| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055473 | A. Building<br>B. Wing | 02/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| New Vista Post-Acute Care Center | 1516 Sawtelle Blvd.<br>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.

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that Certified Nursing Assistant (CNA) 4 was not assigned to provide care to two out of five sampled residents (Resident 4) on 2/17/2026 on the 11pm to 7 am shift according to f the facility ‘s policies and procedures (P&P) titled , Abuse Reporting and Prevention date 7/11/2025, and Rules of conduct dated 01/2026. The facility was aware that Resident 4 had requested that CNA4 not be assigned to Resident 4.This deficient practice resulted in:A loud argument and possible physical altercation between Resident 4 and CNA4.Resident 5 complaining that he did not like how CNA4 turned him when providing care to him. Findings: On 2/23/2026 at 10:40 am, an unannounced visit was made to the facility to investigate facility reported allegations of staff on resident abuse. A review of Resident 4's admission record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (paralysis) following cerebral infarction (brain tissue death resulting from a severe, prolonged lack of oxygen and nutrients) affecting the left non-dominant side, cellulitis (acute bacterial infection of the deep middle layer and subcutaneous skin tissues) of the left lower limb, Type 2 diabetes mellitus (a chronic condition characterized by high blood sugar), hypertension (elevated high blood pressure), gastro-esophageal reflux disease (GERD- digestive disorder where stomach acid or contents frequently flow back (reflux) into the esophagus), asthma (inflammatory disease of the airways that causes them to swell, produce excessive mucus, and tighten, resulting in reversible airflow obstruction) and lack of coordination. A review of Resident 4's history and physical dated 10/21/2025, indicated Resident 4 has the capacity to make decisions. A review of Resident 4's Minimum Data Set (MDS - resident assessment tool) dated 11/6/2025, indicated the resident 4's cognition (The mental ability to make decisions of daily living) was intact. The MDS indicated Resident 4 required setup/clean up assistance with eating, substantial/maximal assistance with oral hygiene, toileting, hygiene, shower/bath, and personal hygiene. A review of Resident 5's admission record indicated Resident 5 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that include non-[NAME] lymphoma (a group of blood cancers that develop in your lymphatic system), benign neoplasm of the pancreas (noncancerous, tumor slow-growing, and do not spread (metastasize) to other parts of the body), anemia (a blood disorder in which the blood has a reduced ability to carry oxygen), lack of coordination, difficulty walking bilateral osteoarthritis (a degenerative joint disease) of the hip, and polyneuropathy (widespread, simultaneous damage to multiple peripheral nerves) A review of Resident 5's MDS dated [DATE] indicated Resident 5's cognition was severely impaired. The MDS indicated Resident 5 required setup/clean up assistance with eating, is dependent for oral hygiene, toileting hygiene, shower/bath, upper body dressing and personal hygiene, Resident 5 requires substantial maximal assistance with rolling from left and right and moving from sitting to lying position. During an interview on 2/23/2026 at 12:01 pm, Resident 4 stated she (Resident 4) told Licensed<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Vocational Nurse (LVN) 2 on 2/17/2026 at the beginning of the 11pm to 7 am shift, that she (Resident4) did not want CNA4 assigned to provide care to her (Resident 4). Resident 4 stated that LVN2 told Resident 4 that the CNA who was assigned her (Resident 4) was running late because it was raining heavily. Resident 4 stated that in the past (unable to recall the date/time), CNA4 had forced a glove into Resident 4's hand, applied some A&D (topical medication/skin protectant and emollient used to treat and prevent skin diaper rash) on the same glove that CNA4 had forced into the resident's hand. Resident 4 continued to state that CNA4 then told Resident 4 to apply the A&D on herself (Resident 4). Resident 4 stated that again on 2/18/2026 during the 11pm-7am shift (unable to recall exact time), CNA4 gave Resident 4 a towel and told Resident 4 to clean herself (Resident 4). Resident 4 stated she cleaned herself and then placed the used towel on the side of the bed, however, the towel fell to the floor. Resident 4 stated CNA4 picked up the towel of the floor and told Resident 4 that, don't throw it (towel) at me. Resident 4 stated CNA4 told her (Resident 4) that, next time it will be worse for you if you do that (towel on the floor). Resident 4 stated CNA4 told Resident 4 I am from [NAME]; we do not play that in [NAME]. Resident 4 stated (CNA4) makes me feel like I am less than them. During