

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 09/18/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff followed proper infection prevention and control practices when attempting to provide care to one of three sampled residents, Resident 2. A Certified Nursing Assistant (CNA) 2 was observed dropping a clean towel onto the floor and then mixing the towel with clean linen and gown attempting to use the same towel on a resident. This deficient practice had the potential to place Resident 2 at risk of cross contamination and exposure to infectious agents from environmental surfaces. Findings:A review of Resident 2's admission record indicated, Resident 2 was admitted to the facility on [DATE] with a diagnosis including acute respiratory failure with hypoxia ((a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), benign neoplasm of meninges (a slow growing, non-cancerous tumor that develops around the brain and spinal cord), acute kidney failure (when kidneys are damaged and cannot filter blood as well as they should). A review of Resident 2's History and Physical (H&P) indicated, Resident 2 has tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe to help breathe). During an observation on 9/18/2025 at 10:36 AM, while surveyor conducting facility rounds in the hallway, CNA 2 was observed carrying towels, linen, gown, and chux pads (an absorbent, waterproof pad used to protect mattresses, from moisture by incontinence). A towel slipped from CNA 2's hand and fell on the floor. CNA 2 picked the towel up, mixed the towel with the rest of the clean towels, linen, gown and chux pad and proceeded towards Resident 2's room with the intention of using it. When confronted by the surveyor, CNA 2 placed all the items on hand on top of the Personal Protective Equipment (PPE) container in front of Resident 2's room. During an interview on 9/18/2025 at 10:36 with CNA2, CNA 2 acknowledged the towel had been on the floor and was about to be used for a resident. CNA 2 acknowledged it is a violation of infection prevention protocol and facility's practice, discarded the cross contaminated towels, linen, gown, and chux pad in a dirty linen bag. During an interview on 9/18/2025 at 11:25 AM with Licensed Vocational Nurse (LVN)1, LVN 1 stated, mixing dirty towel or linen to use on resident places residents at risk of being infected. Most of the residents in the facility are at risk of being infected and immunocompromised (having weak immune system). During an interview on 9/18/2025 at 11:36 AM with Infection Prevention Nurse (IP), IP stated, any apparels on the floor should not be used on a resident, because it is a risk for infection, against the infection prevention standards, and facility policies. During an interview on 9/18/2025 at 12:26 PM with the Director of Staffing Development (DSD), the DSD stated, infection prevention protocol and policy trainings are provided for staff involved in resident care upon hire and as needed. All staff is expected to practice standard infection precautions. Also stated, any resident care item on the floor should not be picked up for use on a resident because it exposes residents to infections.A review of the facility's Policies and Procedure (P&P) titled Infection Control Policy-Laundry Services reviewed 7/11/2025 indicated, Routine Handling of Linen: all used linen should be handled as potentially contaminated and standard precautions should be used.</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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