

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 11/05/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 protect the resident's right to be free from resident to resident physical abuse for one of two sampled residents (Resident 1). The facility was aware for a couple of months, that Resident 2 had been asking Resident 1 to marry Resident 2.</p> <p>As a result, on 10/20/2024 at 1:50 PM, Resident 1 got upset with Resident 2 after Resident 2 sneezed on Resident 1's shoulder. Also, Resident 2 hit Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's face sheet (Admission Record -front page of the chart that contains a summary of basic information about the resident), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including: hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), dementia (a progressive state of decline in mental abilities), lack of coordination (loss of muscle control in the arms and legs), and glaucoma (a group of eye diseases that can cause vision loss and blindness).</p> <p>During a review of Resident 1's history and physical (H&P - a physician's complete patient examination) dated 1/12/2024, indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's care plan titled Cognitive Loss/Dementia, dated 1/15/2024, indicated, Resident 1 was at risk for falls, injuries, and further decline related to dementia.</p> <p>During a review of Resident 1's Minimum Data Sheet (MDS - a federally mandated resident assessment tool) dated 10/16/2024, indicated, Resident 1 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life).</p> <p>During a review of Resident 1's Physician Progress Note (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 10/17/2024, indicated, Resident 1 did not have the capacity for medical decision making due to dementia.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Skin Assessment (inspecting overall skin color and temperature, moisture level, elasticity, and any skin damage) dated 10/20/2024, indicated, Resident 1 did not have any skin discoloration and no complains of pain.</p> <p>During a review of Daily Medicare Notes (a formal record that documents the care a patient receives) titled Physical to Physical Altercation, dated 10/20/2024, indicated, Resident 1 was involved in an altercation with another resident [Resident 2].</p> <p>During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) dated 10/20/2024, indicated, Resident 1 had the following diagnoses: hemiplegia dementia and malignant neoplasm (cancer) of the prostate (a gland that produces some of the fluid that carries the sperm). The SBAR also indicated that on 10/20/2024 at 1:50 PM, Resident 1 tapped (Resident 2) on the shoulder when Resident 2 sneezed at Resident 1. The SBAR indicated a physician ordered a psychiatric (a meeting with a psychiatrist to evaluate a patient's mental health condition and create a treatment plan) consult for Resident 1.</p> <p>During a review of Resident 1's Licensed Nurses Notes dated 10/20/24 at 5:08 PM, indicated, Resident 1's family member was notified about the physical altercation with another resident.</p> <p>During a review of Resident 1's Interdisciplinary Team Conference (IDT - a group of different healthcare professionals working together towards a common goal for a resident) Record dated 10/21/2024, indicated, Resident 1 had a disagreement, a misunderstanding with another resident (Resident 2) when Resident 2 accidentally sneezed on Resident 1's back and Resident 1 got upset. The IDT Record indicated Resident 1 was educated to report to staff and to stay away from negative situation to avoid conflict with other residents. The IDT Record also indicated Resident 1's brother family member was informed of the incident.</p> <p>During a review of Resident 1's Psychiatric Follow Up Evaluation (a standardized tool used by psychiatrist to record resident's mental health evaluation, diagnosis, treatment plans, and progress updates) dated 10/28/2024, indicated, Resident 1 had significant disturbances associated with dementia, had occasional confusion, was irritable and guarded suggesting discomfort in his surroundings. The psychiatric follow up evaluation also indicated facility reported recent incidents of aggression which included engaging in verbal altercation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 2 on 11/04/2024 at 9:46 AM, Resident 2 stated Resident 2 has been asking Resident 1 to marry me [Resident 2] for several times before; like lots and lots of times; for weeks now, maybe a couple of months. Resident 2 also stated I like [Resident 1] very much and I think [Resident 1] likes me, too, but I don't know that for sure, but I think [Resident 1] does. Resident 2 stated Resident 1 has never done or say anything to suggest Resident 1 liked Resident 