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	02/16/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedures (P&P) titled Change of Condition - SBAR [situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents] -Assessment reviewed by the facility on 7/11//2025, for one of three sampled residents (Resident 1). By failing to notify Resident 1's physician on 2/10/2026, when the resident was assessed as a high risk for elopement (the act of leaving a facility unsupervised and without prior authorization). This deficient practice resulted in Resident 1 not receiving orders for a wander guard (an electronic safety technology used in care facilities to prevent residents with dementia or cognitive impairment from wandering off or eloping [leaving]) and eloping from the facility without staff knowledge on 2/11/2026. Placing Resident 1 at risk for serious injury, harm, or death.Findings: During a review of Resident 1's admission record, the admission record indicated the facility admitted the resident on 2/10/2026, with diagnoses that included dementia (a progressive state of decline in mental abilities) with other behavioral disturbance, depression (a common, serious mood disorder characterized by a persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities), and psychoactive substance (is a chemical that enters the brain and changes how a person feels, thinks, or behaves by affecting the central nervous system, like alter mood, perception, and consciousness, and include everything from legal substances like caffeine and alcohol to prescription medication and illegal drugs) abuse (physical or psychological dependence). During a review of Resident 1's undated preadmission inquiry, the inquiry indicated Resident 1 was admitted to [General Acute Care Hospital - GACH] since 1/17/26 for FTT [Failure to Thrive] had lost 20 lbs. [pounds] drank only beer and not food, PSUD [psychostimulant Use Disorder]. The same document indicated, Resident 1 had severe dementia and did not have capacity to make decisions. During a review of Resident 1's elopement risk assessment dated [DATE], the elopement risk assessment indicated Resident 1 scored at 24 (17 or higher deemed high risk). During a review of Resident 1's Visual hourly check log initiated on 2/10/2026 at 3pm, the log indicated the resident attempted to exit the building at the following times in the west hallway: 7 pm - Resident 1 was attempting to exit the building, was able to redirect him from doing so and brought him back to his room. 9 pm - Residents attempted to exit the building, successfully redirected him and walked him back to his room.2/11/2026 1 am - Resident 1 attempted to exit the building, was successful in redirecting him and assisting him back to his room. 4 am - Resident 1 was no longer in his room. During a review of Resident 1's nursing progress notes dated 2/10/2026 at 8 pm, the progress notes indicated Resident 1 Was seen on bed during room rounds lying down with the head of the bed elevated with no signs of respiratory distress or facial grimacing. Later in the night residents were seen walking the hallway looking for an exit. Redirected him and talked to him about the reason for an exodus from the facility, He verbalized he wants to leave because (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he wants to live his life to the fullest. Told him that he should stay here as his doctor ordered it. He is still insistent so hard to redirect him even more. Eventually he returned to his room. During an interview with Certified Nursing Assistant (CNA) 1 on 2/17/2026 at 4:26 pm, CNA 1 stated Resident 1 was admitted to the facility on the morning of 2/10/2026. CNA 1 stated that he had not observed any exit seeking behaviors throughout the afternoon until after dinner when Resident 1 started wandering around and asking for exits. CNA 1 stated that at one point, Resident 1 got a little upset because the Registered Nurse Supervisor (RNS) assisted him (Resident 1) back to his room when he was trying to leave. CNA 1 stated that Resident 1 slept around 1 am and remained asleep even when he left for his break at 3:30 am. CNA 1 stated when he went to check Resident 1 at 4:20 am, he found that Resident 1 was not in his room or anywhere around the facility. During an interview with Resident 1's family member (FM) 1 12/17/2026 at 4:26 pm, FM 1 stated FM 1 had gone to tour the facility before Resident 1 was admitted about a week and a half prior. During the tour, FM 1 stated the staff member (unidentified) who was showing her (FM 1) around the facility was asked by FM 1 if residents could get out of the facility and was told that there was someone at the door during the day and at night, the alarm was set and the door was locked. FM 1 stated that on the day of admission, while in the company of facility staff unidentified), Resident 1 asked FM 1 if he could go home a few times and reminded him that he needed to stay at the facility. FM 1 stated that she was shocked when she received a call from the facility on 2/11/2026 at 5 am informing her that Resident 1 was not in the facility, and no one knew when the resident had left or where the resident was. FM 1 stated that police eventually called