

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 12/05/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</p> <p>Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of his/her individuality for two (2) out of the 18 sampled residents (Resident 34 and Resident 69) by:</p> <ol style="list-style-type: none"> 1. Staff standing over Resident 34 while assisting her to eat a meal. 2. Failing to describe what food was on the food tray and where each food item was located on the food tray. Resident 69 is visually impaired (is a partial or total inability to see). <p>This deficient practice had the potential to affect Resident s self-esteem, self-worth, and dignity.</p> <p>Findings:</p> <p>A review of Resident 34's admission record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included dementia (a general term impaired thinking, remembering or reasoning that can affect a person ' s ability to function safely) arthritis (is inflammation or degeneration of one or more joints), hypertension (elevated/high blood pressure) and anemia (is a condition in which the body does not have enough healthy red blood cells).</p> <p>A review of the History and Physical (H&P) report completed on 3/7/2024, indicated Resident 34 was g-tube dependent but remains on pureed for oral gratification and does not have the capacity for medical decision making due to dementia.</p> <p>A review of Resident 34's Minimum Data Set (MDS - a resident assessment tool) dated 11/21/2024, indicated Resident 34's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 34 was totally dependent for oral hygiene, toileting hygiene, shower bathing and upper body dressing, personal hygiene, and was non-ambulatory.</p> <p>A review of Resident 69's admission record indicated Resident 69 was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included hyperlipidemia (a medical term for abnormally high levels of fats (lipids) in the blood), lack of coordination, encephalopathy hypertension and blindness to the left and right eye.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the H&P report completed on 9/13/2024, indicated Resident 69 did not have the capacity for medical decision making due to encephalopathy.</p> <p>A review of Resident 69's MDS dated [DATE], indicated Resident 69's cognition was intact. The same MDS indicated Resident 69 was independent with eating and oral hygiene, toileting hygiene, shower bathing and upper and lower dressing, personal hygiene, and was ambulatory.</p> <p>During a concurrent dining observation and interview. on 12/03/24 12:20 PM Resident 69 was observed to be visually impaired and was touching his meal tray to feel for the food placement layout.</p> <p>During a dining observation on 12/03/24 at 12:30 PM in Resident 34's room, Certified Nursing Assistant (CNA) 1 was observed standing while feeding Resident 34. Resident 34 was observed extending her neck to look up at CNA 1.</p> <p>During an interview of 12/3/24 12:45 PM CNA1 stated, she (CNA1) did not describe the foods on the tray and/or the location of each food item on the food tray because Resident 69 was independent with eating.</p> <p>During an interview on 12/03/24 12:52 PM, Director of Staff Development (DSD) stated the staff assisting residents with meals should sit down on a chair at eye level with the resident for dignity.</p> <p>During an interview 12/05/24 3:57 PM, Director of Nursing (DON) stated, the facility policy dictates that staff assisting residents with meals should be seated at eye level, for dignity. DON further stated CNAs are trained on how sit with resident while assisting them with meals. DON also stated, for visually impaired residents, staff should lead the residents hand and describe the food items and layout of the food tray and where the utensils are located and inform the resident if a food item is hot.</p> <p>A review of facility policy and procedures (P&P) titled Resident dignity/Resident Rights dated 7/12/2024 indicated, it is policy of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>A review of facility P&P titled Accommodation of needs and activities dated 7/12/2024 indicated, staff should strive to reasonably accommodate the resident's needs and preferences as the resident makes use of their physical environment. This includes ensuring that items the resident needs to use are available and accessible to encourage confidence and independence.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253</p> <p>Based on observation, interview, and record review, Certified Nursing Assistant (CNA) 1 failed to protect the resident's rights by not closing the privacy curtain to ensure a resident is visually exposed to the roommates while the performing personal care for one of 24 sampled residents (Resident 13).</p> <p>This deficient practice violated the Resident 13's right for privacy.</p> <p>Findings:</p> <p>A review of the admission record indicated Resident 13 was admitted to the facility on [DATE] and was readmitted the resident to the facility on [DATE], with diagnoses including Stage 4 pressure ulcer (deep wound reaching the muscles, ligaments, or bones), respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide) and tracheostomy [an opening created at the front of the neck so a tube can be inserted into the windpipe to help you breathe].