2. Resident 2 continued to state that a couple of weeks before the 10/20/2024 alleged abuse incident happened, Resident 1 said to Resident 2 you're ugly then laughed. Resident 2 stated Resident 2 replied to Resident 1 stating it's better to be ugly than to be a f*cking a**hole like you. Resident 2 stated there were witnesses but Resident 2 couldn't remember who the witnesses were. Resident 2 added I should have apologized to him for kidding. When asked what Resident 2 was kidding about, Resident 2 stated that [Resident 1] was a f*cking a**hole. When asked if Resident 2 was also kidding about asking Resident 1 to marry Resident 2, Resident 2 stated oh no, of course not. I meant it. I wanna marry [Resident 1]. Resident 2 also stated I like [Resident 1] very much and I think [Resident 1] likes me, too, but I don't know that for sure, but I think [Resident 1] does. When asked if Resident 1 had done anything to suggest that Resident 1 likes Resident 2, Resident 2 stated no, he never did; he was always angry at me every time I asked [Resident 1] to marry me [Resident 2]. I'm not like stalking him or anything like that. I just want to marry him, but he keeps avoiding me. Resident 2 stated that on 10/20/2024 at 1:50 PM, Resident 2 was sitting on a wheelchair behind Resident 1 when Resident 2 sneezed on Resident 1's right shoulder of Resident 1. Resident 2 stated Resident 1 then turned around and hit Resident 2 on the right shoulder causing Resident 2 to hit Resident 1 back I don't know where I hit [Resident 1], I just started hitting [Resident 1].</p> <p>During an interview with Activity Assistant (AA) on 11/04/2024 at 10:19 AM, AA stated AA witnessed the alleged abuse incident between Residents 1 and 2. AA stated Resident 2 was sitting in a wheelchair just behind Resident 1. AA saw Resident 2 spoke to Resident 1 but did not hear what was said. AA stated I didn't stare at them because I wanted to give them privacy to talk .then I heard Resident 1 said no loudly to Resident 2. AA stated I already know why Resident 1 said no loudly to Resident 2. AA stated Resident 2 is always asking Resident 1 to marry Resident 2. AA stated sometime in the month of October 2024, AA overheard Resident 2 say to Resident 1 will you marry me? AA stated Resident 1 told AA this a**hole won't leave me alone. AA stated Resident 1 continued to ask Resident 2 to marry [Resident 1] over and over When AA was asked if AA reported about Resident 2 always asking Resident 1 to marry Resident 2, AA stated AA notified the Administrator (Adm) and other co-workers (unable to name). AA stated the Adm stated to AA, I will look into it. AA stated AA did not document the incident between Resident 1 and Resident 2.</p> <p>During an interview with Certified Nurse's Aide 3 (CNA 3) on 11/04/2024 at 12:06 PM, CNA 3 stated CNA 3 heard Resident 1 say to Resident 2 don't talk to me very, very loud.</p> <p>During an interview with CNA 4 on 11/04/2024 at 2:28 PM, CNA 4 stated CNA 4 heard Resident 2 tell Resident 1, will you marry me. CNA 4 stated Resident 1 tell Resident 2, No in a louder voice, like to the point. CNA 4 stated CNA 4 reported the incident between Resident 1 and Resident 2 to the charge nurse (not able to recall the name).</p> <p>During an interview with Administrator (Adm) on 11/05/2024 at 6:01 PM, Adm stated Adm did not recall AA reporting to Adm the marry me incident between Resident 1 and Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Behavior Assessment Intervention and Monitoring, revised on 12/2016, indicated, nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition. New or changes in (resident's) behavior will be documented regardless of the degree of risk to the resident or others.</p> <p>During a review of the facility's P&P titled Abuse Prevention/Investigation/Reporting and Resolution, reviewed on 7/12/2024, indicated, facility will protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition) while under the facility's care and treatment against all forms of physical, verbal .abuse.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</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 thoroughly investigate resident to resident physical abuse and harassment for one of two sampled residents (Resident 1). The facility was aware that for a couple of months, Resident 2 had been asking Resident 1 to marry Resident 2.</p> <p>This deficient practice resulted in two months continuous verbal abuse and harassment to Resident 1 by Resident 2 which resulted in Resident 1 and Resident 2 hitting each other on 10/20/2024.