stated she was not aware Resident 28 had no dressing to his right AKA. RN 1 stated it was important to keep Resident 28's right AKA surgical site completely covered to prevent infection, and it to follow the doctor's order. During an interview on 5/18/2025 at 8:00 p.m. with the Director of Nursing (DON), the DON stated we must follow doctors order and keep the wound covered and provide a dressing to prevent infection. During a review of the facility's policies and Procedures (P&P), titled "Resident Rights," revised date February 2021, the P&P indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; communication with and access to people and services, both inside and outside the facility. During a review of the facility's P&P, titled "Dignity," revised date February 2021, the P&P indicated each resident shall be cared for in a matter that promotes and	F684		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F684	enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. Individual needs and preferences of the resident are identified through the assessment process. During a review of the facility's policy and procedure (P&P) titled" Residents Rights" indicates federal and state laws guarantees certain basic rights to all residents of this facility these rights include the residents right to : Equal access to quality care. regardless of source of payment.	F684		
F727 SS=E	RN 8 Hrs/7 days/Wk. Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C),1819(b)(4)(C)(i);483.35(c)(1)-(2) Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers - §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a	F727	**F-tag 727** **I. Corrective Action for residents found to have been affected:** • Resident 21 was no longer in the facility as of 05/22/2025. • Resident 28 admission/readmission evaluation was completed by the licensed nurse on 05/13/2025and reviewed by the DON on 05/19/2025. **II. Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • The MRD completed an audit on 06/06/2025 for the past 14 days, that an admissions/ readmission evaluation was completed by the licensed nurses. No other residents are affected by the deficient practice. **III: Measures and systemic changes put in place to ensure deficient practices do not**	06/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F727	charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of ten sampled residents (Resident 21 and 28) had their admission/readmission assessments completed by Registered Nurses (RNs) This deficient practice had the potential for delay in care and services, due to missed or inaccurate identification of problems. a. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was initially admitted to the facility on 4/18/2025 and was readmitted on 5/14/2024 with diagnoses including unspecified fracture (break in a bone) of unspecified lumbar vertebra (one of the bones that make up the spinal column in the lower back), spinal stenosis (space inside the backbone is too small putting pressure on the spinal cord), and obstructive (urine flow is blocked) and reflux uropathy (occurs when urine flows backward into the bladder often as a result of obstruction). During a review of Resident 21's History and Physical (H&P), dated 4/20/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21 Minimum Data Set [MDS] a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 21'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 21 is dependent on chair/bed-to-chair transfer and toileting hygiene, required	F727	recur: • On 05/18/2025 the DON conducted an in service to facility licensed nurses regarding completion of admission/readmission evaluation of residents. The goal is to ensure that there is no delay of care and services due to missed or inaccurate identification of problems. • The MRD will conduct daily audits for completion of admissions/readmission evaluation of residents by license nurses and validated by RN. Findings will be reported to the Director of Nursing during daily stand-up meeting for follow-up. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.** • The Medical Record Director/designee will report the findings and trends of weekly audits of admissions/readmission evaluation of residents are completed by a licensed nurse during the monthly QA meeting for the next 3 months to ensure compliance • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F727	maximal assistance (provide more than half the effort) for bathing, dressing upper (above waist) and lower (waist below) body, required supervision on personal hygiene and oral hygiene, and required set up for eating. The MDS indicated Resident 21 utilizes a wheelchair and has bilateral (both sides) impairments on the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 21's Change of Condition (COC) dated 5/13/2025 at 4:26p.m., the COC indicated Resident 21 was sent to the hospital for further evaluation for a left elbow skin tear and right forearm skin tear. During an interview on 5/18/2025 at 5:41p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated upon admission, they get the paperwork, introduce the resident, review the resident, do skin assessments with the Certified Nursing Assistant (CNA), assess for smoking, check if they are a fall risk, and do the Braden Scale (tool used to assess a patient's risk for developing damaged skin and tissue). LVN 2 stated they do the head-to-toe assessment and indicated the RN does not do the admission assessments. LVN 2 stated the Licensed Vocational Nurses are the ones that do the skin assessment, and it was primarily their responsibility to do the admission assessments not the Registered Nurses. LVN 2 stated if there is a serious incident such as a fall or bleed, they will notify the RN so they can assess the resident. LVN 2 stated if they do not have an RN, they will notify the physician. During a concurrent interview and record review on 5/18/2025 at 5:49 p.m. with LVN 2, LVN 2 stated Resident 21 went and came back from the hospital and usually an LVN will not do a full readmission assessment	F727		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F727	if the resident comes back from the hospital in the same day. LVN 2 stated the progress note indicated on 5/14/2025 at 12:55a.m., there is documentation that the resident returned from the hospital. LVN 2 stated the skin and pain assessment needs to be completed. LVN 2 stated there was no reassessment done by an LVN or an RN when Resident 21 returned back from the hospital and was supposed to do an assessment. LVN 2 stated an assessment is supposed to be done as Resident 21 has been on a gurney in the emergency room and you want to assess to ensure theres no new issues, and ensure the resident is not in pain. LVN 2 stated if there are no readmission assessments done, the resident may have skin breakdown, so it is important to cover all the basis as they are there to take care of the residents and make sure they are okay. b. