

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 10/09/2024
NAME OF PROVIDER OR SUPPLIER New Vista Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1516 Sawtelle Blvd. Los Angeles, CA 90025	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026</p> <p>Based on observation, interview, and record review, the facility failed to ensure that staff provided adequate supervision and monitoring to prevent elopement (the act of leaving a facility unsupervised and without prior authorization) for one of three sampled residents (Resident 1).</p> <p>This deficient practice resulted in Resident 1 eloping from the facility on 10/04/2024 at 9:36 AM., placing the resident at increased risk to suffer accidents, falls with injuries, physiological (referring to the body and its systems) harm, hospitalization, and death. Resident 1 went to family member 1's (FM 1) residence and never returned back to the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's face sheet (Admission Record- a document containing demographic and diagnostic information) indicated Resident 1 was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (brain dysfunction caused by an underlying condition), end stage renal disease (ESRD- when the kidneys stop functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and iron deficiency anemia (a condition when the body does not have enough iron to produce healthy red blood cells).</p> <p>During a review of Resident 1's care plan titled Elopement, indicated, Resident 1 was at risk for elopement related to history of AMA (against medical advice - when a patient leaves a facility against the advice of the doctor) prior to admission to the facility. The care plan indicated the goals indicated Resident 1 will remain safe in the facility daily for 90 days. The care plan interventions indicated Resident 1 will be assessed for risks for elopement, obtain elopement history and patterns from family, evaluate scenarios that may trigger elopement, and place Resident 1 in an area where the resident can be easily supervised by staff.</p> <p>During a review of Resident 1's Minimum Data Set, (MDS a federally mandated resident assessment tool) dated 8/23/2024, the MDS indicated Resident 1 was cognitively intact (mental ability to make decisions on activities of daily living), was able to walk without any device assistance/device and had no behavioral symptoms (represents the complaints of the patient).</p> <p>During a review of Resident 1's history and physical (H&P - a physician's complete patient examination) dated 12/06/2023, the H&P indicated, Resident 1 had the capacity for medical decision making.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>LVN 3 saw Resident 1 sitting on the couch.</p> <p>During a review of Licensed Nurses Notes dated 10/04/2024 at 7 AM, indicated, licensed vocational nurse 3 (LVN 3), LVN 3 documented that Resident 1 was alert and oriented and was seen by LVN 3 sitting on the couch in the lobby/reception area. LVN 3 documented that LVN 3 administered medications to Resident 1 on 10/04/2024 at 7 AM, at 9:30 AM and at 12:05 PM. LVN 3 documented that LVN 3 saw Resident 1 in resident's room on 10/04/2024 at 1:30 PM, and that LVN 3 saw Resident 1 sitting on the couch on 10/04/2024 at 2:15 PM.</p> <p>During a telephone interview on 10/08/2024 at 10:02 AM with Resident 1's family member 1 (FM 1), FM 1 stated Resident 1 arrived at the FM 1's residence on 10/04/2024 at around 10 AM or 11 AM, [Resident 1] came alone. FM 1 stated FM 1 did not expect Resident 1 to show up at FM 1's residence. FM 1 stated Resident 1 told FM 1 that resident left the facility because the resident did not like the breakfast served at the facility. FM 1 stated the facility did not notify FM 1 that Resident 1 was missing from the facility. FM 1 stated FM 1 contacted the facility and informed Receptionist 2 (R2) that Resident 1 was with FM 1. FM 1 stated Resident 1 was with FM 1 and family since the resident's arrival on 10/04/2024.</p> <p>During an interview with Certified Nurse Assistant 1 (CNA 1) on 10/08/2024 at 2:11 PM, CNA 1 stated Resident 1 walked around in circles in the facility, in the dining room, and in the patio. CNA 1 stated Resident 1 would be sitting on the couch whenever I come to work, I will find [Resident 1] there a lot, just sitting, nothing else.</p> <p>During an interview with LVN 3 on 10/08/2024 at 2:30 PM, LVN 3 stated LVN 3 made resident rounds (check on residents to ensure their safety and well-being) four times during the 7 AM to 3 PM shift on 10/04/24. LVN 3 stated after LVN 3 completed the resident rounds, LVN 3 only documented if there was a change of condition (COC- communication between members of the health care team and used as a tool to foster patient safety) on any of the residents LVN 3 was responsible/assigned to LVN 3 stated on most days, LVN 3 saw Resident 1 sitting on the couch in the facility's front lobby not doing anything. LVN 3 stated Resident 1 sat on the couch in the lobby/reception area every time I am working. LVN 3 stated the facility trained LVN 3 on elopement and wandering within the last 12 months.