</p> <p>Cross Reference F600</p> <p>Findings:</p> <p>During a review of Resident 1's face sheet (Admission Record -front page of the chart that contains a summary of basic information about the resident), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including: hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), dementia (a progressive state of decline in mental abilities), lack of coordination (loss of muscle control in the arms and legs), and glaucoma (a group of eye diseases that can cause vision loss and blindness).</p> <p>During a review of Resident 1's history and physical (H&P - a physician's complete patient examination) dated 1/12/2024, indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's care plan titled Cognitive Loss/Dementia, dated 1/15/2024, indicated, Resident 1 was at risk for falls, injuries, and further decline related to dementia.</p> <p>During a review of Resident 1's Minimum Data Sheet (MDS - a federally mandated resident assessment tool) dated 10/16/2024, indicated, Resident 1 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life).</p> <p>During a review of Resident 1's Physician Progress Note (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 10/17/2024, indicated, Resident 1 did not have the capacity for medical decision making due to dementia.</p> <p>During a review of Resident 1's Skin Assessment (inspecting overall skin color and temperature, moisture level, elasticity, and any skin damage) dated 10/20/2024, indicated, Resident 1 did not have any skin discoloration and no complains of pain.</p> <p>During a review of Daily Medicare Notes (a formal record that documents the care a patient receives) titled Physical to Physical Altercation, dated 10/20/2024, indicated, Resident 1 was involved in an altercation with another resident [Resident 2].</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 2 on 11/04/2024 at 9:46 AM, Resident 2 stated that on 10/20/2024 at 1:50 PM, Resident 2 was sitting on a wheelchair behind Resident 1 when Resident 2 sneezed on Resident 1's right shoulder. Resident 2 stated Resident 1 then turned around and hit Resident 2 on the right shoulder causing Resident 2 to hit Resident 1 back I don't know where I hit [Resident 1], I just started hitting [Resident 1]. Resident 2 also stated Resident 2 has been asking Resident 1 to marry me [Resident 2] for several times before; like lots and lots of times; for weeks now, maybe a couple of months. Resident 2 continued to state that a couple of weeks before the 10/20/2024 alleged abuse incident happened, Resident 1 said to Resident 2 you're ugly then laughed. Resident 2 stated Resident 2 replied to Resident 1 stating it's better to be ugly than to be a f*cking a**hole like you. Resident 2 stated there were witnesses but Resident 2 couldn't remember who the witnesses were. Resident 2 added I should have apologized to him for kidding. When asked what Resident 2 was kidding about, Resident 2 stated that [Resident 1] was a f*cking a**hole. When asked if Resident 2 was also kidding about asking Resident 1 to marry Resident 2, Resident 2 stated oh no, of course not. I meant it. I wanna marry [Resident 1]. Resident 2 also stated I like [Resident 1] very much and I think [Resident 1] likes me, too, but I don't know that for sure, but I think [Resident 1] does. When asked if Resident 1 had done anything to suggest that Resident 1 likes Resident 2, Resident 2 stated no, he never did; he was always angry at me every time I asked [Resident 1] to marry me [Resident 2]. I'm not like stalking him or anything like that. I just want to marry him, but he keeps avoiding me. Resident 2 was asked if Resident 2 had any physical touching of any kind with Resident 1, Resident 2 stated never; most of the time [Resident 1] was too far away from me to reach him quickly; how I wish .we could touch. Resident 2 was asked if Resident 2 told any of the residents or staff members that Resident 2 wanted to marry Resident 1, Resident 2 stated I don't have to tell, anybody who was around me when I said I wanna marry you or will you marry me heard me say it. I want the whole world to know how much I want to marry him. Resident 2 stated Resident 2 cannot remember which residents or staff members heard any of Resident 2's public statements, I don't pay attention who was around me. When Resident 2 was asked if Resident 2 had any interaction with Resident 1 since the 10/20/2024 alleged abuse incident, Resident 2 stated [Resident 1] is still too far from me; he keeps avoiding me; maybe one day we'll get married.