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was initially admitted to the facility on 3/24/2025 and was readmitted on 5/13/2024 with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 28's H&P, dated 5/15/2025, the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 28 MDS dated 3/31/2025, the MDS indicated Resident 2's cognitive skills were severely impaired. The MDS indicated Resident 28 is	F727		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F727	dependent on chair/bed-to-chair transfer, toilet transfer, toileting hygiene, required maximal assistance for lower body dressing, bathing, required moderate assistance (provide less than half the effort) for oral hygiene and upper body dressing, and required supervision for eating and personal hygiene. The MDS indicated Resident 28 utilizes a wheelchair and has bilateral impairments on the lower extremities. During a review of Resident 28's Admission/Readmission Evaluation/Assessment dated 5/13/2025, the admission/readmission evaluation indicated this assessment document was completed by Licensed Vocational Nurse 3 (LVN 3). During a concurrent interview and record review on 5/18/2025 at 3:54 p.m., with Infection Preventionist Nurse (IPN), the IPN stated the LVN's have been doing the admission assessments and Registered Nurse Supervisor 1 (RNS 1) helps and does the care plans. the IPN stated RNS 1 also does the admission assessments, but most of the time, the LVNs do the admission assessments. The IPN stated that when the resident is admitted, the admission assessments have to be documented right away. The IPN stated that when a resident goes to the hospital and comes right back to the facility, they have to do an admission/readmission evaluation assessment right away as the resident might have bruising, there may be new medication orders, and does not want the facility to be blamed. IPN stated they also have to do the skin check and is done by the LVNs. During an interview on 5/18/2025 at 4:01p.m., with RNS 1, RNS 1 stated for admission, transfer, and discharge assessments, the LVN does it and she helps.	F727		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F727	During an interview on 5/18/2025 at 8:31p.m. with Director of Nursing (DON), the DON stated the Registered Nurses (RN) does not usually do the admissions and indicated any licensed nurse can do the head-to-toe assessment. The DON stated if the LVN completes the head-to-toe assessment, the RN should verify the assessment themselves. The DON stated RN completes a comprehensive assessment of the resident because they oversee the plan of care, treatments, and ensure issues are not missed. During a review of the facility's policies and Procedures (P&P), titled "Job Description: Registered Nurse (RN)," dated 1/2025, the P&P indicated participate in the development of written preliminary and comprehensive assessments of the nursing needs of each resident as necessary. Ensure that all personnel involved in providing care to the resident are aware of the resident's care plan. Review nurses' notes to determine if the care plan is being followed. Review resident's medical and nursing treatments to ensure that they are provided in accordance with the resident's care plan and wishes. During a review of the facility's P&P, titled "Job Description: Director of Nursing" revised 1/2025, the P&P indicated the DON is a registered nurse who oversees and supervises the care of all the residents. Essential Duties: Overall management of the entire nursing department and staffing levels. Responsible for ensuring resident safety and that all residents are treated with utmost respect. Liaison between the facility, physicians and family members. Work closely with all other departments to ensure excellent overall resident care. I know During a review of the facility's P&P, titled "Admission Assessment and Follow Up: Role of the	F727		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F727	Nurse" revised September 2012, the P&P indicated the purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including MDS. 7. Conduct an admission assessment (history and physical), including a. A summary of the individual's recent medical history, including hospitalizations, acute illnesses, and overall status prior to admission. b. Relevant medical, social, and family history	F727		
F755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F755	**F-tag 755** **I: Corrective Action for residents found to have been affected:** • Resident 21 was no longer in the facility as of 05/22/2025. • Resident 1 was reassessed by RN on duty for any negative effects due to not administering medication as per physician's order. Resident remains stable at this time. • Clarification of Resident 1 medication was made by RN with physician on 5/18/2025. Resident 1's order for hydrocodone-acetaminophen was communicated and clarified by the licensed nurse to the pharmacy and delivered on 05/18/2025. • Resident 1's MRR was communicated to attending physician on 5/17/2025 by the RN and on 5/18/2025 an order clarification was given by the attending physician. **II. Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and**	06/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, and administering drugs and biologicals per physician orders to meet the needs of each resident for two out of five sampled residents (Resident 1 and 21) by: 1.Failing to follow up with the Medication Regimen Review (MRR: comprehensive evaluation of resident's medication performed by a pharmacist to promote positive outcomes and minimize adverse consequences) recommendations for Resident 1. 2.Failing to communicate new medication order to the pharmacy for Resident 1. 3.Failing to follow doctors orders and remove Lidoderm External Patch five (5) percent (%) (Lidocaine: medication that numbs specific area of the body by blocking pain signals to the brain) for Resident 21. These deficient practices had the potential for Resident 1 to not receive medication to address pain appropriately and increased the risk for adverse reactions for Resident 21 by leaving the Lidocaine patch longer than 12 hours (hrs). 1. During a review of Resident 1's Admission record, the Admission record indicated Resident 1 was admitted to the facility on 4/2/2025 with diagnoses including cerebral infarction (stroke - loss of blood flow to a part of the brain) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the right ankle and foot. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 1 had moderate cognition (ability to learn, reason, remember, understand, and make	F755	**corrective action taken:** • The facility's Medication Regimen Review (MRR) for the current residents was requested from Pharmacy by the DON on 05/21/2025. Recommendations and follow up were completed on 05/28/2025 by the DON. • The RN performed an audit for residents with lidocaine patch orders on 5/17/2025 to ensure orders are followed per the physician orders. • The DON/designee conducted a facility wide audit on 5/28/2025 for all narcotic medications orders for accuracy. No further findings. **III: Measures and systemic changes put in place to ensure deficient practices do not recur:** • On 05/18/2025, DON/designee conducted an in-service regarding the policy and procedure for administering medication, to licensed nurses. The goal is to ensure proper, timely, and safe administration of medication to the residents. • The Medical Records Director/designee will conduct a daily audit of the MRR's for the new admissions and the DON to follow-up for the monthly MRR provided by the pharmacist consultant. • The Medical Records Director/designee shall conduct a monthly audit that the Medication Regimen Review (MRR) pharmacy recommendations are completed and will report the findings to the DON for follow-up. • The Medical Records Director/designee will conduct daily audits of residents new physician's orders to ensure physician's orders	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	decisions) impairment with the ability to recall information, required supervision when eating, required maximal assistance (helper does more than half of the effort) for dressing, and was dependent (helper does all of the effort) for showering and bathing. During a review of Resident 1's Physician Order Summary, the Order Summary indicated Resident 1 had an order for: a.Hydrocodone-acetaminophen (strong pain medication) tablet 5-325 milligrams (MG-unit of measurement) give one tablet by mouth every six hours as needed for severe pain (6-10 pain level) with start date 4/3/2025 and an end date 4/20/2025. b.Hydrocodone-acetaminophen tablet 5-325 MG give one tablet by mouth every six hours as needed for moderate pain (4-6 pain level) with start date 4/20/2025. During an observation on 5/18/2025 at 8:30 a.m., in Resident 1's room, Resident 1 reported a pain level of 7 out of 10. Licensed vocational nurse (LVN) 4 administered one tablet of hydrocodone-acetaminophen tablet 5-325 MG to Resident 1. During a concurrent interview and record review on 5/18/2025 at 10:10 a.m. with Licensed vocational nurse (LVN) 4, Resident 1's order summary, medication blister pack (type of tamper evident packaging that separates medication by dose), and reconciliation count sheet were reviewed. LVN 4 stated Resident 1's order summary indicated hydrocodone-acetaminophen tablet 5-325 MG is to be given for moderate pain (4-6). LVN 4 stated the blister pack and the reconciliation count sheet indicated hydrocodone-acetaminophen 5-325 MG for severe pain (6-10). During a concurrent interview and record review on 5/18/2025 at 1:11 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 1's MRR for	F755	are accurate and being followed. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.** • The DON/designee will report issues or trends from the weekly audits conducted for Lidocaine orders are followed per physician orders during the monthly QAA meeting x 3 months to ensure compliance. • The MRD/designee will report issues or trends from the weekly audits of new medication orders are communicated to the pharmacy and the Medication Regimen Review (MRR) are completed during the monthly QAA meeting x 3 months to ensure compliance. • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	hydrocodone-acetaminophen 5-325 MG dated 4/29/2025 was reviewed. The MRR indicated pharmacist (PHARM) 1 recommended to the facility to ensure that the order on the pain assessment flow sheet (also known as the MAR-Medication administration record) matches with the reconciliation or count sheet (Paper documentation for narcotic and controlled substance medications). RNS 1 stated she reviewed Resident 1's MRR and left a message with the MD on 5/17/2025. RNS 1 stated they should have reviewed the pain assessments on the MAR and compared it to the reconciliation sheet During an interview on 5/18/2025 at 2:52 p.m., with pharmacist (PHARM) 2, PHARM 2 stated when a medication order is changed or updated, the facility has to print and fax the new order to the pharmacy. PHARM 2 stated the pharmacy did not receive an updated order for Resident 1 which indicated hydrocodone-acetaminophen 5-325 MG for moderate pain (4-6). During an interview on 5/18/2025 at 7:27 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if a medication order's parameters were changed, it should have been faxed to the pharmacy. LVN 2 stated it is the LVN's responsibility to ensure the medication blister pack has the correctly ordered dose and parameters. During an interview 5/18/2025 at 11:29 a.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated MRR recommendations should be followed up with or acted upon within 5 days. RNS 2 stated the pain medication order should have been clarified with the physician and addressed. RNS 2 stated Resident 1 was at risk for pain not being managed adequately. During an interview on 5/18/2025 at 8:08 p.m., with the	F755		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	Director of Nursing (DON), the DON stated it is important for medications to be administered within the ordered pain level parameters. The DON stated if there is a discrepancy, the nurse should have clarified the order with the physician. The DON stated if the blister pack does not match the order, it can potentially cause a medication error. The DON stated Resident 1 could be at risk for being under or over medicated. During a review of the facility's policies and Procedures (P&P), titled Medication Regimen Reviews, revised February 2025, the P&P indicated the MRR includes a review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities ... irregularities may include incorrect medications, administration times, or dosage forms; or other medication errors, including those related to documentation. The P&P indicated upon receiving the MRR report from the pharmacist, the attending physician review and responds to the report ...if the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or the administrator. 3. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was initially admitted to the facility on 4/18/2025 and was readmitted on 5/14/2024 with diagnoses including unspecified fracture (break in a bone) of unspecified lumbar vertebra (one of the bones that make up the spinal column in the lower back), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and spinal stenosis (space inside the backbone is too small putting pressure on the spinal cord).	F755		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	During a review of Resident 21's H&P, dated 4/20/2025, the H&P indicated Resident 21 has the capacity to understand and make decisions. During a review of Resident 21 MDS, dated 4/24/2025, the MDS indicated Resident 21's cognitive skills were mildly impaired. The MDS indicated Resident 21 was dependent on chair/bed-to-chair transfer and toileting hygiene, required maximal assistance (provide more than half the effort) for bathing, dressing upper (above waist) and lower (waist below) body, required supervision on personal hygiene and oral hygiene, and required set up for eating. The MDS indicated Resident 21 utilizes a wheelchair and has bilateral (both sides) impairments on the upper (arms/shoulders) and lower (hips/legs) extremities. During a review of Resident 21's Order Summary Report (physician orders) dated 5/18/2025, the order summary indicated Lidoderm External Patch five (5) percent (%) (Lidocaine: medication that numbs specific area of the body by blocking pain signals to the brain): apply to low back topically (applied to the skin) in the morning for low back pain for 14 days. Apply in the morning and remove at bedtime for 14 days. The Lidoderm order was placed on 5/15/2025 and started on 5/16/2025. During a review of the Medication Administration Record (MAR: detailed record of medication administered to residents) dated 5/1/2025 - 5/31/2025, the MAR indicated Lidoderm External Patch 5% scheduled at 9:00a.m. was administered on 5/16/2025 and 5/17/2025. There is no indication that the Lidoderm External Patch 5% was removed at bedtime. During a review of the location of the administration	F755		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	report dated 5/1/2025 thru 5/31/2025, the administration report indicated the Lidoderm External Patch 5% was administered at the following times: 5/16/2025 administration time 10:21 a.m. and 5/17/2025 administration time 10:19 a.m. During an interview on 5/17/2025 at 9:32 a.m. with Resident 21, Resident 21 stated they had started putting the Lidocaine patch on 2 days ago and they have not removed the patch. During a concurrent observation and interview on 5/17/2025 at 9:46a.m. with Licensed Vocational Nurse 1 (LVN 1), the Lidocaine patch was observed on Resident 21's back with no date. LVN 1 stated he placed the Lidocaine patch on yesterday 5/16/2025. During an interview on 5/17/2025 at 1:54 p.m. with LVN 1, LVN 1 stated if medication is due at 9:00a.m., there is a 2-hour (hr.) time frame in which the medication can be administered 2 hrs before and after the medication due time. LVN 1 stated despite the 2-hr. time frame, the medication preferably should be given closer to 9:00 a.m. LVN 1 stated for Lidocaine patches, if the administration time is 9:00a.m., it should be administered closer to 9:00 a.m. and has to be on for 12 hrs and be off for 12 hrs as that is the usual order for Lidocaine patches. LVN 1 stated the Lidocaine patch observed on Resident 21 was supposed to be removed during the night shift per physician's orders. LVN 1 stated leaving the Lidocaine patch on longer than 12 hrs is not good for the skin as it can cause irritation. During a concurrent interview and record review on 5/18/2025 at 12:15p.