STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055473	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Post-Acute Care Center	1516 Sawtelle Blvd. Los Angeles, CA 90025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43454

Based on observation, interview, and record review, the facility failed to implement a comprehensive care plan that met the care/services based on the resident's individual assessed needs for two of five sampled residents (Resident 3 and Resident 4) by failing to ensure that a comprehensive care plan (CP) was implemented for administering medications.

This deficient practice had the potential to result negative impact on residents ' health and safety, as well as the quality of care and services received.

Findings:

1. A review of Resident 3's Admission Record indicated the facility originally admitted the resident on 11/10/2023 and readmitted on [DATE] with diagnoses including hypertension (HTN - elevated blood pressure), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide).

A review of Resident 3's Minimum Data Set (MDS-standardized assessment and screening tool), dated 9/3/2024, indicated Resident 3 ' s cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired for daily decision-making and required maximal assistance from staff for activities of daily living (ADL- toileting hygiene, shower/bathing and lower body dressing).

A review of Resident 3's Physician ' s Order, dated 8/28/2024, included the following medications:

i. Lisinopril (can treat high blood pressure and heart failure) 40 milligrams (mg - unit of measurement), one tablet daily at 9 a.m.

ii. Methimazole (can treat excess thyroid hormone) 5 mg, one tablet by mouth three times daily at 9 a.m., 1 p.m. and 5 p.m.

iii. Nifedipine (lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard) 60 mg, one tablet by mouth in the morning at 9 a.m.

