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	01/09/2026

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 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 reviews, the facility failed to meet professional standards of quality for two of five sample residents (Resident 1, Resident 2) by failing to:Ensure Resident 1 was not allowed to self-administer medications and treatment as indicated in Resident 1's Self Administration of Drugs Assessment which indicated that Resident 1 was not safe to self-administer drugs.Ensure the physician's orders for skin treatments were carried through and documented properly for Resident 1 and Resident 2.These deficient practices placed residents at risk of infection and failure in the delivery of necessary care and services for Resident 1 and Resident 2.Findings:During a review of the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including neuromuscular dysfunction of bladder (refers to bladder control problems caused by damage to the nerves, spinal cord, or brain), hypertension (HTN-high blood pressure) and atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart).During a review of the Minimum Data Set (MDS - resident assessment tool) dated [DATE], indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate to maximal assistance 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). The MDS also indicated, Resident 1 has an indwelling catheter (a thin, flexible tube left inside the bladder to drain urine into a bag, using a small, inflated balloon to hold it in place).During a review of Resident 1's Self-Administration of Drugs Assessment, undated, the Self-Administration Assessment indicated, the Interdisciplinary team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) has determined that it is not safe for the resident (Resident 1) to self-administer drugs.During a review of Resident 1's Order Summary Report (OSR), dated [DATE] and [DATE], the OSR indicated the following physician's order:flush suprapubic (catheter - a medical device that helps drain urine from bladder) with 30 cubic centimeter (cc - unit of measurement) of normal saline (NS - a mixture of sodium chloride [salt] and water) slow push, do not aspirate, daily and as needed (prn) for maintenance.Left ischium (the lower, back part of the hip bone) wound cleanse with NS, pat dry, then apply collagen powder (provides the body with its own natural building blocks to speed up healing), followed by border foam to secure dailyRight ischium wound cleanse with NS, pat dry, then apply collagen powder, followed by border foam to secure dailySuprapubic catheter care daily cleanse urinary insertion site (the location on the body where a flexible tube is placed to drain urine from the bladder) with NS and pat dry and cover with dry dressing daily and prnDuring a review of Resident 1's Treatment Administration Record (TAR), the TAR indicated the following treatment orders were blank and did not have any documentation why the TAR was blank and/or if resident refused the treatment:Dated [DATE], Flush suprapubic with 30 cc of normal saline, slow push, do not (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aspirate daily and as neededDated [DATE], [DATE] - Left ischium wound cleanse with NS, pat dry, then apply collagen powder, followed by border foam to secure dailyDated [DATE], [DATE] - Suprapubic catheter care daily cleanse urinary insertion site with NS and pat dry and cover with dry dressing daily and prnDuring a review of Resident 1's TAR, the TAR indicated the following treatment order was signed and documented as given:Dated [DATE], flush suprapubic with 30 cc of normal saline, slow push, do not aspirate daily and as needed.During an interview with Resident 1 on [DATE] at 12:22 p.m., Resident 1 stated, on [DATE], he did not receive any skin treatment that was supposed to be given daily because there was no treatment nurse available for that day. Resident 1 further stated, he has a suprapubic catheter that needed daily care.During a concurrent interview and record review with Treatment Nurse 1 (TXN 1) on [DATE] at 12:46 p.m., TXN 1 stated, she did not do any skin treatment done to Resident 1 on [DATE] because he refused to get his suprapubic catheter daily care. TXN 1 stated, she documented and signed on the physician's order for daily flush of suprapubic catheter with normal saline, but Resident 1 is the one who does it himself. TXN 1 stated, Resident 1 would always tell her that he does it himself, but she had not seen him doing it himself. TXN 1 further stated, she documented that she administered and did the treatment care on [DATE] and for the rest of [DATE] and [DATE] for Resident 1 but she did not do it herself. TXN 1 further stated, if she assumed that resident did the treatment himself without doing her own assessment and evaluation that Resident 1 may safely do the treatment himself then this could cause injury to Resident 1 such as obstruction, inflammation and damage to Resident 1's internal organs.During an interview with Registered Nurse 1 (RN 1) on [DATE] at 1:22 p.m., RN 1 stated, residents who are allowed to do self-medication and self-treatment done should be evaluated by the licensed nurses prior to ensure that they can do the treatment by themselves. RN 1 stated, they have to make sure that the supply that resident uses are the correct supply and the medications were not expired. RN 1 stated, if residents do their own treatment without being assessed and evaluated, they are at risk of infection because they might not be doing the treatment correctly.During a review of the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including neuromuscular dysfunction of bladder (refers to bladder control problems caused by damage to the nerves, spinal cord, or brain), hypertension (HTN-high blood pressure) and atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart).During a review of the Minimum Data Set (MDS - resident assessment tool) dated [DATE], indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate to maximal assistance 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). The MDS also indicated, Resident 1 has an indwelling catheter (a thin, flexible tube left inside the bladder to drain urine into a bag, using a small, inflated balloon to hold it in place).During a review of Resident 2's OSR, dated [DATE], the OSR indicated the following physician's order:For sacrococcyx (refers to the connected bones at the very bottom of spine) open wound: cleanse with NS, pat dry, apply medihoney (a special, medical-grade honey used for wounds and burns) cover with dry dressing every dayKetoconazole external cream (a powerful antifungal medication used to treat infections caused by fungus or yeast) two percent (% - unit of measurement) - apply to right lower back topically one time a dayDuring a review of Resident 2's TAR for [DATE], the TAR indicated the following treatment orders were blank and did not have any documentation why the TAR was blank and/or if resident refused the treatment:Dated [DATE], [DATE], [DATE] - For sacrococcyx open wound: cleanse with NS, pat dry, apply cover with dry dressing every dayDated [DATE], [DATE] - (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ketoconazole external cream two percent - apply to right lower back topically one time a dayDuring an interview with RN 1 on [DATE] at 1:07 p.m., RN 1 stated, if TAR is blank and no documentation why the log was blank, it means, the treatment was not done, and the correct process is to document why the treatment was not done and do not leave the TAR log blank. RN 1 stated, if treatments were not done, this can affect resident's wound healing, it may get worse.During a review of the facility's policy and procedures (P&P) titled, Medication - Self Administration, reviewed on [DATE], the P&P indicated that, It is the responsibility of the IDT to determine if it is safe for the resident to self-administer drugs before the resident may exercise that right. The IDT must determine whether the resident or the nursing staff will be responsible for storage and documentation of the administration of the medications, as well as, the location where the medications will be administered. These determinations should appear on the resident's comprehensive plan of care.During a review of the facility's P&P titled, Prevention of Pressure Ulcers/Injuries, reviewed on [DATE], the P&P indicated that, The following information should be documented in the resident's clinical record: The type of skin care rendered, the date and time skin care was given, the name and title of the individual who gave the care; any change in the resident's condition; the condition of the resident's skin; how the resident tolerated the procedure or his/her ability to participate in the procedure; any problems or complains made by the resident related to the procedure, if the resident refused the care, the reason (s) why; observation of anything unusual exhibited by the resident; the signature and title of the person recording the data; documentation of advance directives.