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	05/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interview and record review, the facility failed to honor one of the four sampled residents (Resident 5) rights by failing to treat her with dignity and respect by leaving resident exposed while changing Resident 5 ' s incontinence diaper. This deficient practice had the potential to cause embarrassment for Resident 5 Cross reference F726, F755. Findings: During a review of the admission record for Resident 5 indicated Resident 5 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (HTN-high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 5 ' s Minimum Data Set (MDS - a resident assessment tool) dated 1/30/2025, indicated Resident 5 had severe cognitive impairment (a noticeable decline in thinking skills that significantly impacts daily life, making it harder to perform everyday tasks and manage finances, among other things). The same MDS indicated Resident 5 was dependent for her Activities of Daily Living such as: (ADLs routine tasks/activities such as eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a concurrent observation and interview with CNA 1 on 5/15/2025 at 11:14 am, CNA 1 was observed changing Resident 5 ' s incontinence diaper in Resident 5 ' s room which she shared with two other residents with the privacy curtain open. Resident 5 resident ' s diaper was completely off, and her private parts completely exposed. CNA 1 was unable to verbalize the importance of keeping the privacy curtain closed while performing personal care for Resident 5 and stated, write down how you think is a good way on a piece of paper and give it to me! CNA 1 spoke over this surveyor with clenched fists, bent elbows, puffed up chest and walked towards this surveyor in a loud voice. LVN 3 was present and confirmed the observation and interview. (continued on next page)

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview of Resident 5 and CNA 1 ' s interaction on 5/15/2025 at 11:18 am, LVN 3 stated that when personal care is provided to residents, the privacy curtains must be closed to ensure that residents are afforded their rights to being treated with dignity and respect. During a review of the faciliy's policy and procedure (P&P) titledP&P titled, Professional Standards of Care, reviewed 7/12/2024, the P&P indicated, Regardless of the situation, residents, families, visitors and all employees are to be treated with Dignity and respect at all times. Conduct yourself in a professional manner in all aspects of your relationship with residents, family members and fell ow employees. During a review of a P&P titled, Resident's Rights, reviewed of 7/12/2024, indicated, Employees shall treat all residents with kindness, respect, and dignity. The same P&P policy interpretations and implementations included the following: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be supported by the facility in exercising his or her rights;

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interviews and record review, the facility failed to ensure: 1. Licensed Vocational Nurse (LVN) 2 had the skills and knowledge to safely prepare and administer medications for one-of-one sampled resident (Resident 4) by crushing all morning medications on 5/15/2025 without a physician ' s order. 2. Certified Nursing Assistant (CNA) 1 treated one-of-one sampled resident (Resident 5) with dignity and respect by failing to provide privacy and leaving resident exposed while changing Resident 5 ' s incontinence diaper. This failure had the potential to result in medication side effects such as low blood pressure for Resident 4 and embarrassment for Resident 5. Findings: 1. During a review of the admission record for Resident 4 indicated Resident 4 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (HTN-high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 4's history and physical (a term used to describe a physician's examination of a patient) for Resident 4 dated 5/9/2025 indicated, Resident 4 did not have the capacity for medical decision making. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 2/14/2025, indicated Resident 4 had moderate cognitive impairment (a noticeable decline in thinking skills that significantly impacts daily life, making it harder to perform everyday tasks and manage finances, among other things). The same MDS indicated Resident 4 required between setup or clean-up assistance and substantial/maximum assistance for her Activities of Daily Living such as: (ADLs routine tasks/activities such as eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of Resident 4 ' s Medication Administration Record (MAR- a report that serves as a legal record of all medications administered to a patient by a healthcare professional) for 5/2025 indicated the following medications were administered to Resident 4 on 5/15/2025: - Aripiprazole (Abilify-is an atypical antipsychotic medication used to treat a variety of mental health conditions) 5 mg (milligrams) tablet 1-tab (tablet) po (by mouth) daily for psychosis m/b (manifested by) agitation aeb (as evidenced by) trying to hit staff during care. - Metoprolol tartrate (Lopressor- is used to treat chest pain and high blood pressure) 25 mg tablet, 1 ta bid. Hold for sbp (systolic blood pressure) < (less than)100 or hr (heart rate) <60 dx (diagnosis): HTN. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Gabapentin (Neurontin - works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system) 100 mg capsule 1 cap po bid. Hold for rr 9 respiration rate) <12 or drowsiness dx: neuropathy - Amlodipine 5 Mg Tablet 1 Tab Po Daily, H I For Sbp < 110 Dx: HTN - Multivitamins With Minerals 1 Tab po daily as a supplement - Vitamin C 500 mg po daily as a supplement - Senna 8.6 mg tablet 1-tab po daily. hold f loose stool dx: bowel management - Polyethylene glycol powder 3350 mix 17 with 120 ml h2o po daily. hold for loose stool dx: bowel management - Benztropine 0.5 mg tablet 1 tab po daily dx: tremors - Atorvastatin 40-mg tablet 1-tab po qhs (at bedtime) HTN. 2. During a review of the admission record for Resident 5 indicated Resident 5 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities),HTN, and dysphagia. During a review of Resident 5 ' s MDS dated [DATE], indicated Resident 5 had severe cognitive impairment (a noticeable decline in thinking skills that significantly impacts daily life, making it harder to perform everyday tasks and manage finances, among other things). The same MDS indicated Resident 5 was dependent for her ADLs. During a concurrent observation and interview with LVN 2 5/15/2025 10:27 am, LVN 2 was observed standing by the medication cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment) removing medications from four different medication bubble packs (a type of packaging where individual doses of medication such as tablets, capsules, etc.) and placing three tablets and one capsule in a clear small medication cap. LVN 2 was then observed placing the bubble packs back in the med cart, locked it and pushed it towards the end of the hallway and left the cart by the corner, picked up the clear cup containing the medication in one hand (left) and held onto another resident who was independently walking (steady gait) the hallways with her right arm, walking the resident about 6 feet to the patio door. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 stated that the medications she had prepped were for Resident 4 but was unable to verbalize where Resident 4 was and rolled her eyes as she stated that Resident 4 may have been in the patio but that her (Resident 4) room was located in the next hallway. LVN 2 hastily and forcefully pulled out the pill crusher along with a small medication pouch form the med cart. She placed the three tablets in the pouch and crushed them, opened the capsule and placed the contents in a clear medicine cup containing applesauce as along with the other three tabs she had crushed. LVN 2 was unable to verbalize what medications she had placed in the applesauce and stated, honey, I do not have time for this! I am running late. LVN 2 sighed and admitted that she knew that she needed to identify a resident, go over physician orders, verify meds with Resident 4 before dispensing them. LVN 2 admitted that the resident was not present when she was pulling the meds out, she was unable to verbalize what medications she was giving. LVN 2 was unable to verbalize the reason medications must not be crushed together and stated, My dear, you saw that I did not crush all the meds together! I crushed all 3 pills because they are all BP meds and THEN opened the gabapentin to mix it in, with her arms folded in front of her chest. LVN 2 later acknowledged that the potential of crushing meds together could increase side effects which may include decreased BP, dizziness, which may result in hospitalization and/or death. During a concurrent interview and record review of Resident 4 ' s physician ' s orders with the Registered Nurse Supervisor (RNS) on 5/15/2025 at 11:06 am, the RNS confirmed that LVN 2 had crushed all three tabs and mixed them all together with gabapentin capsule in applesauce. RNS verified that Resident 4 did not have a physician ' s order to have medications crushed and that LVN 2 should have verified Resident 4 ' s identity, reviewed orders, explained all the medications before administering the medications. If there is an order to crush meds, then medications that are appropriate to crush must be crushed on at a time to prevent untoward adverse reactions such as reduced BP. During a concurrent