iv. Folic acid (helps the body make healthy new cells) 1 mg, one tablet by mouth daily at 9 a.m.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Post-Acute Care Center	1516 Sawtelle Blvd. Los Angeles, CA 90025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3's Care Plan for risk for exacerbation of elevated blood pressure (BP) due to HTN, dated 8/29/2024 indicated interventions including medications as ordered: lisinopril and nifedipine, BP as ordered and notify medical doctor (MD) if out of range. During a medication pass observation with Licensed Vocational Nurse 1 (LVN 1) on 9/19/2024 at 12:15 p.m., observed LVN 1 administered the following medications: lisinopril, methimazole, nifedipine and folic acid to Resident 3. After administering the medications, LVN 1 then signed the MAR under 9 a.m. schedule. When asked if she administered the medications as scheduled, LVN 1 stated, no. LVN 1 stated, Resident 3 was getting physical therapy in the morning, and she was unable to administer the medications on time. LVN 1 further stated, Resident 3's BP was elevated at 174/84 (normal blood pressure is 120/80 or lower) prior to administering his BP medications. During an interview with Certified Occupational Therapist Assistant 1 (COTA 1) on 9/20/2024 at 9:58 a.m., COTA 1 stated, Resident 3 had physical therapy (PT) exercise yesterday (9/19/2024) after lunch at around 1 p.m. During an interview with the Director of Rehabilitation Department (DOR) on 9/20/2024 at 10:00 a.m.,the DOR stated and confirmed, Resident 3 had his PT exercise yesterday (9/19/2024) after lunch and she saw him walking in the hallway with COTA 1. During an interview with Registered Nurse 1 (RN 1) on 9/20/2024 at 12:30 p.m., medications should be administered as scheduled and per physician ' s order. RN 1 stated, Resident 3's BP of 174/84 indicated an elevated BP and medications for HTN should be administered on time because it ' s what helps with their BP to be maintained at a normal range. RN 1 further stated, if medications were administered late, the clinical nurse should explain in the MAR the reasons, and to also notify the physician. RN 1 further stated, there should also be a monitoring of Resident 3's BP to ensure if the medications were effective. During a follow-up concurrent interview with RN 1 on 9/20/2024 at 12:35 p.m., and record review of Resident 3's MAR and Progress Notes (Nurse's notes) as of 9/20/2024, there was no notes if monitoring was done when LVN 1 administered Resident 3's medications late on 9/19/2024. There were no notes as well that indicated LVN 1 notified a medical doctor (MD) regarding Resident 3's elevated BP. RN 1 stated, this was not a safe standard of practice for Resident 3. A review of the facility's policy and procedure (P&P) titled, Medication Administration, reviewed on 7/14/2023 indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time, except before or after meal orders . 2. A review of Resident 4's Admission Record indicated the facility originally admitted the resident on 12/16/2022 and readmitted on [DATE] with diagnoses including respiratory failure, DM, and HTN. A review of Resident 4's MDS dated [DATE], indicated Resident 4 ' s cognition was intact for daily decision-making and required maximal assistance to total dependent from staff for ADL - toileting hygiene, shower/bathing and upper/lower body dressing). A review of Resident 4's Physician ' s Order, dated 8/28/2024, included the following medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Famotidine (used to prevent and treat heartburn due to acid indigestion and sour stomach caused by eating or drinking certain foods or drinks) 20 mg, one tablet by mouth daily ii. Losartan (treat high blood pressure) 25 mg tablet, one tablet by mouth twice daily A review of Resident 4's Care Plan for risk for cardiac monitoring risk for elevated BP related to HTN, dated 6/17/2024 indicated an intervention including medications as ordered. During an interview with Resident 4 on 9/20/2024 at 10:07 a.m., Resident 4 stated, about two weeks ago, he did not receive his morning medications for three days. Resident 4 stated, he asked about his medications in which he was told that they were short staffed and therefore, there were no nurse assigned to him. During a concurrent interview with Licensed Vocational Nurse 2 (LVN 2) and record review of Resident 3's MAR and medication bubble pack for famotidine and losartan on 9/20/2024 at 10:42 a.m., the bubble pack for famotidine and losartan tablet for September indicated, the tablets for 9/5/2024, 9/6/2024 and 9/7/2024 were still in the medication bubble pack. LVN 2 stated, the medications were filled by the Pharmacy on 9/4/2024 and once delivered, they switched the medications to the new bubble pack that were delivered so they can use the new bubble pack and administer medications according to the date. LVN 2 stated, she does not know what happened why the tablets were still in the bubble pack for dates 9/5/2024, 9/6/2024 and 9/7/2024. During an interview with RN 1 on 9/20/2024 at 12:38 p.m., RN 1 stated, according to the bubble pack for losartan and famotidine that were filled on 9/4/2024 for Resident 4, the tablets for 9/5/2024, 9/6/2024 and 9/7/2024 were not given as the tablets were still in the bubble pack. RN 1 stated, according to the MAR, losartan and famotidine were signed on 9/4/2024 - 9/7/2024 which means it was administered. RN 1 stated, the bubble pack does not reflect the correct documentation and were inaccurate in the MAR for famotidine and losartan. During an interview with the Director of Nursing (DON) on 9/20/2024 at 3:10 p.m., DON stated, nurses should be signing in the MAR according to the time they administered the medications. The DON stated, medications should be administered as scheduled and ordered by MD. The DON stated, LVN 1 did not document correctly on the MAR, and if medications were given late, MD should be notified, especially that Resident 3's BP were elevated. The DON stated, medications should be given according to the bubble pack. The DON stated, Resident 4's losartan and famotidine for 9/5/2024 - 9/7/2024 were still in the bubble pack, therefore, it does not reflect that it was given to Resident 4. The DON stated, this was documented inaccurately. A review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, reviewed 7/12/2024 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. A review of the facility's P&P titled, Medication Administration, reviewed on 7/14/2023 indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time, except before or after meal orders .