</p> <p>During an interview with Activity Director (AA) on 11/04/2024 at 10:19 AM, AA stated AA witnessed the alleged abuse incident between Residents 1 and 2. AA stated Resident 2 was sitting in a wheelchair just behind Resident 1. AA saw Resident 2 spoke to Resident 1 but did not hear what was said. AA stated I didn't stare at them because I wanted to give them privacy to talk .then I heard Resident 1 said no loudly to Resident 2. AA stated I already know why Resident 1 said no loudly to Resident 2. AA stated Resident 2 is always asking Resident 1 to marry Resident 2. AA stated sometime in the month of October 2024, AA overheard Resident 2 say to Resident 1 will you marry me? AA stated Resident 1 told AA this a**hole won't leave me alone. AA stated Resident 1 continued to ask Resident 2 to marry [Resident 1] over and over. AA stated to Resident 1 to respect [Resident 1's] decision, Resident 1 replied I want to figure out why [Resident 1] does not want to marry me. AA stated AA heard Resident 1 say no, no, no to Resident 2 very loudly to ensure everyone around and Resident 2 knows Resident 1 said no. When AA was asked if AA reported about Resident 2 always asking Resident 1 to marry Resident 2, AA stated AA notified the Administrator (Adm) and other co-workers (unable to name). AA stated the Adm stated to AA, I will look into it. AA stated AA did not document the incident between Resident 1 and Resident 2.</p> <p>During an interview with Certified Nurse's Aide 3 (CNA 3) on 11/04/2024 at 12:06 PM, CNA 3 stated CNA 3 heard Resident 1 say to Resident 2 don't talk to me very, very loud.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/04/2024 at 1:21 PM with LVN 3, LVN 3 stated on 11/03/2024 around 8 AM and 8:30 AM, LVN 3 was taking Resident 2's blood pressure reading when Resident 2 said to LVN 3 I love you, then [Resident 2] made kisses in the air after [Resident 2] said this. LVN 3 stated Resident 2 made LVN 3 very, very uncomfortable. LVN 3 stated LVN 3 told Resident 2 to stop it, Resident 2 stayed quiet but did not apologize to LVN 3. When LVN 3 was asked if LVN 3 reported the incident to anyone, LVN 3 stated no; my thinking is, if it happens again then that's a pattern then I will report it. I know what he did to me was inappropriate. LVN 3 stated LVN 3 never saw Resident 2 did anything similar to any of the residents or staff members in the facility.</p> <p>During an interview on 11/04/2024 at 2:28 PM with CNA 4, CNA 4 stated CNA 4 stated on 10/18/2024 or 10/19/2024, CNA 4 heard Resident 2 tell Resident 1, will you marry me. CNA 4 stated Resident 1 told Resident 2, No in a louder voice, like to the point. CNA 4 stated CNA 4 reported the incident between Resident 1 and Resident 2 to the charge nurse (not able to recall the name).</p> <p>During an interview with Administrator (Adm) on 11/05/2024 at 6:01 PM, Adm stated Adm did not recall AA reporting to Adm the marry me incident between Resident 1 and Resident 2. Adm was asked what can the facility do to ensure Resident 1's safety, Adm stated protocol will be put in place, there will be behavioral monitoring and psychiatric evaluation for both Residents 1 and 2, psychosocial intervention from Social Services Director (SSD - manages and coordinates social service programs [example mental health] and organizations that provide assistance to people in need), help Residents 1 and 2 channel their emotions by engaging them in activities to re-direct their minds, nursing will perform a 72-hour monitoring of Residents 1 and 2's behavior and when necessary. Adm stated the facility missed these inappropriate behaviors, a psychological referral for Resident 2 will provide the facility suggestions on appropriate interventions. When Adm was asked what potential harm may come to Resident 1 when Resident 2 continued these inappropriate behaviors (marry me), Adm stated Resident 1 may become irritable, some anger, will escalate into outbursts, like the one on 10/20/2024.</p> <p>During a review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Behavior Assessment Intervention and Monitoring, revised on 12/2016, indicated, nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition. New or changes in (resident's) behavior will be documented regardless of the degree of risk to the resident or others. The P&P indicated the IDT will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may contributed to the resident's change in condition.</p> <p>During a review of the facility's P&P titled Abuse Prevention/Investigation/Reporting and Resolution, reviewed on 7/12/2024, indicated, facility will protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition) while under the facility's care and treatment against all forms of physical, verbal .abuse.</p> <p>During a review of the facility's P&P titled Change of Condition, reviewed on 7/12/2024, indicated that any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician as soon as identified.</p> <p>During a review of the facility's P&P titled Competency Nursing Staff, reviewed on 7/12/2024, indicated, competency in skills and techniques necessary to care for residents' needs includes .preventing abuse .and identification of changes in condition.</p>		