an interview on 2/23/2026 at 12:27pm, CNA2 stated that Resident 4 told her (CNA2) that Resident 4 does not like the staff who work the 11pm-7am shift. CNA2 also stated that Resident CNA4 told CNA2 that CNA4 had an attitude, and that Resident 4 and CNA4 had argued. During a telephone interview on 2/23/2026 at 2:23pm LVN2 stated she (LVN2) completed the facility staff to Resident assignment for the 11pm-7am shift on 2/17/2026. LVN2 stated my understanding is the only Resident CNA4 cannot be assigned is Resident 5. LVN2 stated the previous shift 3pm-11pm Resident 5 had requested not to be assigned CNA4. LVN2 stated LVN3 reported to RN1 during the 11pm-7pm shift that CNA4 and an altercation with Resident 4. During an interview on 2/23/2026 at 2:41pm Registered Nurse (RN1) stated he did not witness the alleged abuse on Resident 4 by CNA4. RN1 stated that on 2/17/2026 at 11pm to 7 am shift, one (1) staff had called in sick and therefore CNA4 was assigned to Resident 4. RN1 stated CNA4 did not want to be assigned to Resident 4, and that RN1 asked Resident 4 to give CNA4 a chance. RN1 stated that Resident 4 and CNA4 agreed to work together. RN1 stated CNA4 insisted on working with Resident 4, and that CNA4 did not mention any history that prohibited her (CNA4) from working with Resident 4. RN1 stated CNA4 told RN1 that while assisting Resident 4 with ADL cleaning, Resident 4 did not want CNA4's help, and that Resident 4 cleaned her (Resident 4) own perianal area (between the private area and the rectum) and then threw the dirty towel on the floor and that Resident 4 kicked CNA4. RN1 stated that CNA4 told RN1 that there was no trigger for Resident 4's behavior. RN1 stated that CNA4 told RN1 that Resident 4 threw the used towel at CNA4 because Resident 4 doesn't like CNA4. RN1 further stated he later found out from CNA4 after the altercation between Resident 4 and CNA4, that CNA 4 was not supposed to be assigned to Resident 4. RN1 stated he (RN1) reported the incident to the Administrator (ADM), ADM told RN1 to tell CNA4 that CNA4 is suspended to and send CNA4 home. During an interview on 2/24/2026 at 6:45am CNA4 stated on Resident 4 asked LVN2 if there was anyone other CNA other than CNA4 to work with Resident4. CNA4 stated RN1 said that he (RN1) would accommodate Resident 4's request by not assigning CNA4tof Resident 4 had objected to not wanting CNA4. CNA4 stated LVN2 knew/was aware that CNA4 could not work with Resident 4 but LVN2 told CNA4 that she (LVN2) could not change the assignment. CNA4 further stated RN2 usually makes the work assignment and never assigns CNA4 to Resident 4, however, RN2 was on vacation. CNA4 stated that on 2/18/2026 on the 11 pm to 7 am shift, she (CNA4) went to introduce herself to Resident 4 who had requested for incontinent brief change. CNA4 stated that as soon as she (CNA4) walked into Resident 4's room, Resident 4 said, no, no, no. and asked for another CNA. CNA4 stated LVN3 told Resident 4, If you don't<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | want (CNA4) to change (incontinent care) you then you will not be changed. We are short of staff. You must let CNA4 change you. CNA4 stated she cleaned Resident 4 and asked Resident 4 to turn, and then Resident 4 told CNA4 that she (Resident 4) was still wet in the perineal area and requested for a dry clean washcloth to dry herself. CNA4 stated that when Resident 4 was finished/ done drying herself, Resident 4 threw the dirty washcloth (towel) at CNA4 which hit CNA4 in the stomach (abdomen). CNA4 stated while still cleaning Resident 4, Resident 4 resisted and kicked CNA4 in the stomach. CNA4 stated she reported the sequence of events to RN1, and RN1 investigated and reported Resident 4 complaint incident to the administrator. CNA4 stated that the administrator told RN1 to tell CNA4 that because it is abuse, CNA4 was placed on a 3-day suspension. CNA4 stated that was not the first time Resident 4 had reported CNA4 to the director of nursing and Administrator. CNA4 stated Resident 5 did not want CNA4 to take care of him (Resident 5) because CNA5 had told Resident 5 to file a grievance against CNA4. During an interview on 2/24/2026 at 7:12 am, LVN3 stated she was unaware CNA4 could not be assigned to Resident 4 until Resident 4 and CNA4 had an altercation. LVN 3 stated on 2/18/2026 at 1:30 am, CNA4 came out of Resident 4's room and called LVN3 stating please come. LVN3 stated when she got to Resident 4's room, CNA4 and Resident 4 were arguing, Resident 4 told LVN3, CNA4 hit her (Resident 4) with a towel on her (Resident 4's) face. LVN3 sated that CNA4 said, I did not through a towel at Resident 4's face and that CNA4 said you (Resident 4) hit me too and I just came out of the hospital. LVN3 stated that Resident 4 said yes you did hit me and that CNA4 repeated you hit me too. LVN3 stated she asked CNA4 to step outside of Resident 4's room and told CNA4 that LVN3 would finish changing Resident 4. LVN3 stated Resident 