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated medication can be administered upto one hour before and upto one hour after the scheduled administration time. RNS 1 stated Lidocaine patches are on for 12 hrs and off for 12	F755		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F755	hrs and indicated the Lidocaine patch would be administered at 9:00 a.m. and removed at 9:00p.m. RNS 1 stated leaving the Lidocaine patch on for longer than 12 hrs may irritate the skin and cause the skin to break down. RNS 1 stated the MAR dated 5/1/2025 - 5/31/2025 that indicated the Lidocaine patch to be applied to the low back topically in the morning and remove at bedtime should reflect the removal time of the Lidocaine patch and the way the MAR is documents needs to be clarified with the physician. During an interview on 5/18/2025 at 8:31p.m., with the DON, the DON stated medications are administered one hour before and after and Lidocaine patches are left on for 12 hrs and are off for 12 hrs. The DON stated the Lidocaine patch is removed after 12 hrs as that is the dosage for pharmacy. During a review of the facility's policies and Procedures (P&P), titled "Administering Medications," revised dated April 2019, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions; and c. honoring resident choices and preferences, consistent with his or her care plan. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).	F755		
F759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F759	**F-tag 759** **I: Corrective Action for residents found to have been affected:** • Resident 1 order for aspirin chewable was	06/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X8) DATE

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F759	This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure its medication error rate was less than five (5) percents (%). Three medication errors out of 25 total opportunities yielded a medication error rate of 8%, in 1 of 4 sampled residents (Residents 1) observed during medication administration (med pass). This deficient practice of med pass error rate at 8% exceeded the 5 % threshold and had the potential of adversely affecting residents' health condition. Findings: During medication administration (med pass) observation on 5/18/2025 at 8:30 a.m, in Resident 1's room, Licensed Vocational Nurse (LVN) 4 prepared 11 medications for Resident 1. The medications included one tablet of chewable aspirin 81 milligrams (MG- unit of measurement) and one tablet of hydrocodone-acetaminophen (strong pain medication) tablet 5-325 MG for Resident 1's reported seven out of 10 pain level. Resident 1 was observed swallowing both tablets. During an interview on 5/18/2025 at 8:30 a.m. with Resident 1, Resident 1 stated he did not chew any of the medications; he swallowed all his medication. During an interview on 5/18/2025 at 8:31 a.m. with LVN 4, LVN 4 stated resident did not chew the medication. LVN 4 stated not chewing the medication as ordered could alter the medication's effectiveness. During a review of Resident 1's Admission record, the Admission record indicated Resident 1 was admitted to	F759	clarified with physician by the RN on 5/28/2025. • Resident 1's pain observation/assessment was completed by RN on 5/18/2025. • A 1:1 in-service education was provided by the DON to LVN 4 regarding the Policy and Procedure on administering medication to ensure that residents received their medication per physician orders. **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • On 5/28/2025, the Medical Records Director/designee conducted a facility wide audit of residents on aspirin chewable tablets and hydrocodone-acetaminophen orders to ensure that residents are provided medication per physician orders. • No other residents have been affected by the deficient practice. **III: Measures and systemic changes put in place to ensure deficient practices do not recur:** • On 05/18/2025, DON/designee conducted an in-service regarding the policy and procedure for administering medication, to licensed nurses. The goal is to ensure proper, timely, and safe administration of medication as prescribed by the physician. • The Pharmacy Nurse consultant will conduct a 3-way medication cart audit on a monthly basis for the presence of medications and accuracy of orders. Findings will be reported	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F759	the facility on 4/2/2025 with diagnoses including cerebral infarction (stroke - loss of blood flow to a part of the brain) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the right ankle and foot. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 1 had moderate cognition (ability to learn, reason, remember, understand, and make decisions) impairment with the ability to recall information, required supervision when eating, required maximal assistance (helper does more than half of the effort) for dressing, and was dependent (helper does all of the effort) for showering and bathing. During a review of Resident 1's Physician Order Summary, the Order Summary indicated Resident 1 had an order for: a.Aspirin tablet chewable 81 MG- give one tablet by mouth one time a day for cerebral vascular accident (CVA) prophylaxis (prevention) with start date 5/5/2025 b.Hydrocodone-acetaminophen tablet 5-325 MG-give one tablet by mouth every six hours as needed for severe pain (6-10 pain level) with start date 4/3/2025 and an end date 4/20/2025. c.Hydrocodone-acetaminophen tablet 5-325 MG give one tablet by mouth every six hours as needed for moderate pain (4-6 pain level) with start date 4/20/2025. During a concurrent interview and record review on 5/18/2025 at 10:10 a.m., with Licensed vocational nurse (LVN) 4, Resident 1's order summary, medication blister pack (type of tamper evident packaging that separates medication by dose), and reconciliation count sheet were	F759	to the DON for follow-up. • The Medical Records Director/ designee will conduct a daily audit for new Physicians orders for accuracy and will report findings to the DON during the daily stand up meeting for follow up. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.** • DON/designee will report issues or trends per the weekly random audits made on residents on pain management during the monthly QAA meeting x 3 months to ensure compliance. • The Pharmacy consultant will report issues or trends of monthly medication administration given by the pharmacy nurse consultant and monthly in-service educations provided regarding medication administration and review of residents on pain management. • Trends and patterns will be discussed for further recommendations and interventions • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F759	reviewed. LVN 4 stated Resident 1's order summary indicated hydrocodone-acetaminophen tablet 5-325 MG is to be given for moderate pain (4-6). LVN 4 stated the blister pack and the reconciliation count sheet indicated hydrocodone-acetaminophen 5-325 MG for severe pain (6-10). During an interview on 5/18/2025 at 2:52 p.m., with pharmacist (PHARM) 2, PHARM 2 stated when a medication order is changed or updated, the facility has to print and fax the new order to the pharmacy. PHARM 2 stated the pharmacy did not receive an updated order for Resident 1 which indicated hydrocodone-acetaminophen 5-325 MG for moderate pain (4-6). During an interview on 5/18/2025 at 7:27 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if a medication order's parameters were changed, it should have been faxed to the pharmacy. LVN 2 stated it is the LVN's responsibility to ensure the medication blister pack has the correctly ordered dose and parameters. During an interview 5/18/2025 at 11:29 a.