

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 08/20/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure one of two sample residents (Resident 1) received ophthalmology (is the branch of medicine dedicated to eye and vision care) services. This failure resulted in Resident 1 having untreated bilateral itchy and discolored (change in the color or pigmentation of the skin) eyes since 2023. Finding: During a record review, Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with a diagnoses of type 2 diabetes (a condition where your body either doesn't make enough insulin or can't use the insulin it makes to get energy from food), and essential hypertension (high blood pressure with no identifiable medical cause). During a record review, Resident 1's Minimum Data Set (MDS- a resident assessment and screening tool) dated 6/19/2025, indicated the resident's cognition (mental ability to make decisions) was moderately impaired. The MDS indicated Resident 1 required maximum assistance with Activities of Daily Living (ADL's- activities related to personal care). During a record review of Resident 1's Order Summary Report Active Orders as of 7/1/2025, there were no orders for Resident 1 to see the Ophthalmologist (is a medical doctor who specializes in the branch of medicine dedicated to eye and vision care). During an observation and concurrent interview on 8/20/25 at 10:35 a.m., Resident 1 was sitting up in bed. Resident 1 noted with dark skin discoloration to her right eye. Resident 1 stated none of the staff has ever abused her or hit her in her right eye. Resident 1 stated that sometimes her bilateral (both) eyes itch and rub them. Resident 1 stated she had no pain in the right eye. During an interview on 8/20/25 at 1:33 p.m., Certified Nursing Assistant (CNA) 1 stated that for two months, she noticed Resident 1 rub bilateral (both) eyes and had skin discoloration to the right eye for two months. CAN 1 stated that she did not report to the charge Nurse that the resident had discolored and itchy eyes. CNA 1 stated Resident 1 has discoloration has always been there due to Resident 1 always rubbing her eyes. During an interview on 8/20/25 at 1:52 p.m., Family Member (FM) 1 stated Resident 1 bilateral eyes have been itching since the resident was admitted to the facility and that was the reason the resident was constantly rubbing both eyes and would rub them. FM1 stated FM1 reported to a charge nurse (unable to recall the name) in 8/2024 that Resident 1's eyes were itching. FM1 stated over time the discoloration in the resident's both eyes got darker and darker and then would go away. FM1 stated FM1 thought the nurses had notified a medical doctor (MD) and that Resident 1 was already receiving medication for the itchy eyes. During an interview on 8/20/25 at 2:21 p.m., Registered Nurse Supervisor (RNS) stated none of the staff ever reported to her that Resident 1 had itchy eyes. The RNS stated Resident 1 has always had darker skin under both eyes During an interview on 8/20/25 at 2:24 p. m., License Vocational Nurse (LVN) stated Resident 1 had discoloration around both eyes since he started working at the facility. LVN stated he has witnessed Resident 1 rubbing both eyes early in the morning but never reported the itchy eyes to an MD. During an interview and concurrent record review on 8/20/25 at 2:57 p.m., Resident 1's physician orders and progress notes were reviewed with Director of Social Service (DSS). DSS stated she had not scheduled eye doctor appointment for Resident 1 because she (DSS) has not reviewed Resident 1's medical records. DSS stated there was no documented evidence that indicated that Resident 1 had been seen by an ophthalmologist since Resident 1 was admitted to the facility in 2/14/23. DSS stated it is very important that all the residents are seen by the eye doctor at least every 3 to 4 months and as needed to prevent a delay in eye care. During an interview and concurrent record review on 8/20/25 at 3:34 p.m., Director of Nursing (DON) stated according to the facility's Eye Care Policy and Procedures all residents are supposed to see the eye doctor approximately every 3-6 months and as needed. During an interview and concurrent record review of Resident 1's medical records with the DON, there was no documented evidence that an eye doctor had seen Resident 1 since 2/14/23. DON stated if residents are not seen by the eye doctor it can cause a delay in eye care. During an interview on 8/21/25 at 2:45 p.m., the Ophthalmologist stated he conducts eye visits once a year at the facility for the residents. The Ophthalmologist stated none of the nurses have ever reported to him that Resident 1 was experiencing itchy eyes or having discoloration bilaterally to her eyes. The Optometrist stated if the residents are experiencing issues with their eyes and a problem exists and left untreated the resident's eyes can get worse. During an interview on 8/20/25 at 3:59 p.m., the Administrator stated a resident only sees the ophthalmologist based on the resident's needs and that the optometrist only sees the residents in the facility as needed. The Administrator stated the facility does not have a policy for eye care or vision care.</p>		