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	06/05/2025

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 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** Based on interview and record review, the facility failed to develop a comprehensive care plan (CP) that met the care/services based on the resident's individual assessed needs for one of six sampled residents (Resident 1) behavior of removing mittens and pulling on tracheostomy (a surgical procedure where a hole, called a stoma, is made in the neck to access the windpipe [trachea]) and gastrostomy tube (g-tube - a tube surgically inserted through the skin and directly into the stomach). 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: During a review of the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), dependence on respiratory [ventilator] status (means that a person needs a machine to breathe for them, either partially or completely), type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and anxiety (feeling of worry). During a review of the Minimum Data Set (MDS – resident assessment tool) dated 4/4/2025, it indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Daily Skilled Nurse ' s Notes, dated 5/19/2025, it indicated, Resident 1 ' s on bilateral hand mitten due to pulling on tracheostomy and g-tube. During a review of Resident 1 ' s Nurse ' s Notes, dated 5/22/2025, it indicated, (Resident 1) ' s GT malfunction secondary to deflate with tube out. During a review of Resident 1 ' s Care Plan as of 6/4/2025, it indicated, there was no CP developed for Resident 1 ' s behavior of removing her mittens after her COC of pulling tracheostomy. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During an interview with Certified Nursing Assistant 1 (CNA 1) on 6/3/2025 at 10:20 a.m., CNA 1 stated, Resident 1 has a behavior of pulling out her tracheostomy and g-tube, so they put hand mittens on her to prevent her from pulling out tubes. CNA 1 stated, on 5/27/2025, Resident 1 removed her hand mittens about 4-5 times during the morning shift and he needed to readjust and reapplied it on her (Resident 1) ' s hand. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 5/27/2025 at 11:40 a.m., LVN 1 stated, Resident 1 had a recent change of condition for replacement of her g-tube because Resident 1 pulled it and it got dislodged. LVN 1 stated, they added hand mittens on her to prevent her from pulling out her g-tube and tracheostomy tube. During a review of the facility ' s policy and procedure (P&P) titled, Comprehensive Care Planning, reviewed on 7/12/2024, the P&P indicated, It is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objections and timeframes to meet each resident ' s medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident received treatment and care in accordance with professional standards of practice for one of three sampled residents, Resident 1 by failing to: A. Implement Resident 1 ' s blood sugar check (BSS - measures the glucose levels in the blood) according to physician ' s order and care plan (CP). B. Implement facility ' s policy and procedure (P&P) titled, Death of a Resident, Documentation when Resident 1 expired on [DATE]. These deficient practices placed Resident 1 in incomplete assessment and documentation required per facility ' s policy and procedure upon death. Findings: A. During a review of the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), dependence on respiratory [ventilator] status (means that a person needs a machine to breathe for them, either partially or completely), type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and anxiety (feeling of worry). During a review of the Minimum Data Set (MDS – resident assessment tool) dated [DATE], it indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Order Summary Report, dated [DATE], it indicated physician ordered, FSBS (Finger Stick Blood Sugar – refers to the method of obtaining a small sample of blood usually by pricking a finger) monitoring every 12 hours with regular insulin (a short-acting human-made insulin, it helps adults and children with Type 1 and Type 2 diabetes control their blood sugar levels) sliding scale at 6 a.m. and 6 p.m. During a review of Resident 1 ' s Care Plan for Risk for hypoglycemia (low blood sugar)/hyperglycemia (high blood sugar) secondary to DM, dated [DATE], indicated an intervention that included, FSBS monitoring with insulin sliding scare as ordered. During a review of Resident 1 ' s Daily Skilled Nurse ' s Notes, dated [DATE] at 12 p.m., it indicated, Accu-check (blood glucose monitoring system that is designed to be easy to use and accurate) done with 120 milligram per deciliter (mg/dL - generally considered low to normal, depending on their individual target range set by their healthcare provider). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on [DATE] at 11:40 a.m., LVN 1 stated, on [DATE] at around 12 p.m., he checked Resident 1 ' s accu-check and it was low enough in which he did not have to give insulin coverage. LVN 1 reviewed physician ' s order for Resident 1 ' s Accu-check which indicated, accu-check was ordered every 12 hours at 6 a.m. and 6p.m. LVN 1 appeared confused and stated, he checked the blood sugar level (BS) but not according to physician ' s order. LVN 1 stated, it was his nursing judgement because Resident 1 was on tube feeding. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on [DATE] at 1:58 p.m., RN 1 reviewed Resident 1 ' s MAR and insulin level and stated, Resident 1 ' s BS has been on the normal range and was not receiving any insulin coverage for the month of [DATE]. RN 1 stated, LVN 1 did not follow physician ' s order and there is no reason to do an extra accu-check unless there is a trend that her (Resident 1) ' s BS has been going up, in which they need to notify the physician. During a review of the facility ' s policy and procedure (P&P) titled, Diabetes – Clinical Protocol, reviewed on [DATE], the P&P indicated, As indicated, the Physician will order appropriate lab tests and adjust treatments based on these results and other parameters . For the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day if on insulin . The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care plan. B. During a review of Resident 1 ' s Record of Death, it indicated, Resident 1 expired on [DATE] at 3:10 p.m., pronounced by paramedics at the facility. During a record review of Resident 1 ' s medical record as of [DATE], there was no Death Certificate on file. During an interview with Medical Record Director (MRD) on [DATE], MRD indicated, there was no Death Certificate on file by the Physician. During a review of the facility ' s P&P titled, Death of Resident, Documentation, reviewed on [DATE], the P&P indicated, The attending Physician must record the cause of death in the progress notes, and must complete and file a death certificate with the appropriate agency within twenty-four (24) hours of the resident ' s death or as may be prescribed by state law.