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated the pain medication order should have been clarified with the physician and addressed. RNS 2 stated Resident 1 was at risk for pain not being managed. During an interview on 5/18/2025 at 8:08 p.m. with the Director of Nursing (DON), the DON stated it is important for medications to be administered as ordered and within the ordered pain level parameters. The DON stated if chewable aspirin is not chewed, it can affect the absorption and efficacy. The DON stated if there is a discrepancy, the nurse should have clarified the order	F759		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F759	with the physician. The DON stated if the blister pack does not pmatch the order, it can potentially cause a medication error. The DON stated Resident 1 could be at risk for being under or over medicated. During a review of the facility's policy and procedure (P&P), titled Administering Medications, revised April 2019, the P&P indicated medications are administered in accordance with prescriber orders, including any required time frame.	F759		
F760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to administer: 1.Hydrocodone-acetaminophen with the ordered pain level parameters for Resident 1 2.Oxycodone with the ordered pain level parameters for Resident 21. This deficient practice had the potential to under or over-medicate Resident 1 and Resident 21. Findings: During medication administration (med pass) observation on 5/18/2025 at 8:30 a.m., in Resident 1's room, the Licensed Vocational Nurse (LVN) 4 administered one tablet of hydrocodone-acetaminophen (strong pain medication) tablet 5-325 MG for Resident 1's reported seven out of 10 pain level. During a review of Resident 1's Admission record, the Admission record indicated Resident 1 was admitted to	F760	**F-tag 760** **I: Corrective Action for residents found to have been affected:** · Resident 21 is no longer in the facility as of 05/22/2025. • Resident 1 was reassessed by RN on duty on 05/18/2025 for any negative effects due to an incorrect hydrocodone-acetaminophen order. Resident remains stable at this time. • A one-on-one in-service education was provided to LVN 4 on 05/18/2025 by the DON regarding hydrocodone-acetaminophen administration within the pain level parameters per the physician order. **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • On 06/06/2025, the DON conducted an audit to review residents on pain management to ensure residents are receiving pain medication based on pain level parameters as ordered by the physician. • No other residents have been affected by the deficient practice.	06/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F760	the facility on 4/2/2025 with diagnoses including cerebral infarction (stroke - loss of blood flow to a part of the brain) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the right ankle and foot. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 1 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment with the ability to recall information, required supervision when eating, required maximal assistance (helper does more than half of the effort) for dressing, and was dependent (helper does all of the effort) for showering and bathing. During a review of Resident 1's Physician Order Summary, the Order Summary indicated Resident 1 had an order for: a.Hydrocodone-acetaminophen tablet 5-325 MG-give one tablet by mouth every six hours as needed for severe pain (6-10 pain level) with start date 4/3/2025 and an end date 4/20/2025. b.Hydrocodone-acetaminophen tablet 5-325 MG give one tablet by mouth every six hours as needed for moderate pain (4-6 pain level) with start date 4/20/2025 During a concurrent interview and record review on 5/18/2025 at 10:10 a.m., with Licensed vocational nurse (LVN) 4, Resident 1's order summary, medication blister pack (type of tamper evident packaging that separates medication by dose), and reconciliation count sheet were reviewed. LVN 4 stated Resident 1's order summary indicated hydrocodone-acetaminophen tablet 5-325 MG is to be given for moderate pain (4-6). LVN 4 stated the blister pack and the reconciliation count sheet indicated	F760	**III: Measures and systemic changes put in place to ensure deficient practices do not recur:** • On 05/18/2025, DON/designee conducted an in-service regarding the policy and procedure for administering medication, to licensed nurses. The goal is to ensure proper, timely, and safe administration of medication as prescribed by the physician. • The Pharmacy Nurse consultant will conduct a 3-way medication cart audit on a monthly basis for the presence of medications and accuracy of orders. Findings will be reported to the DON for follow-up. • The Pharmacy Nurse consultant will continue monthly medication pass skills competency to licensed nurses. Any findings will be reported to the DON for follow up. • The Medical Records Director/ designee will conduct a daily audit for new Physicians orders for accuracy and will report findings to the DON during the daily stand up meeting for follow up. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.** • DON/designee will report issues or trends per the weekly random audits made on residents on pain management during the monthly QAA meeting x 3 months to ensure compliance. • The Pharmacy consultant will report issues or trends of monthly medication administration given by the pharmacy nurse consultant and monthly in-service educations provided	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F760	hydrocodone-acetaminophen 5-325 MG for severe pain (6-10). During an interview on 5/18/2025 at 2:52 p.m., with pharmacist (PHARM) 2, PHARM 2 stated when a medication order is changed or updated, the facility has to print and fax the new order to the pharmacy. PHARM 2 stated the pharmacy did not receive an updated order for Resident 1 which indicated hydrocodone-acetaminophen 5-325 MG for moderate pain (4-6). During an interview on 5/18/2025 at 7:27 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if a medication order's parameters were changed, the new parameters should have been faxed to the pharmacy. LVN 2 stated it is the LVN's responsibility to ensure the medication blister pack has the correctly ordered dose and parameters. During concurrent interview and record review 5/18/2025 at 11:29 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 1's May 2025 Medication Administration Record (MAR) was reviewed. RNS 2 stated Resident 1 received hydrocodone-acetaminophen 5-325 outside of the ordered pain level parameters seven times: 5/9/2025 (for pain 7/10), 5/10/2025 (for pain 7/10), 5/11/2025 (for pain 7/10), 5/15/2025 (for pain 7/10), 5/17/2025 (once for pain 10/10), 5/17/2025 (for pain 7/10), and 5/18/2025(for pain 7/10). RNS 2 stated the pain medication order should have been clarified with the physician and addressed. RNS 2 stated Resident 1 was at risk for pain not being managed. During an interview on 5/18/2025 at 8:08 p.m. with the Director of Nursing (DON), the DON stated it is important for medications to be administered within the ordered pain level parameters. The DON stated Resident 1 could be at risk for being under or over medicated. During a review of the	F760	regarding medication administration and review of residents on pain management. • Trends and patterns will be discussed for further recommendations and interventions • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F760	facility's policy and procedure (P&P), titled Administering Medications, revised April 2019, the P&P indicated medications are administered in accordance with prescriber orders, including any required time frame.	F760		