</p> <p>A review of Resident 13's Minimum Data Set (MDS-a resident assessment tool) dated 11/26/2024, indicated Resident 13's cognition (ability to think, understand, and reason) was severely impaired. The MDS further indicated Resident 13 was totally dependent upon staff for all 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 13 had a feeding tube, indwelling catheter and two stage 4 pressure ulcers.</p> <p>During a concurrent observation and interview on 12/2/2024 at 10:49 AM, CNA 1 was observed performing morning care (routine hygiene and personal care provided to a resident to start their day feeling clean and comfortable) for Resident 13. Resident 13's privacy curtain was not closed and Resident 13 was in the direct view of the two other roommates. Resident 13's room window blinds were also open and there was a clear view to the alley outside beyond the window. CNA 1 stated Resident 13's privacy curtain should have been closed completely to maintain Resident 13's privacy.</p> <p>During an interview on 12/05/2024 at 3:23 PM, the Director of Nursing (DON) stated the during a resident's care, the privacy curtain is closed to maintain the resident's dignity and privacy.</p> <p>A review of the facility's policy and procedures (P&P) titled, Resident Rights, reviewed 7/12/2024, indicated employees shall treat all residents with kindness, respect, and dignity.</p> <p>A review of the facility's P&P titled, Activities of Daily Living, reviewed 7/12/2024, indicated during any ADL's that are of a personal nature, maintain as much privacy as possible. If the patient is in a private room, close the door. If it is a shared room, always pull the curtain around the bed and be sure that others do not intrude during bathing, use of the bedpan, grooming or dressing activities.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46843</p> <p>Based on observation, and interview, the facility failed to ensure a safe, comfortable, and clean homelike environment for one out of three sampled residents (Resident 101) by failing to:</p> <ol style="list-style-type: none"> 1. Repair the window frame was broken and the window glass that had detached from the window frame was repaired. 2. Trash was not left on the floor. 3. The floor was not partially cleaned. <p>These failures resulted in cold air to continuously enter Resident 101's room making the resident feel uncomfortably cold at night, and was ashamed of her living area.</p> <p>Findings:</p> <p>A review of Resident 101's admission record indicated the facility admitted Resident 101 on 11/12/24 with diagnoses including, Raynaud's syndrome (A condition affecting fingers and toes, causing them to loose blood flow when exposed to cold temperatures),sSchizophrenia (a chronic (a condition or something that continues or occurs again over a long period of time) mental illness that affects how a person thinks feels, and behaves), depression (a mental health condition that involves a prolonged period of feeling sad, hopeless, and unable to enjoy activities of daily life).</p> <p>A review of Resident 101's Minimum Data Set (MDS - a resident assessment tool) dated 11/19/2024, indicated Resident 101's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) is intact. Resident 101 needs 1 person assistance with toileting hygiene also, to put on and take off footwear, and lower body dressing.</p> <p>During an interview, on 12/02/24 at 9:10 AM, Resident 101 stated the resident's (Resident 1) room is cold at night because the window does not close shut all the way.</p> <p>During observation on 12/02/24 at 9:27 am of Resident 101's room, the window of the resident's room would not close, and the glass of the window was loose causing it to become separated from the main part of the window frame. The window was facing the outside of the facility looking out into the street and there were bushes just outside the window. However, the window was clearly visible from the sidewalk outside the resident's room. The window screen that faces outside and towards the street was bent away from the frame of the window and was loose.</p> <p>During a concurrent observation and interview, on 12/02/24 at 9:32 am., Maintenance Director (MD) stated the window in Resident 101's room was observed to be in disrepair. MD stated that he would fix the window immediately.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 12/02/24 at 9:50 am the Administrator (Adm) stated, I am not aware of any broken window. However, if anything is broken or malfunctioning the Maintenance supervisor will take care of it immediately by fixing the problem or contacting the appropriate company to handle the job.</p> <p>During an interview, on 12/02/24 at 10:30 am., MD stated that he temporarily secured the window in Resident 101's room, allowing the window to close to keep the resident's room warm at night. MD stated he contacted the window company, and they will be out to the facility to repair the window frame and replace the window if it could not be repaired.