observation and interview with CNA 1 on 5/15/2025 at 11:14 am, CNA 1 was observed changing Resident 5 ' s incontinence diaper in Resident 5 ' s room which she shared with two other residents with the privacy curtain open. Resident 5 resident ' s diaper was completely off, and her private parts completely exposed. CNA 1 was unable to verbalize the importance of keeping the privacy curtain closed while performing personal care for Resident 5 and stated, write down how you think is a good way on a piece of paper and give it to me! CNA 1 spoke over this surveyor with clenched fists, bent elbows, puffed up chest and walked towards this surveyor in a loud voice. LVN 3 was present and confirmed the observation and interview. During a concurrent observation and interview of Resident 5 and CNA 1 ' s interaction on 5/15/2025 at 11:18 am, LVN 3 stated that when personal care is provided to residents, the privacy curtains must be closed to ensure that residents are afforded their rights to being treated with dignity and respect. During a review of the facility's policy and procedure (P&P) titled, Competency Nursing Staff, reviewed 7/12/2024, the P&P indicated, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents, as identified through resident assessments and described in the plans of care. The same P&P indicated competency in skills and techniques to care for residents included the following: - Resident rights - Person centered care. - Communication - Basic nursing skills. - Medication management. During a review of a P&P titled, Medication administration, reviewed of 7/12/2024, indicated, The facility has sufficient staff to allow administering of medications without unnecessary interruptions. The same P&P indicated the need for crushing medications must be indicated on orders and MAR for all staff to be aware and consulting pharmacists can advise on safety issues and alternatives. The P&P indicated, Medications are administered at the time they are prepared. Medications are not pre-poured. Medications are administered without unnecessary interruptions. Residents are identified before medication is administered. Methods of identification include: I. Checking identification band 2. Checking photograph attached to medical record. 3. Calling resident by name 4. If necessary, verifying resident identification with other facility personnel.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interviews, and record reviews the facility failed to implement procedures to ensure safe dispensing and administration of medications for one out of one observed residents (Resident 4) by failing to: 1. Properly identify Resident 4 when preparing her (Resident 4) morning medications. 2. Crushing medications without a physician ' s order 3. administering all medications as ordered by the physician. This deficient practice had the potential to increase the risk of medication adverse reactions. Cross reference F726. Findings: 1. During a review of the admission record for Resident 4 indicated Resident 4 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (HTN-high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 4's history and physical (a term used to describe a physician's examination of a patient) for Resident 4 dated 5/9/2025 indicated, Resident 4 did not have the capacity for medical decision making. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 2/14/2025, indicated Resident 4 had moderate cognitive impairment (a noticeable decline in thinking skills that significantly impacts daily life, making it harder to perform everyday tasks and manage finances, among other things). The same MDS indicated Resident 4 required between setup or clean-up assistance and substantial/maximum assistance for her Activities of Daily Living such as: (ADLs routine tasks/activities such as eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of Resident 4 ' s Medication Administration Record (MAR- a report that serves as a legal record of all medications administered to a patient by a healthcare professional) for 5/2025 indicated the following medications were administered to Resident 4 on 5/15/2025: - Aripiprazole (Abilify-is an atypical antipsychotic medication used to treat a variety of mental health conditions) 5 mg (milligrams) tablet 1-tab (tablet) po (by mouth) daily for psychosis m/b (manifested by) agitation aeb (as evidenced by) trying to hit staff during care. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Metoprolol tartrate (Lopressor- is used to treat chest pain and high blood pressure) 25 mg tablet, 1 ta bid. Hold for sbp (systolic blood pressure) < (less than)100 or hr (heart rate) <60 dx (diagnosis): HTN. - Gabapentin (Neurontin - works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system) 100 mg capsule 1 cap po bid. Hold for rr 9 respiration rate) <12 or drowsiness dx: neuropathy - Amlodipine 5 Mg Tablet 1 Tab Po Daily, H I For Sbp < 110 Dx: HTN - Multivitamins With Minerals 1 Tab po daily as a supplement - Vitamin C 500 mg po daily as a supplement - Senna 8.6 mg tablet 1-tab po daily. hold f loose stool dx: bowel management - Polyethylene glycol powder 3350 mix 17 with 120 ml h2o po daily. hold for loose stool dx: bowel management - Benztropine 0.5 mg tablet 1 tab po daily dx: tremors - Atorvastatin 40-mg tablet 1-tab po qhs (at bedtime) HTN. During a concurrent observation and interview with LVN 2 5/15/2025 10:27 am, LVN 2 was observed standing by the medication cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment) removing medications from four different medication bubble packs (a type of packaging where individual doses of medication such as tablets, capsules, etc.) and placing three tablets and one capsule in a clear small medication cap. LVN 2 was then observed placing the bubble packs back in the med cart, locked it and pushed it towards the end of the hallway and left the cart by the corner, picked up the clear cup containing the medication in one hand (left) and held onto another resident who was independently walking (steady gait) the hallways with her right arm, walking the resident about 6 feet to the patio door. LVN 2 stated that the medications she had prepped were for Resident 4 but was unable to verbalize where Resident 4 was and rolled her eyes as she stated that Resident 4 may have been in the patio but that her (Resident 4) room was located in the next hallway. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 hastily and forcefully pulled out the pill crusher along with a small medication pouch form the med cart. She placed the three tablets in the pouch and crushed them, opened the capsule and placed the contents in a clear medicine cup containing applesauce as along with the other three tabs she had crushed. LVN 2 was unable to verbalize what medications she had placed in the applesauce and stated, honey, I do not have time for this! I am running late. LVN 2 sighed and admitted that she knew that she needed to identify a resident, go over physician orders, verify meds with Resident 4 before dispensing them. LVN 2 admitted that the resident was not present when she was pulling the meds out, she was unable to verbalize what medications she was giving. LVN 2 was unable to verbalize the reason medications must not be crushed together and stated, My dear, you saw that I did not crush all the meds together! I crushed all 3 pills because they are all BP meds and THEN opened the gabapentin to mix it in, with her arms folded in front of her chest. LVN 2 later acknowledged that the potential of crushing meds together could increase side effects which may include decreased BP, dizziness, which may result in hospitalization and/or death. During a concurrent interview and record review of Resident 4 ' s physician ' s orders with the Registered Nurse Supervisor (RNS) on 5/15/2025 at 11:06 am, the RNS confirmed that LVN 2 had crushed all three tabs and mixed them all together with gabapentin capsule in applesauce. RNS verified that Resident 4 did not have a physician ' s order to have medications crushed and that LVN 2 should have verified Resident 4 ' s identity, reviewed orders, explained all the medications before administering the medications. If there is an order to crush meds, then medications that are appropriate to crush must be crushed on at a time to prevent untoward adverse reactions such as reduced BP. During a review of the facility's policy and procedures (P&P) titled, Competency Nursing Staff, reviewed 7/12/2024, the P&P indicated, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. The same P&P indicated competency in skills and techniques to care for residents included the following: - Resident rights - Person centered care. - Communication - Basic nursing skills. - Medication management. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Medication administration, reviewed of 7/12/2024, indicated, The facility has sufficient staff to allow administering of medications without unnecessary interruptions. The same P&P indicated the need for crushing medications must be indicated on orders and MAR for all staff to be aware and consulting pharmacists can advise on safety issues and alternatives. The P&P indicated, Medications are administered at the time they are prepared. Medications are not pre-poured. Medications are administered without unnecessary interruptions. Residents are identified before medication is administered. Methods of identification include: I. Checking identification band 2. Checking photograph attached to medical record. 3. Calling resident by name 4. If necessary, verifying resident identification with other facility personnel.