F800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review the facility failed to ensure a banana was not placed on Resident 194's breakfast tray when the diet tag indicated Resident 194 was allergic to bananas. This deficient practice had the potential to subject Resident 194 to have an allergic reaction(an unpleasant or dangerous immune system reaction after a certain food is eaten. Findings: During a review of Resident 194's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on 4/30/2025 with diagnoses including dysphagia (difficulty swallowing) , oropharyngeal phase (swallowing difficulty related to mouth and throat), asthma (when a person's airway became inflamed , narrow, swell and becomes difficult to breathe) and repeated falls. During a review of Resident 194's Minimum Data Set (MDS), a resident assessment tool, dated 5/6/2025, the MDS indicated Resident 194's cognition was moderately impaired. The MDS indicated Resident 194 was	F800	**F-tag 800** **I: Corrective Action for residents found to have been affected:** • On 05/17/2025, a banana was removed from Resident 194's meal tray by the dietary supervisor prior to meal tray delivery. **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • Residents with food allergies were audited by the dietary supervisor on 5/17/2025. No other residents identified with the same deficient practice. • An immediate in-service education was provided by the dietary supervisor on 5/18/2025 to dietary staff to ensure that residents identified allergies are not provided in the resident's meal tray. **III: Measures and systemic changes put in place to ensure deficient practices do not recur:** • The Registered Dietitian will conduct a tray line observation on a weekly basis x 1 month, then monthly x 3 months to ensure resident will not receive identified food allergy items on the food tray. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.**	06/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F800	dependent (helper does all the effort. Residents does none of the effort to complete the activity) with shower/ bathing self, substantial/ maximum assistance (helper lifts holds trunk or limbs and provides more than half the effort) with toilet hygiene, lower body dressing and putting on/ taking off footwear. During a record review of Resident 194's Order Summary Report (OSR), the Order Summary Report dated 4/30/2025 indicated Resident 194 was allergic to avocado, banana and strawberries. During a breakfast tray line observation and interview on 5/17/2025 at 7:59 a.m. with the Dietary Aide (DA), DA observed ½ of a banana on Resident 194's breakfast tray . The DA stated he was nervous and did not see the allergy sign on resident's tray. The DA stated if the resident gets the banana and eats it his health can be affected . DA stated the process is we must pay attention the allergy tag written in red double check the foods on the tray to prevent errors. During an observation and interview on 5/17/20256 at 8:15 a.m., with the Dietary Supervisor (DS), the DS stated the DA checks the meal cart to make sure Resident who are allergic to foods do not get them. The DS stated he also checks the trays . The DS stated it is important to make sure you do not put foods residents are allergic on their food tray it because could make the resident sick. During a review of the facility's policy and procedure (P&P) titled" Food Allergy and Food Intolerances" dated 2001, the P&P indicates residents with food allergies and/or Intolerances are identified upon admission and offered food substitutions od similar appeal and nutritional value, Steps are taken to prevent resident	F800	• The result of tray line observation conducted by the RD will be reported by the Dietary Supervisor during the monthly QAA meeting x 3 months to ensure compliance. • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/25**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F800	exposure to the allergens. Meals for residents with severe food allergies are specially prepared so that cross- contamination with allergens does not occur. During a review of the facility's policy and procedure (P&P) titled" Tray identification" dated revised April 2007 indicates the food service Manager or supervisor will check trays for correct diets before the food carts are transported to their designated area.	F800		
F867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)(d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the	F867	**F-tag 867** **I: Corrective Action for residents found to have been affected:** • On May 2025, four QAPI's were initiated: Wound Management (05/06/2025), Informed Consents for initiation and renewal of Psychotropic Drugs (05/06/2025), Risk Management Process (05/06/2025), Pharmacy Recommendation Compliance (05/13/2025). **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • QAPI's were initiated based on the identified issues will be presented during the monthly QA meeting. **III: Measures and systemic changes put in place to ensure deficient practices do not recur:** • An in-service education were provided by the Assistant Regional Director of Clinical Services (ARDCS) to the Administrator and Department Members on 6/09/2025 regarding the QAPI/QAA Activities, roles and responsibilities of each member of the QAPI/QAA Committee	06/12/2025

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F867	methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must	F867	members to ensure a system and processes are in place for reporting/identifying problems in the facility, establishing corrective actions by the committee, establishing methodology for analysis of the action plans, measuring progress against the established goals and benchmarks, communicating information to staff and residents and the committee members responsibilities in reporting findings to the administrator and the governing body. • The Administrator /designee shall initiate posted information monthly to the residents and staff regarding projects that the QAPI committee is working on including progress of each project. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.** • The Assistant Regional Director of Clinical Services (ARDCS) will review the quarterly activities of the QAPI program that is discussed in the quarterly QA Committee and posted in the facility. • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F867	track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA: committee that focuses on identifying and addressing	F867		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F867	quality deficiencies in resident care) failed to implement and ensure effective oversight of the facility and implementation of their Quality Assurance and Performance Improvement (QAPI: systemic approach to improve the quality of care and services provided to residents) plan. This deficient practice had the potential to have reoccurring deficient practices that can impact the quality of care for the residents. During a concurrent interview and record review on 5/18/2025 at 6:25p.m., with the Administrator (ADM), the ADM stated they have QAPI meetings monthly and QAPIs are structured to identify potential solutions to yield positive outcomes. The ADM stated they did not have documentation of QAPI meetings prior to March 2025. The ADM stated there were issues regarding call light response time at the end of February 2025, and in March 2025, call light issues were present during the resident council meetings, so a QAPI was implemented regarding call light response