</p> <p>During a review of the facility's policy and procedures titled, Sanitary and Homelike Environment dated: 7/12/2024; indicated, Policy: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. General Guidelines: 2. The facility and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. There characteristics include: a. Clean, sanitary and orderly environment; h. Comfortable and safe temperatures (71 F - 81 f); and</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843</p> <p>Based on observation, interview, and record review, for two of six sampled residents (Residents 21 and 101), the facility failed to ensure:</p> <ol style="list-style-type: none"> Residents clothes received back the exact number and color of clothes after the cclothes were washed, Residents did not wear other residents clothes. <p>These failures resulted in Resident 101, and 21 loosing their clothes, Resident 101's T-shirt was bleached from black color to biege color, and another resident wearing Resident 101's T-shirt.</p> <p>Findings:</p> <p>A review of Resident 21's Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including, hypertension (high blood pressure), depression (a common but serious mood disorder that causes a persistent feeling of sadness and loss of interest), and vertigo (dizziness).</p> <p>A review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 11/20/24, indicated Resident 21 cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) is intact. Resident 21 requires primarily stand by supervision and touch assistance when transferring from bed to wheelchair.</p> <p>A review of Resident 101's Admission Record; indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including, Raynaud's syndrome (A condition affecting fingers and toes, causing them to loose blood flow when exposed to cold temperatures), Schizophrenia (a chronic (a condition or something that continues or occurs again over a long period of time) mental illness that affects how a person thinks feels, and behaves), Depression (a mental health condition that involves a prolonged period of feeling sad, hopeless, and unable to enjoy activities of daily life).</p> <p>A review of Resident 101's MDS dated [DATE], indicated Resident 101's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) is intact. Resident 101 needs 1 person assistance with toileting hygiene also, to put on and take off footwear, and lower body dressing.</p> <p>During an interview, on 12/2/24 at 8:06 am, Resident 21 stated, he sent his clothes to the facility's laundry and never got them back. Resident 21 stated he had one pair of Lucky jeans, one pair of Guess jeans, three pairs of tube socks and three pairs of underwear. Resident 21 stated all his clothes were labelled with his name before sending them to the facility's laundry and never got them back. Resident 21 stated he asked several staff members about his missing items; however, he was not sure of the names of the staff members he spoke with about the issue.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/2/24 at 8:18 am, Certified Nursing Assistant (CNA) 3 stated Resident 21's clothes are labelled with the resident's name and room number. CNA 3 stated that when the clothes are placed inside aa mesh bag before they are taken to the laundry room. CNA 3 stated if the clothes get lost then the CNA on duty will go to the laundry room to try and find them. CNA 3 stated that if they (the CNA) are not able to locate them (the clothes) then we (Staff) will report it to the Social Services Director (SSD). CNA 3 stated Resident 21 had not complained to CNA 3 about losing his clothes.</p> <p>During an interview on 12/02/24 at 9:10 am., Resident 101 stated, when she sent her cloths to be washed here at the facility, she (Resident 101) did not get back four of her designer T-shirts. Resident 101 stated her a fifth Tee-shirt was bleached from a solid black with the design on it to a beige bleached looking color. Resident 101 stated she was at physical therapy and noticed one of her T-shirts on another resident (no name provided). Resident 101 stated she has a total of four shirts still missing and a T-shirt that was damaged when it was bleached from a solid black T-shirt to a beige in color.</p> <p>During observation on 12/02/24 at 9:27 am., Resident 101's T-shirt appeared to be bleached from its original color. Resident 101 stated that the T-shirt was black when she purchased it.</p> <p>During an interview on 12/03/24 at 12:41 pm., the SSD stated she was not aware of any missing, or damaged cloths. For either Resident 101, or Resident 21. The SSD stated that she would speak to the Residents 101 and 21 and fill out a Theft and Loss Report for each resident, to have a record of what was lost in the laundry. The SSD stated that once she finds out what the had lost, she will then speak to the Administer to get approval in writing to allow her to replace the lost items.