her (Fm 1) around 9 pm on 2/11/2026, informing FM 1 the resident was located in a city far away from the facility with bruises and scratches. FM 1 believed Resident 1 had walked all night and stated that Resident 1 kept stating that he 9resident 1) had fallen. During an interview with RNS 1 on 2/18/2026 at 3:23 pm, RNS 1 stated that admission process included a thorough assessment including an elopement risk assessment. RNS 1 stated that abnormal findings such as a high elopement risk had to be reported to the physician for orders for wander guard. RNS 1 confirmed that t Resident 1 was assessed to be a high elopement risk but that the resident's physician was not informed. During an interview with the Director of Nursing (DON) on 2/19/2026 at 12:26 pm, the DON stated that once a resident was identified as an elopement risk, protocol was initiated such as alerting staff, and a wander guard placed with the consent of the resident or their representative. The DON stated a wander guard required a physician order. The DON stated the protocol had to be initiated as soon as possible to avoid adverse side effects such as a resident leaving the facility without staff knowledge. During a review of a P&P titled, Wandering/Exit Seeking Behavior, reviewed by the facility on 7/11/2025, indicated The facility will evaluate residents for wandering and/or exit seeking behavior and implement appropriate interventions as indicated via the evaluation process. The same P&P indicated under procedure which included the following: Nursing completes the Wandering/Exit Seeking Evaluation form as appropriate.Based on the results of the evaluation, care plan interventions to manage wandering and/or exit seeking behaviors are initiated/implemented.If the resident exhibits wandering and/or exit seeking behavior, the episodes should be documented in the progress notes of the medical record. Documentation should include interventions used and their effectiveness. During a review of a P&P titled, Change of Condition - SBAR [situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents] -Assessment reviewed on 7/11//2025 indicated, It is the policy of this facility that any changes in a resident's condition be thoroughly assessed and evaluated using the SBAR process with physician notification for early clinical management to avoid unnecessary readmissions to acute hospitals. The (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	same P&P indicated, The assessment results should assist the physician in determining the course of clinical management for the resident.

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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 observation, interview, and record review the facility to develop and implement and individualized and comprehensive care plan to meet the individual needs for one out of three sampled residents (Resident 1), who was identified to be at high risk for elopement (the act of leaving a facility unsupervised and without prior authorization) risk. As a result, on 2/11/2026 Resident 1 eloped (left) from the facility unsupervised without staff knowledge and the resident's whereabouts unknown for 17 hours. Placing Resident 1 at risk for serious injury, harm, or death.Findings:A review of Resident 1's admission record indicated the facility admitted the resident on 2/10/2026, with diagnoses that included dementia (a progressive state of decline in mental abilities) with other behavioral disturbance, depression (a common, serious mood disorder characterized by a persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities), and psychoactive substance (is a chemical that enters the brain and changes how a person feels, thinks, or behaves by affecting the central nervous system, like alter mood, perception, and consciousness, and include everything from legal substances like caffeine and alcohol to prescription medication and illegal drugs) abuse (physical or psychological dependence). During a review of Resident 1's undated preadmission inquiry, the inquiry indicated Resident 1 was admitted to [General Acute Care Hospital - GACH] since 1/17/26 for FTT [Failure to Thrive] had lost 20 lbs. [pounds] drank only beer and not food, PSUD [psychostimulant Use Disorder]. The same document indicated, Resident 1 had severe dementia and did not have capacity to make decisions. During a review of Resident 1's elopement risk assessment dated [DATE], the elopement risk assessment indicated Resident 1 scored at 24 (17 or higher deemed high risk). During a review of Resident 1's Visual hourly check log initiated on 2/10/2026 at 3pm, the log indicated the resident attempted to exit the building at the following times in the west hallway: 7 pm - Resident 1 was attempting to exit the building, was able to redirect him from doing so and brought him back to his room. 9 pm - Residents attempted to exit the building, successfully redirected him and walked him back to his room.2/11/2026 1 am - Resident 1 attempted to exit the building, was successful in redirecting him and assisting him back to his room. 4 am - Resident 1 was no longer in his room. During a review of Resident 1's nursing progress notes dated 2/10/2026 at 8 pm, the progress