</p> <p>During an interview with R2 on 10/08/2024 at 3 PM, R2 stated R2 did not know which residents were at risk for leaving the facility without permission. R2 stated R2 sees Resident 1 sit on the couch every time I work and several times a day doing nothing .I come in the morning and [Resident 1] is already sitting on the couch.</p> <p>During an interview with Registered Nurse 1 (RN 1) on 10/08/2024 at 3:25 PM, RN 1 stated documentation on the residents' locations was done only when the resident/s developed any changes of condition. RN 1 stated Resident 1, wanders around from one place to another .activity room, lobby/reception, dining room, patio/smoking areas. Looks like [Resident 1] is always in deep thoughts; like .thinking all the time. RN 1 stated Resident 1 left the facility against medical advice (AMA - when a patient leaves a facility against the advice of the doctor) sometime in 8/2024. When RN 1 was asked what interventions were implemented to prevent elopement, RN 1 stated obtaining elopement history or patterns from family, evaluate scenarios that may trigger elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with receptionist 1 (R1) on 10/09/2024 at 12:06 PM, R1 stated R1 did not know which residents were at risk for leaving the facility without permission. R1 stated R1 had seen on multiple times Resident 1 sit on the couch on and off all day and [Resident 1] just sits there and doesn't do anything; no book, no phone, just sits there.</p> <p>During a concurrent observation, interview, and record review on 10/09/2024 at 12:38 PM with administrator (ADM) and payroll assistant (PA), the facility's video footage dated 10/04/2024 was reviewed. When asked if ADM had seen the video footage where Resident 1 was seen leaving the facility, the ADM stated I did, but it's not .it's .I was just scrolling and maybe I was going too fast. I didn't see [Resident 1] in any of the videos. The facility video footage indicated the following:</p> <p>During and concurrent interview and record review on 10/09/2024 at 12:38 PM with the ADM and the PA, the facility's video footage dated 10/04/2024 was reviewed. The video footage indicated Resident 1 was standing in the lobby area and was looking at the facility's front door. The PA stated, looks like he [Resident 1] is getting ready to leave and ADM also stated, yeah, he [Resident 1] is. The video footage indicated that on 10/04/2024 at 9:36 AM, there was no staff in the lobby/reception area and that Resident 1 left the facility through the facility's front door and then made a left turn.</p> <p>During the same concurrent observation, interview and facility video footage review on 10/09/2024 at 12:38 PM with ADM and PA, the ADM stated, now we know when [Resident 1] left.</p> <p>During a concurrent observation, interview and record review with R1 on 10/09/2024 at 3:02 PM, the facility's video footage dated 10/04/2024 was reviewed. The facility video footage indicated the following:</p> <p>On 10/04/2024 at 9:34 AM, R1 left the reception desk without someone covering/monitoring the desk/front lobby during R1's absence.</p> <p>On 10/04/2024 at 9:36 AM, Resident 1 left the facility through the front door.</p> <p>During a concurrent observation, interview, and record review with R1 on 10/09/2024 at 3:02 PM, R1 was observed with an open mouth and covered her mouth with her right hand while watching the video footage of Resident 1 leaving the facility.</p> <p>On 10/04/2024 at 9:38 AM, R1 was seen returning to the reception desk. When R1 was asked who covers the reception desk when R1 was away from the desk, R1 stated, we don't really have a specific person who covers the front desk. R1 stated that whenever R1 needs to do or see someone for a minute or so .I [R1] usually just go .do what I needed to do.