</p> <p>During an interview on 12/4/24 at 1:50 pm, the Administrator (ADM) stated, if a resident has an item lost or stolen by staff or another resident, first the inventory list will be checked to see if the items was brought in with the resident. When a resident is admitted to the facility an inventory list is made to make sure that the resident's property is accounted for. The ADM stated if a resident brings in clothing or other items after they are admitted to the facility either by purchasing the items or friends and family bring the resident new items, then the CNA's or other staff will log the new items into the residents chart by adding it to the property list. If a resident's property is lost by the laundry staff or stolen, then the facility will replace the items after a search of the facility for the item is concluded. First the laundry room is checked by the Social Services Director or the CNA familiar with the resident, if the item is not found in the laundry room. Next staff will go room by room and check the cabinets, with permission of the residents. After every attempt to find the lost property is made then it will be replaced by the SSD with facility funds.</p> <p>During an interview on 12/5/24 at 11:22 pm., the SSD stated SSD interviewed both Residents 101 and 21 and the theft and loss report completed. The SSD stated, the ADM signed the loss report documents and SSD had started to replace the items that were lost.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedures (P&P) titled, Incidents of Theft and/or Misappropriation of Resident Property, dated revised 7/12/2024; indicated, Policy Statement All reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated. Policy Interpretation and Implementation 1. When an incident of theft or misappropriation of resident property is reported, the administrator will appoint a staff member to investigate the incident. 2. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.</p> <p>During a review of the facility's policy and procedure titled, Grievances, dated revised 7/14/2024; indicated, Purpose: Staff should strive to reasonably accommodate the resident's needs and preferences as the resident resides in the facility to ensure that the patient's highest practicable well-being is achieved. Any resident, his or her representative, family member, or appointed advocate may file grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>44253</p> <p>Based on interview and record review the facility failed to develop a comprehensive care plan (a document outlining a detailed approach to care customized to an individual resident's need) for physical restraints one of 24 sampled residents (Resident 30).</p> <p>This deficient practice had the potential for Resident 30 to not be provided with effective personalized care.</p> <p>Findings:</p> <p>A review of Resident 30's Admission Record indicated the facility originally admitted the resident on 10/11/2022 and readmitted the resident on 9/18/2024 with diagnoses that included respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide) epilepsy (a brain condition that causes recurring seizures[a sudden, uncontrolled burst of electrical activity in the brain]), tracheostomy [an opening created at the front of the neck so a tube can be inserted into the windpipe to help you breathe] and ventilator dependence (a person requires a machine called a ventilator to breathe for them).</p> <p>A review Resident 30's Minimum Data Set (MDS - a resident assessment tool) dated 10/4/2024, indicated the resident had severely impaired cognition (the mental ability to understand and make decisions). The MDS indicated Resident 30 was dependent on help for, oral hygiene, toileting hygiene, showering/bathing self, upper body dressing and personal hygiene. The MDS further indicated Resident 30 used a limb restraint less than daily.</p> <p>A review of Resident 30's Physician's Orders dated 9/18/2024, indicated to apply hand mittens on bilateral (right and left) hands to prevent pulling of tracheostomy, and/or gastrostomy tubing [g-tube: a tube inserted through the belly that brings nutrition directly to the stomach]). The physician's order further indicated to release hand mittens every two hours for skin check and circulation.</p> <p>A review of Resident 30's of tracheostomy and gastrostomy tube (g-tube- a surgically inserted tubes that provides direct access to deliver nutrition, fluids, and medication) dated 9/18/2024, indicated that a telephone consent was obtained from Resident 30's responsible party.</p> <p>During an observation on 12/02/2024 at 8:25 AM, Resident 30 was observed sitting up in bed wearing hand mitten restraints on both hands.</p> <p>During a concurrent interview and observation on 12/3/2024 at 12:54 PM with Resident 30, at Resident 30's bedside, Resident 30 was observed wearing hand mitten restraints on the right hand only. Resident 30 was unable to speak due to tracheostomy but nodded in assent that she wears the hand mittens daily.