4 said that she (Resident 4) asked CNA4 to dry her (Resident 4) because she (Resident 4) was still feeling wet on the front of the private area but CNA4 gave Resident 4 an attitude and said, I'm done, if you want to do it (dry the vaginal area) yourself, here is the towel. LVN3 stated Resident 4 said that even though she felt uncomfortable when CNA4 spoke to her in that manner and that she (Resident 4) dried herself and then gave the towel to CNA4. LVN3 stated Resident 4 said that CNA4 got upset and said, why did you throw that towel at me? CNA4 then grabbed the same towel and threw it at Resident 4's face. LVN3 stated Resident 4 stated she felt abused and she (Resident 4) kicked CNA4 with her (Resident 3's) right leg. LVN 3 stated CNA4 ran out of the room and called LVN3. LVN3 stated after listening to Resident 4, I assessed her (Resident 4) again. LVN3 stated that CNA4 is not allowed to have (be assigned) Resident 5. LVN3 stated that CNA4 was upset because she was not assigned Resident 5 on 2/23/2025 on the 11 pm-7 am shift, gave the charge nurses including LVN3 an attitude and told LVN3 that the only Resident she (CNA4) is not allowed to have is Resident 4. During an interview on 2/24/2026 at 7:34 am CNA5 stated on 2/16/2026 on the 7am-3pm shift the while picking up Resident 5 breakfast tray in the morning, Resident 5 told CNA5 I want to speak to your supervisor. I need to make a report of abuse. CNA5 stated she reported Resident 5's request to the charge nurse, supervisor and administrator. CNA5 stated the Administrator spoke to Resident 5 and that CNA4 can no longer provide care to Resident 5. During an interview on 2/24/2026 at 8:05 am, Resident 5 stated last week (unable to recall date) a CNA4 grabbed his (Resident 5's) left arm, swung Resident 5 to the left side, and was rude to Resident 5. Resident 5 stated the Administrator spoke to him (Resident 5) and told him that the CNA4 will no longer be assigned to him (Resident 50. During an interview on 2/24/2026, Social Services Director (SSD) stated Resident 5 had a grievance last week (unable to recall date), Resident 5 stated CNA4 placed very greasy lotion on him, (SSD does not know type of lotion) SSD stated she is aware that CNA4 was removed from taking care of Resident 5 but does not know why. SSD stated she does not know how Resident 5 developed the bruise to his arm and fore fingers. SSD stated Resident 4 informed SSD that she (Resident 4)<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | placed towel on side of the bed, the CNA4 picked up the towel and threw it at Resident 4's face. SSD stated that Resident 4 said that Resident 4 kicked CNA4 in self-defense. SSD stated, I know they (CNA4 and Resident 4) have a history but Resident 4 did not go into details about her previous experience with CNA4. During an interview on 2/24/2026, Administrator (ADM) stated, if a Resident does not want a staff to care for them, staff should honor Residents request. Administrator stated that Resident4 alleged that when she was done cleaning herself with towel, CNA4 took towel and threw it on Resident 4's face. CNA4 stated Resident 4 cleaned herself with towel, Resident 4 dropped it (towel) on the floor at CNA4's feet, CNA4 asked Resident4 why she (Resident 4) dropped towel on the floor and Resident 4 kicked her without provocation. Administrator stated CNA4 was barred from being assigned to Resident 5, it was Resident 5's preference. Resident 5 stated he did not like the care he received when the CNA4 changed him. I asked Resident 5 what the appropriate step to take was, Resident 5 stated he does not want CNA4 assigned to him. Resident 5 stated he did not like how the CNA4 turned him. He was not upset with the physical part but CNA4 did not communicate what she was going to do. Administrator stated he is exploring options, and he (ADM) is concerned about CNA4's code of conduct and how this will affect other Residents. Administrator stated he (ADM) is hesitant to bring CNA4 back to full duty. A review of the facility ‘s policy and procedures (P&P) titled , Abuse Reporting and Prevention date 7/11/2025 indicated, abuse means the willful infliction of.Physical Abuse - A willful physical action that is meant to inflict physical harm. Mental abuse, humiliation, harassment, threats of punishment or deprivation resulting in harm, pain, or mental anguish that are necessary to attain or maintain physical, mental, and psychosocial well-being. A review of facility P&P titled Rules of conduct dated 01/2026 indicated, It is important to us that all employees maintain proper standards of conduct and observe certain rules to ensure the orderly and efficient operation. employees who do not comply with Company policies, rules and directives will be disciplined or terminated, examples of misconduct Abuse or neglect of the residents. Rude, discourteous or un-business-like behavior, creating a disturbance on Company premises or creating discord with ., employees. |