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation, interview, and record review on 10/09/2024 at 3:32 PM with LVN 3, the facility's video footage dated 10/4/2024 was reviewed. LVN 3 reviewed the video footage where Resident 1 was seen leaving the facility on 10/4/2024 at 9:36 AM through the front door. LVN 3 was observed shaking her right leg, straightened her back and observed her eyes widened. LVN 3 stated I saw the patient [Resident 1] the entire shift on 10/04/2024, like the hours I told you (referring to the Licensed Nurses Notes document dated 10/04/2024) and that video that one (pointing to the video screen), I . I don't know. All I know is that I saw the patient on each hour that I wrote on the document. When LVN 3 was asked why LVN 3 documented on the Licensed Nurses Notes dated 10/04/2024 that LVN 3 saw Resident 1 on 10/04/2024 at 12:05 PM, 1:30 PM, 2:15 PM, and 3 PM despite the video footage indicating that Resident 1 already left the facility on [DATE] at 9:36 AM, LVN 3 stated, because I gave the medicine that morning at the time I wrote it, he was here; for all I know, I saw [Resident 1]. I cannot tell anymore because I saw [Resident 1] at 2:15 pm and at 3pm. That's the last time I saw him, at 3pm. That's it. LVN 3 stated that LVN 1 told LVN 3 that Social Service Director (SSD) and Social Service Assistant (SSA) saw Resident 1 sitting on the couch in the lobby/reception area on 10/04/2024 approximately 2:15 PM. When LVN 3 was asked why LVN 1 would tell LVN 3 that information, LVN 3 stated I don't know.</p> <p>During an interview on 10/09/2024 at 3:45 PM with LVN 1, LVN 1 acknowledged that LVN 1 told LVN 3 that both SSD and SSA told LVN 1 that SSD and SSA saw Resident 1 sitting on the couch in the lobby/reception area on 10/04/2024 at approximately 2:15 PM. When LVN 1 was asked what the reason was for telling LVN 3 about what SSD and SSA told LVN 1, LVN 1 stated I also asked [LVN 3] what time [LVN 3] saw the patient. That's it. It was just a random question. I just wanted to share with [LVN 3] what I know, and I was just curious.</p> <p>During a concurrent interview and record review on 10/09/2024 at 4:08 PM with SSD, the facility's video footage dated 10/04/2024 was reviewed. SSD acknowledged telling LVN 1 that SSD saw Resident 1 sitting on the couch in the lobby/reception area on 10/04/2024 at approximately 2:15 pm. After viewing the facility video footage showing Resident 1 leaving the facility on 10/04/2024 at 9:36 AM, SSD stated SSD may have confused the dates when SSD saw Resident 1 sitting on the couch in the lobby/reception area. SSD was asked what potential harm may come to Resident 1 as a result of Resident 1 leaving the facility without permission, SSD stated Resident 1 cannot go to [Resident 1's] dialysis appointment, Resident 1 was fluid restricted (doctor limits the amount a patient may drink per day) so [Resident 1] may drink a lot or do drugs .</p> <p>During a concurrent interview and record review on 10/09/2024 at 4:25 PM with SSA, the facility's video footage dated 10/04/2024 was reviewed. SSA acknowledged telling LVN 1 that SSA saw Resident 1 sitting on the couch in the lobby/reception area on 10/04/2024 at approximately 2:15 pm. SSA stated SSA, I am absolutely sure it was Resident 1. After viewing the facility video footage showing Resident 1 leaving the facility on 10/04/2024 at 9:36 AM, SSA was asked if SSA was still absolutely sure it was Resident 1 who SSA saw sitting on the couch, SSA stated SSA may have confused the day with another day.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 10/09/2024 at 5:27 PM with the Director of Nursing (DON) and ADM, the facility's video footage dated 10/04/2024 was reviewed. The DON was resistive in answering questions. The DON stated, the DON started working at the facility on 09/03/2024 and that, I just started here so I am not sure if that is [Resident 1]. I cannot tell just by looking at that video if that's him . hmm, nahh ah. The ADM confirmed that it was Resident 1 on the video leaving the facility. The DON asked the SA in a slightly higher tone, how do you know the resident didn't come back? When asked what potential harm for Resident 1 leaving the facility on 10/04/2024 at 9:36 AM without permission, the DON stated, it could be harmful, but I don't want to speak about it. Problem for infection, fluid overload if [Resident 1] is not going for dialysis. [Resident 1] may go to the store, get a soda or something. Luckily he was not harm. That's it. I'm done talking.</p> <p>During a review of the facility's policy and procedures (P&P) titled Routine Resident Checks revised on 07/2013, indicated, nurses shall keep documentation related to routine checks that included time, identity of the person making the checks, and any outcomes of each check.</p> <p>During a review of the facility's P&P titled Safety and Supervision of Residents revised on 07/2017, indicated, the type and frequency of resident supervision was determined by the individual resident's assessed needs, and their individual resident risk factors. The P&P indicated, implementing interventions to reduce accident risks and hazards on any of the residents will be communicated to all relevant staff and assigning responsibility for carrying out interventions.</p>		