notes indicated Resident 1 Was seen on bed during room rounds lying down with the head of the bed elevated with no signs of respiratory distress or facial grimacing. Later in the night residents were seen walking the hallway looking for an exit. Redirected him and talked to him about the reason for an exodus from the facility, He verbalized he wants to leave because he wants to live his life to the fullest. Told him that he should stay here as his doctor ordered it. He is still insistent so hard to redirect him even more. Eventually he returned to his room. During an interview with Certified Nursing Assistant (CNA) 1 on 2/17/2026 at 4:26 pm, CNA 1 stated Resident 1 was admitted to the facility on the morning of 2/10/2026. CNA 1 stated that he had not observed any exit seeking behaviors throughout the afternoon until after dinner when Resident 1 started wandering around and asking for exits. CNA 1 stated that at one point, Resident 1 got a little upset because the Registered Nurse Supervisor (RNS) assisted him (Resident 1) back to his room when he was trying to leave. CNA 1 stated that Resident 1 slept around 1 am and remained asleep even when he left for his break at 3:30 am. CNA 1 stated when he went to check Resident 1 at 4:20 am, he found that Resident 1 was not in his room or anywhere around the facility. During an interview with Resident 1's family member (FM) 1 12/17/2026 at 4:26 pm, FM 1 stated FM 1 had gone to tour the facility before Resident 1 was admitted about a week and a half prior. During the tour, FM 1 stated the staff member (unidentified) who was showing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her (FM 1) around the facility was asked by FM 1 if residents could get out of the facility and was told that there was someone at the door during the day and at night, the alarm was set and the door was locked. FM 1 stated that on the day of admission, while in the company of facility staff unidentified), Resident 1 asked FM 1 if he could go home a few times and reminded him that he needed to stay at the facility. FM 1 stated that she was shocked when she received a call from the facility on 2/11/2026 at 5 am informing her that Resident 1 was not in the facility, and no one knew when the resident had left or where the resident was. FM 1 stated that police eventually called her (Fm 1) around 9 pm on 2/11/2026, informing FM 1 the resident was located in a city far away from the facility with bruises and scratches. FM 1 believed Resident 1 had walked all night and stated that Resident 1 kept stating that he 9resident 1) had fallen. During an interview with RNS 1 on 2/18/2026 at 3:23 pm, RNS 1 stated that admission process included a thorough assessment including an elopement risk assessment. RNS 1 stated that abnormal findings such as a high elopement risk had to be reported to the physician for orders for wander guard. RNS 1 confirmed that t Resident 1 was assessed to be a high elopement risk but that the resident's physician was not informed and t a care plan for elopement risk was not developed which could have prevented him (Resident 1) from eloping. During an interview with the Director of Nursing (DON) on 2/19/2026 at 12:26 pm, the DON stated that once a resident was identified as an elopement risk, protocol was initiated such as alerting staff, and a wander guard placed with the consent of the resident or their representative. The DON stated a wander guard required a physician order. The DON stated the protocol had to be initiated as soon as possible to avoid adverse side effects such as a resident leaving the facility without staff knowledge. The DON stated that a care plan had to be initiated upon discovering a resident was an elopement risk to ensure staff across all shifts were aware of the interventions to provide for the residents. During a review of a policy and procedure (P&P) titled, Comprehensive Care. Planning reviewed by the facility on 7/11/2026, the policy indicated It is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The same P&P indicated, On admission, based on information accompanying the resident and results of admission assessments completed by the licensed nurses, a baseline care plan will be developed to address minimum health care information required to properly care for each resident, including goals and objectives. The care plan must address effective and person-centered care that meets professional standards for quality of care. During a review of a P&P titled, Wandering/Exit Seeking Behavior, reviewed by the facility on 7/11/2025, indicated The facility will evaluate residents for wandering and/or exit seeking behavior and implement appropriate interventions as indicated via the evaluation process. The same P&P indicated under procedure which included the following: Nursing completes the Wandering/Exit Seeking Evaluation form as appropriate.Based on the results of the evaluation, care plan interventions to manage wandering and/or exit seeking behaviors are initiated/implemented.If the resident exhibits wandering and/or exit seeking behavior, the episodes should be documented in the progress notes of the medical record. Documentation should include interventions used and their effectiveness.