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER New Vista Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1516 Sawtelle Blvd. Los Angeles, CA 90025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview, and record review, the facility failed to provide sufficient staffing to accommodate the residents needs and request by not administering medications to one of five sampled residents (Resident 4). This deficient practice resulted in Resident 4 not receiving needed services timely and efficiently and had the potential to affect the quality of life and treatment given to the residents. Findings: A review of Resident 4 ' s Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), hypertension (HTN - elevated blood pressure), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). A review of Resident 4 ' s Minimum Data Set (MDS-standardized assessment and screening tool), dated 7/30/2024, indicated Resident 4 ' s cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact for daily decision-making and required maximal assistance to total dependent from staff for activities of daily living (ADL - toileting hygiene, shower/bathing and upper/lower body dressing). A review of Resident 4 ' s Physician ' s Order, dated 8/28/2024, included the following medications: i. Famotidine (used to prevent and treat heartburn due to acid indigestion and sour stomach caused by eating or drinking certain foods or drinks) 20 mg, one tablet by mouth daily ii. Losartan (treat high blood pressure) 25 mg tablet, one tablet by mouth twice daily During an interview with Resident 4 on 9/20/2024 at 10:07 a.m., Resident 4 stated, about two weeks ago, he did not receive his morning medications for three days. Resident 4 stated, he asked about his medications and was told that they (facility) was short staffed and therefore, and that there were no nurse assigned to him. During a concurrent interview with Licensed Vocational Nurse 2 (LVN 2) and record review of Resident 3 ' s MAR and medication bubble pack for famotidine and losartan on 9/20/2024 at 10:42 a.m., the bubble pack for famotidine and losartan tablet for September i2024, ndicated, the tablets for 9/5/2024, 9/6/2024 and 9/7/2024 were still inside the medication bubble pack. LVN 2 stated, the medications were filled by the Pharmacy on 9/4/2024 and once delivered, they switched the medications to the new bubble pack that were delivered so they can use the new bubble pack and administer medications according to the date. LVN 2 stated, she does not know what happened why the tablets were still in the bubble pack for 9/5/2024, 9/6/2024 and 9/7/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Reregistered Nurse 1 (RN 1) on 9/20/2024 at 12:38 p.m., RN 1 stated, according to the bubble pack for losartan and famotidine that were filled on 9/4/2024 for Resident 4, the tablets for 9/5/2024, 9/6/2024 and 9/7/2024 were not given as the tablets were still in the bubble pack. RN 1 reviewed the staffing schedule on 9/5/2024 - 9/7/2024 for morning shift (7 a.m. - 3 p.m.) which indicated that there were only 3 charge nurses scheduled but there should be at least 4 charge nurses. A review of the facility ' s policy and procedures (P&P) titled, Medication Administration, reviewed on 7/14/2023 indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time, except before or after meal orders . A review of the facility ' s P&P titled, Staffing reviewed on 7/14/2024 indicated, The policy of Facility will employ sufficient nursing staff to ensure that the residents obtain the appropriate care to achieve their highest potential, physical, mental and psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, facility failed to ensure two of five sampled residents (Resident 3 and Resident 4) was free from significant medication error by failing to ensure Resident 3 and Resident 4's medications were given on time and as ordered by the physician and according to facility's policy and procedure. These deficient practices have the potential to result in residents' unintended complications related to the management of medications. Cross Reference: F656 Findings: 1. A review of Resident 3's Admission Record indicated the facility originally admitted the resident on 11/10/2023 and readmitted on [DATE] with diagnoses including hypertension (HTN - elevated blood pressure), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide). A review of Resident 3's Minimum Data Set (MDS-standardized assessment and screening tool), dated 9/3/2024, indicated Resident 3 ' s cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired for daily decision-making and required maximal assistance from staff for activities of daily living (ADL- toileting hygiene, shower/bathing and lower body dressing). A review of Resident 3's Physician's Order, dated 8/28/2024, included the following medications: i. Lisinopril (can treat high blood pressure and heart failure) 40 milligrams (mg - unit of measurement), one tablet daily at 9 a.m. ii. Methimazole (can treat excess thyroid hormone) 5 mg, one tablet by mouth three times daily at 9 a.m., 1 p. m. and 5 p.m. iii. Nifedipine (lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard) 60 mg, one tablet by mouth in the morning at 9 a.m. iv. Folic acid (helps the body make healthy new cells) 1 mg, one tablet by mouth daily at 9 a.m. A review of Resident 3's Care Plan for risk for exacerbation of elevated blood pressure (BP) due to HTN, dated 8/29/2024 indicated interventions including medications as ordered: lisinopril and nifedipine, BP as ordered and notify medical doctor (MD) if out of range. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass observation with Licensed Vocational Nurse 1 (LVN 1) on 9/19/2024 at 12:15 p.m., observed LVN 1 administered the following medications: lisinopril, methimazole, nifedipine and folic acid to Resident 3. After administering the medications, LVN 1 then signed the MAR under 9 a.m. schedule. When asked if she administered the medications as scheduled, LVN 1 stated, no. LVN 1 stated, Resident 3 was getting physical therapy in the morning, and she was unable to administer the medications on time. LVN 1 further stated, Resident 3's BP was elevated at 174/84 (normal blood pressure is 120/80 or lower) prior to administering his BP medications. During an interview with Certified Occupational Therapist Assistant 1 (COTA 1) on 9/20/2024 at 9:58 a.m., COTA 1 stated, Resident 3 had his physical therapy (PT) exercise yesterday (9/19/2024) after lunch around 1 p.m. During an interview with Director of Rehabilitation Department (DOR) on 9/20/2024 at 10:00 a.m., DOR stated and confirmed, Resident 3 had his PT exercise yesterday (9/19/2024) after lunch and she saw him walking in the hallway with COTA 1. During an interview with Registered Nurse 1 (RN 1) on 9/20/2024 at 12:30 p.m., medications should be administered as scheduled and per physician ' s order. RN 1 stated, Resident 3 ' s BP of 174/84 indicated an elevated BP and medications for HTN should be administered on time because it ' s what helps with their BP to be maintained at a normal range. RN 1 further stated, if medications were administered late, the clinical nurse should explain in the MAR the reasons, and to also notify the physician. RN 1 further stated, there should also be a monitoring of Resident 3's BP to ensure if the medications were effective. During a follow-up concurrent interview with RN 1 on 9/20/2024 at 12:35 p.m., and record review of Resident 3 ' s MAR and Progress Notes (Nurse ' s notes) as of 9/20/2024, there was no notes if monitoring was done when LVN 1 administered Resident 3's medications late on 9/19/2024. There were no notes as well if LVN 1 notified MD regarding Resident 3 ' s elevated BP. RN 1 stated, this was not a safe standard of practice for Resident 3. A review of the facility's policy and procedures (P&P) titled, Medication Administration, reviewed on 7/14/2023 indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time, except before or after meal orders . 2. A review of Resident 4's Admission Record indicated the facility originally admitted the resident on 12/16/2022 and was readmitted on [DATE] with diagnoses including respiratory failure, DM, and HTN. A review of Resident 4's dated 7/30/2024, indicated Resident 4 ' s cognition was intact for daily decision-making and required maximal assistance to total dependent from staff for ADL - toileting hygiene, shower/bathing and upper/lower body dressing). A review of Resident 4's Physician ' s Order, dated 8/28/2024, included the following medications: i. Famotidine (used to prevent and treat heartburn due to acid indigestion and sour stomach caused by eating or drinking certain foods or drinks) 20 mg, one tablet by mouth daily (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. Losartan (treat high blood pressure) 25 mg tablet, one tablet by mouth twice daily A review of Resident 4's Care Plan for risk for cardiac monitoring risk for elevated BP related to HTN, dated 6/17/2024 indicated an intervention including medications as ordered. During an interview with Resident 4 on 9/20/2024 at 10:07 a.m., Resident 4 stated, about two weeks ago, he did not receive his morning medications for three days. Resident 4 stated, he asked about his medications in which he was told that they were short staffed and therefore, there were no nurse assigned to him. During a concurrent interview with Licensed Vocational Nurse 2 (LVN 2) and record review of Resident 3 ' s MAR and medication bubble pack for famotidine and losartan on 9/20/2024 at 10:42 a.m., the bubble pack for famotidine and losartan tablet for September indicated, the tablets for 9/5/2024, 9/6/2024 and 9/7/2024 were still in the medication bubble pack. LVN 2 stated, the medications were filled by the Pharmacy on 9/4/2024 and once delivered, they switched the medications to the new bubble pack that were delivered so they can use the new bubble pack and compare it according to the date. LVN 2 stated, she does not know what happened why the tablets were still in the bubble pack for 9/5/2024, 9/6/2024 and 9/7/2024. During an interview with RN 1 on 9/20/2024 at 12:38 p.m., RN 1 stated, according to the bubble pack for losartan and famotidine that were filled on 9/4/2024 for Resident 4, the tablets for 9/5/2024, 9/6/2024 and 9/7/2024 were not given as the tablets were still in the bubble pack. RN 1 stated, according to the MAR, losartan and famotidine were signed on 9/4/2024 - 9/7/2024 which means it was administered. RN 1 stated, the bubble pack does not reflect the correct documentation and were inaccurate in the MAR for famotidine and losartan. During an interview with Pharmacist 1 (PH 1) on 9/20/2024 at 1:14 p.m., PH 1 stated and confirmed, Resident 4 ' s losartan and famotidine were filled on 9/4/2024 and delivered to the facility on [DATE]. PH 1 stated, the nurses should be administering the medication accordingly by the date of the bubble pack. During an interview with the Director of Nursing (DON) on 9/20/2024 at 3:10 p.m., the DON stated, nurses should be signing in the MAR according to the time they administered the medications. The DON stated, medications should be administered as scheduled and ordered by a medical doctor (MD). The DON stated, LVN 1 did not document correctly on the MAR, and if medications were given late, MD should be notified, especially that Resident 3 ' s BP were elevated. The DON stated, medications should be given according to the bubble pack. The DON stated, Resident 4 ' s losartan and famotidine for 9/5/2024 - 9/7/2024 were still in the bubble pack, therefore, it does not reflect that it was given to Resident 4. The DON stated, this was documented inaccurately. A review of the facility's policy and procedures (P&P) titled, Medication Administration, reviewed on 7/14/2023 indicated, Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time, except before or after meal orders . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Charting and Documentation, reviewed on 7/12/2024 indicated, The following information is to be documented in the resident medical record: medications administered . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.