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/4/2024 at 10:30 AM with Registered Nurse (RN0 1, Resident 30's care plans were reviewed. RN 1 stated the facility did not initiate a mitten restraint care plan for Resident 30. RN 1 stated a care plan addressing the resident's physical restraints should have been developed. RN 1 further stated a care plan should be developed in order for staff to know the interventions and goals for the resident. RN 1 stated there was a potential for Resident 30 to have a delay in care if the care plan is not developed as staff would not know if the interventions are effective.</p> <p>During an interview on 12/5/2024 at 3:20 PM, with the Director of Nursing (DON), the DON stated Resident 30 IS required to have a care plan for the mitten restraints. The DON stated the facility must initiate a care plan in order to monitor, assess, and evaluate the required interventions. The DON stated the potential outcome of not initiating a care plan is the lack of care and inability to deliver necessary interventions and monitoring for a resident.</p> <p>A review of the facility's policy and procedures (P&P) titled, Restraints, reviewed 7/12/2024, indicated, care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s) and care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.</p> <p>A review of the P&P titled Development of Resident Care Plan/IDT reviewed 7/12/2024, indicated, the facility utilizes an interdisciplinary team to provide an individualized - person centered comprehensive resident assessment and care planning process in order to maximize and maintain every resident's functional potential and quality of life. The P&P also indicated individual care and treatment goals are identified. These goals are reasonable and measurable. Each resident's care plan identifies goals that:</p> <ul style="list-style-type: none"> o reflect the resident's unique needs o are realistic and measurable o include a time frame for achievement, when appropriate and Services and care are identified and planned to meet resident's care goals. The Interdisciplinary Care Plan team members to provide care or service are identified. The care plan indicates how frequently specific services will be provided. 		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>45528</p> <p>Based on interview and record review, the facility failed to provide restorative nursing assistance program (RNA -a program/person that helps patient regain their ability to perform daily activities after an illness or injury) according to the physician's orders for one of five sampled residents (Resident 38).</p> <p>This deficient practice resulted in Resident 38 not receiving therapy for two out of 31 days in 11/2024 placing Resident 38 at increased risk for decline in physical function and possibly contractures.</p> <p>Findings:</p> <p>A review of Resident 38's Admission Record indicated the facility admitted Resident 38 on 5/2/2019 and readmitted Resident 38 on 10/19/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), Diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN -high blood pressure).</p> <p>A review of Resident 38's physician orders, dated 10/28/2024, indicated, Restorative Nurse Assistant (RNA -a healthcare professional who helps patients regain their ability to perform daily activities after an illness or injury) to perform passive range of motion (PROM -moving a part of the body without using the individuals muscle), on bilateral upper extremities (BUE -both arms, including the shoulders and hands) and place hand roll in each hand for 6 hours daily three times a week or as tolerated.</p> <p>A review of Resident 38's Minimum Data Set (MDS - a resident assessment tool) dated 10/29/2024, indicated Resident 38 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 38 was dependent on staff for activities of daily living.</p> <p>During a concurrent interview and record review, on 12/4/2024, at 12:10 P.M., with RNA, Resident 38's Restorative flow sheet, dated 11/2024 was reviewed. The Restorative flow sheet indicated, blank for nine days for dates:</p> <p>11/1/2024, 11/2/2024, 11/3/2024, 11/4/2024, 11/5/2024, 11/7/2024, 11/8/2024, 11/9/2024, 11/10/2024. RNA stated blank means RNA was not provided on those days.</p> <p>During a concurrent interview and record review, on 12/4/2024, at 1:00 P.M., with Registered Nurse Supervisor, (RNS), Resident 38's Restorative flow sheet, dated 11/2024 was reviewed. RNS states RNA week started on Sunday and ended on Saturday. RNS stated during the week of 11/2/2024 to 11/9/2024 RNA was only provided one time. RNS stated RNA should have been provided three times that week per physician's order. RNS stated RNA is provided to prevent Resident 38's muscles from getting contracted (tightened, or pulled together), promote circulation and not providing RNA can lead to decline in the movement of the muscles.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/5/2024, at 1:33 P.M., with the Director of Nursing (DON), the DON stated facility needs to follow the physician's orders for RNA and sign the Residents Restorative floe sheet. RNA is provided to a resident to maintain joint mobility which when not done may lead to losing joint mobility, decreased mobility and contracture.