times. The ADM stated there were no other issues that they were aware of for March 2025 and indicated skin integrity issues were identified at a later time. The ADM stated when he took over as the ADM in January 2025, upon observing trends, he provided additional nursing support [Assistant Director of Nursing (ADON)] to help with care and support and to see if any changes would be made. ADM stated the QAPI was initiated in March 2025 as he wanted to give the previous Director of Nursing (DON) the benefit of the doubt on her opinions and believed it was not necessary to do a QAPI at the time when the trends were present and indicated it could have helped if a QAPI was initiated at that time. During a concurrent	F867		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F867	interview and record review on 5/18/2025 at 6:39 p.m. with the ADM, the ADM stated there is no QAPI in April 2025 and indicated the call light issue has not been resolved in April. The ADM stated during the resident council meeting; the residents did not complain about call lights. ADM stated he looked through the Director of Nursing (DON)'s office and was not able to locate previous QAPI documents. ADM stated if a QAPI is not implemented, the trend identified will continue and impose more risks to the residents and not enhancing care. ADM stated the QAPI is not complete. ADM stated the QAPI is constantly monitored each day and indicated if an issue continues to trend, it will be added to the QAPI. During a review of the facility's policy and procedure (P&P) titled, "Quality Assessment and Performance Improvement (QAPI) Program," revised on February 2020, the P&P indicated this facility shall develop, implement, and maintain an ongoing, facility-wide, data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to: 1. provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. reinforce and build upon effective systems and processes related to the delivery of quality care and services. 4. establish systems through which to monitor and evaluate corrective actions. Authority: 1. The owner and/or governing board (body) of our	F867		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F867	facility is ultimately responsible for the QAPI program. 2. The governing board/owner evaluates the effectiveness of its QAPI program at least annually and presents findings to the QAPI committee. 3. The administrator is responsible for assuring that this facility's QAPI program complies with federal, state, and local regulatory agency requirements. Implementation 1. The QAPI committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of systemic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and f. monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. 3. The committee meets monthly to review reports, evaluate data, and monitoring QAPI-related activities and make adjustments to the plan. During a review of the facility's P&P titled, "Quality Assessment and Performance Improvement (QAPI) Program - Analysis and Action," revised on March 2020,	F867		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F867	the P&P indicated quality deficiencies that are identified through feedback and data and will undergo appropriate corrective action. Corrective actions are monitored against established goals and benchmarks by the QAPI committee. The QAPI program, overseen the QAPI committee is designed to identify and address quality deficiencies through the analysis of underlying cause and actions targeted at correcting systems at a comprehensive level. The methodology for analysis and action is guided by a written QAPI plan that includes: a. Definition of the problem, based on information obtained through data, self-assessment and feedback systems b. An analysis of the root cause of the problem from a systems perspective. c. Establishing measurable goals or benchmarks for improvement. d. Specific interventions aimed at correcting the problem and achieving the stated goals or benchmarks. e. Methods and frequency of monitoring performance improvement objectives. The QAPI committee is responsible for analyzing identified problems, establishing corrective actions, measuring progress against the established goals and benchmarks, communicating information to staff and residents, and reporting findings to the administrator and governing board.	F867		
F880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a	F880	**F-tag 880** **I: Corrective Action for residents found to have been affected:** • Resident 21 is no longer in the facility as of 05/22/2025. • The IP Nurse will conduct direct observation of	06/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F880	safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements. §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F880	• LVN 1 was provided one on one in-service by the IP Nurse on 5/18/2025 regarding donning and doffing of PPE with residents on Enhanced Barrier Precaution (EBP). **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • On 5/28/2025, the IP Nurse conducted a direct observation on random facility staff in regard to proper donning and doffing of PPE with residents on EBP. 5/5 facility staff were observed and all are compliant. • No other residents were affected by the deficient practice. **III: Measures and systemic changes put in place to ensure deficient practices do not recur:** • The IP Nurse provided in-service to facility staff on 05/18/2025, regarding the policy and procedure for Enhanced Barrier Precaution (EBP). The goal is to prevent and control the risks of spreading infectious microorganisms to residents. facility staff x1 month then monthly of 5 staff observation that proper donning and doffing of PPE is used when in contact with residents that is on Enhance Barrier Precaution (EBP). Audit findings will be reported to the DON for follow up. **IV. Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process.** • The IP Nurse will report findings of donning	

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F880	prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement their Enhanced Barrier Precaution (EBP: infection control practices to prevent the spread of multidrug-resistant organisms (MDRO's) control measures for one of three sampled residents (Residents 21) by failing to wear proper Personal Protective Equipment (PPE: to protective clothing, helmets, gloves, face shields, goggles, face masks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness) when coming in contact with /administering Resident 21's Lidocaine Patch (medication that numbs specific area of the body by blocking pain signals to the brain) and when handling the indwelling catheter (known as Foley catheter, a tube that allows urine to drain from the bladder into a bag that is usually attached to the thigh) drainage bag. These deficient practices had the potential to transmit	F880	and doffing observations during the monthly QAA meeting x 3 months to ensure compliance. • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance. **V. Corrective Action Completion Date: 6/12/2025**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F880	infectious microorganisms and increase the risk of infection for the residents.	F880		

During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was initially admitted to the facility on 4/18/2025 and was readmitted on 5/14/2024 with diagnoses including unspecified fracture (break in a bone) of unspecified lumbar vertebra (one of the bones that make up the spinal column in the lower back), spinal stenosis (space inside the backbone is too small putting pressure on the spinal cord), and obstructive (urine flow is blocked) and reflux uropathy (occurs when urine flows backward into the bladder often as a result of obstruction).