</p> <p>A review of the facility's policy and procedures (P&P) titled, Range of Motion Exercises reviewed 7/12/2024, indicated, Passive Range of motion -patient takes no part in the activity, moving the body part around a fixed point or joint through the patient's available ROM. Passive ROM exercises must be planned, scheduled and documented . The Restorative Nursing Assistant (RNA) is responsible in the performance of the ROM exercises and documenting in the RNA flow sheet.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</p> <p>Based on interview and record review, the facility failed to fully identify, evaluate, and implement accident risks and hazard interventions for one out of 18 sampled residents (Resident 51) to prevent Resident 51 from falling.</p> <p>These deficient practices resulted in Resident 51 falling on 5/9/2024. Resident 51 was transferred a general acute care hospital (GACH) on 5/9/2024 where the resident was diagnosed with acute on chronic right frontal convexity subdural hematoma measuring approximately 11 millimeters (mm-unit of measurement) in depth with associated 4mm of leftward midline shift. On 5/10/2024, Resident 51 developed for altered mental status (AMS- a change in mental function that stems from illnesses), was intubated (a process where a healthcare provider inserts a tube through a person's mouth or nose, then down into their trachea [airway/windpipe] so that air can get through) disorders and injuries affecting the brain), and then transferred to Intensive Care Unit (ICU-a unit in a hospital that provides the critical care and life support for acutely ill and injured patients) for further care and management.</p> <p>Findings:</p> <p>A review of Resident 51s Admission Record indicated Resident 51 was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included traumatic subdural hematoma (a type of bleeding near the brain that can happen after a head injury) without loss of consciousness, cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and hypertensive chronic kidney disease (a condition in which chronic high blood pressure damages the kidneys).</p> <p>A review of the Fall Risk evaluation dated 4/30/2024, indicated Resident 51 score was 20 (If a total score is 10 or greater, the resident should be considered at high risk for potential falls).</p> <p>A review of the Resident Care Plan dated 4/30/2024, indicated Resident 51 tries to get up of bed unassisted. The resident care plan goal indicated Resident 51 will be free of injury resulting from falls and will not have further fall incidents. The resident care plan interventions included to apply a tab alarm (a device that alerts staff when a resident is moving) in bed, to not leave the resident in room unattended, low bed and floor mat.</p> <p>A review of the History and Physical report completed on 5/20/2024, indicated Resident 51 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 51s Minimum Data Set (MDS - a resident assessment tool) dated 11/21/2024, indicated Resident 51s cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 51 required setup or clean-up assistance with eating and oral hygiene, required substantial to maximum assistance for toileting hygiene, shower bathing and upper and personal hygiene, and was non-ambulatory.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team) form and progress notes dated 5/9/2024, indicated that on 5/9/2024 at around 12:40 pm Resident 51 was found on the floor from an unwitnessed fall. Resident 51 was assessed and had no complaints of pain, no visible injuries, vital signs were within normal limits and neuro checks were initiated and Resident 51's doctor was notified of the fall. The doctor order was issued to transfer Resident 51 to GACH for a higher level of care and evaluation.</p> <p>A review of Resident 51s GACH records dated 5/9/2024 indicated, that on 5/9/2024, Resident 51 had an unwitnessed fall and was found down on the ground/next to his bed at the skilled nursing facility. His initial Glasgow coma scale (GCS- neurological assessment tool that measures a patient's level of consciousness and the severity of a brain injury) was 14 (Mild traumatic brain injury). Resident 51 was intubated for AMS; a head computerized tomography scan (CT scan) revealed an acute on chronic right frontal convexity subdural hematoma measuring approximately 11 mm in depth with associated 4mm of leftward midline shift. On 5/10/2024, Resident 51 was admitted to GACH ICU.</p> <p>During an interview on 12/5/2024 at 4 pm, the Director of Nursing (DON) stated, if the acute on chronic injury was due to a fall, facility should have reported fall incident per CDPH guidelines and facility policy.</p> <p>A review of facility policy and procedures titled Accident Prevention dated 7/12/2024 indicated staff identifying any incident, resident safety issues Shall report to the Administrator, Director of Nursing or other person in charge to include:</p> <p>a. Injuries/accidents of Resident/s . Immediately to supervisor and/or administrator, an incident report completed and follow-up action recorded.