During a review of Resident 21's History and Physical (H&P), dated 4/20/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions.

During a review of Resident 21 Minimum Data Set [MDS] a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 21'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 21 was dependent on chair/bed-to-chair transfer and toileting hygiene, required maximal assistance (provide more than half the effort) for bathing, dressing upper (above waist) and lower (waist below) body, required supervision on personal hygiene and oral hygiene, and required set up for eating. The MDS indicated Resident 21 utilizes a wheelchair and has bilateral (both sides) impairments on the upper (arms/shoulders) and lower (hips/legs) extremities.

During a review of Resident 21's Order Summary Report

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F880	(physician orders) dated 5/18/2025, the order summary indicated enhanced barrier precautions during high contact resident care activities secondary to (foley cath) every shift with an active date of 4/18/2025. During an observation on 5/17/2025 at 9:46 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed exposing Resident 21's Lidocaine patch located on the lower back without wearing proper PPE. LVN 1 was then observed touching Resident 21's foley catheter bag without wearing proper PPE. During an interview on 5/17/2025 at 1:54 p.m., with LVN 1, LVN 1 stated EBP's are for residents with wounds and foley catheters, and gowns are worn when performing nursing care that can possibly expose you to fluids or wounds. LVN 1 stated when giving medications, gowns are not worn since you are not giving direct patient care. LVN 1 stated gowns are worn when you have direct patient skin to skin contact and when emptying the foley catheter bag. LVN 1 stated as long as there is a possibility of liquid or splashing during nursing care, a gown is worn. LVN 1 stated if gowns are not worn, whatever is being handled such as bodily fluids can splash and wearing a gown can prevent that from occuring. During an interview on 5/18/2025 at 10:41a.m. with the Infection Preventionist Nurse (IPN), the IPN stated EBPs are for residents who have foleys, gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), or chronic wounds that require dressing. The IPN stated high contact includes providing activities of daily living (ADL: shower, bed bath) care and emptying the foley bag. The IPN stated a gown should be worn if you are touching the foley bag even if you are not emptying it as it might spill. The IPN stated you wear the	F880		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F880	gown to protect yourself and the resident and not wearing a gown can contaminate your clothing and increase the chance of spreading it to other residents. During an interview on 5/18/2025 at 1:59 p.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated PPE should be worn since you are coming in contact with the resident when putting on the Lidocaine patch as it is worn for precaution. During an interview on 5/18/2025 at 8:31p.m., with the Director of Nursing (DON), the DON stated EBPs are for residents that have some kind of invasive device like a foley catheter and staff should wear a gown when you are going to anticipate having contact with the resident. The DON stated a gown is worn to protect the residents The DON stated a gown is worn when applying a Lidocaine patch on a resident who is on EBP because you are having contact with the patient. During a review of the facility's policies and Procedures (P&P), titled "Administering Medications," revised April 2019, the P&P indicated staff follows stablished facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications, as applicable. During a review of the facility's P&P titled "Enhanced Barrier Precautions," revised December 2024, the P&P indicated enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. Enhanced barrier precautions apply when a resident has a wound or	F880		

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

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.

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 _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F880	Indwelling medical device, and has secretions or excretions that are unable to be covered or contained. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a.Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care); device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.)	F880		
F912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure two of 20 resident bedrooms met the requirements of 80 square feet ([sq. ft.] a unit of area measurement) per residents in multi-bed resident rooms and 100 sq. ft for each single bed resident room. This deficient practice had the potential to result in inadequate space to provide privacy, space during daily care, and access during an emergency. During a review of the facility's Client Accommodations Analysis form, provided by the facility on 5/18/2025, the facility had 2 rooms that measured less than 80 sq. ft.	F912	**F-tag 912** **I: Corrective Action for residents found to have been affected:** • On 06/09/2025, the Social Services Director/designee conducted a room visit to residents in rooms 5 and 6, no signs or indications of any adverse effects from being in a room with more than occupancy required. Resident's feel safe, privacy not invaded, and no negative outcomes with care and treatment. Current needs are met. **II: Facility's identification of other residents having the potential to be affected by the same affected by the deficient practice and corrective action taken:** • On 06/09/2025, the Maintenance Director updated the room measurements for all rooms	06/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	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
F912	per resident in multi-bed rooms and two rooms that measured less than 100 sq. ft for a single bedroom. The resident rooms were as follows: Room 5: 14 inches (in: unit of length) x 10.1 in [141.4 sq ft.] approved capacity: 2 Room 6: 14 in x 10.7 in [149.8 sq. ft.] approved capacity: 2 During a concurrent observation and interview on 5/18/2025 at 8:43a.m. with Maintenance Supervisor (MS), the room size measured for 5 was 14 in x 10.7 in and room 6 was 14 in x 10 6 in. MS stated he does not know what the right measurement for each resident is and indicated the room is small for 2 beds. MS stated there is a room waiver that is submitted for the rooms and indicated if the room is small, the staff and residents may bump into things. During an interview on 5/18/2025 at 8:40p.m. with Director of Nursing (DON), DON stated if the resident's room is deemed too small per guidance, there is potential for the room to be cluttered and the resident may fall due to not having enough space.	F912	to ensure residents have adequate space for care, access and use of assistive devices and furniture and for visitors. • All other rooms are in compliance. **III: Measures and systemic changes put in place to ensure deficient practices do not recur:** · Application for the room waiver was sent to Feven Isaac on 06/10/2025. · Department managers will conduct room rounds daily to ensure resident satisfaction and validate through feedback. **IV: Facility's plan to monitor corrective actions are achieve & sustain compliance; Integrate the POC to QA Process:** • The Social Services Director/designee will report findings of the daily room rounds during the monthly QAA meeting x 3 months for compliance. • Trends and patterns will be discussed for further recommendations and interventions. • The administrator will monitor compliance.** **V. Corrective Action Completion Date: 6/12/2025**	

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

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.