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>45528</p> <p>Based on observation, interview, and record review, the facility failed to label tube feeding (nutrition in a liquid form) according to facility policy and procedure for one of ten sampled residents (Resident 44).</p> <p>This deficient practice had the potential to cause infection.</p> <p>Findings:</p> <p>A review of Resident 44's Admission Record indicated the facility admitted Resident 44 on 1/10/2020 and readmitted Resident 44 on 11/8/2024 with diagnoses including Dependent on respiratory ventilator (a medical device to help support or replace breathing), dysphagia (difficulty swallowing), and hypertension (HTN -high blood pressure).</p> <p>A review of Resident 44's Minimum Data Set (MDS - a resident assessment tool) dated 11/29/2024, indicated Resident 44 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 44 was dependent on staff for activities of daily living.</p> <p>During an observation on 12/2/2024, at 9:12 A.M., in Resident 44's room, the tube feeding bottle was observed hanging from Resident 44's feeding pole without a label (date and time hang) on the feeding formular bottle, water bag and tubing.</p> <p>During a concurrent observation and interview on 12/2/2024, at 9:20 A.M., with the Licensed Vocational Nurse (LVN) 1, in Resident 44's room, the tube feeding formular bottle, water bag and tubing was observed hanging from Resident 44's feeding pole without a label with resident's name, type of feeding formular, rate, time or nurses initials. LVN 1 stated, the tube feeding formular bottle, water bag and tubing were not labeled with date and time, no label on the feeding bag that shows everything the time it was hang, who hang it, when it was hang. The label needs to be on the feeding, water and tube so the nurses can know when the feeding was hang to prevent infection, it is part of infection control practices.</p> <p>During a concurrent observation and interview on 12/2/2024, at 9:25 A.M., with the Registered Nurse Supervisor (RNS) 1, in Resident 44's room, the tube feeding formular bottle, water bag and tubing was observed hanging from Resident 44's feeding pole without a label with resident's name, type of feeding formular, rate, time or nurses initials. RNS 1 stated, tube feeding, water bag, and tubing need to be changed and labeled for infection control reasons.</p> <p>During an interview on 12/5/2024, at 1:33 P.M., with the Director of Nursing (DON), the DON stated a tube feeding set needs to have a label on it with the resident's name, room number, name of the formula, rate, date, and the nurse initials that hang it. DON stated the label ensures that the resident is being given the right feeding formular, the label should match the physician orders, the date because there is a certain amount of time to infuse the formular and for infection control purposes.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedures titled, Enteral Feeding reviewed 7/12/2024, indicated, The facility will remain current in and follow accepted best practices in enteral nutrition .</p> <p>4. On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44253</p> <p>Based on observation, interview, and record review, the facility failed to ensure outside staff food was not stored in the kitchen refrigerator #3.</p> <p>This deficient practice placed the residents at increased risk to suffer foodborne illness (food poisoning).</p> <p>Findings:</p> <p>During an observation in the kitchen on 12/2/2024 at 7:32 AM, a half filled 20 ounce (oz) cup from an outside coffee shop, a can of carbonated soda, an open undated bag of tortillas, and an unlabeled plastic container of an unknown substance was stored in the kitchen top freezer refrigerator #3.</p> <p>During a concurrent interview and observation on 12/2/2024 at 7:36 AM, with [NAME] (CK) 1 the tortillas, soda, coffee drink and plastic container were not foods for the residents. CK 1 stated those items should not be stored in the kitchen refrigerator and CK 1 asked another kitchen staff member to remove the items. stated</p> <p>During an interview on 12/2/2024 at 7:46 AM, with the Dietary Supervisor (DS), the DS stated those were staff food items and should not have been stored in the kitchen refrigerator. The DS further stated outside food is not stored in the kitchen refrigerators for infection control.</p> <p>During an interview on 12/5/2024 at 3:19 PM, the Director of Nursing (DON) stated staff store their food in the employee lounge. The DON further stated personal food were not stored in the kitchen refrigerator due to infection control and bringing in outside food and storing it with resident food could cause foodborne illness.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Food Brought by Family/Visitors, dated revised 7/12/2024, indicated, Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. The P&P further indicated Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator, containers will be labeled with the resident's name, the item and the use by date and the facility staff will discard perishable foods on or before the use by date.</p>		

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<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** 45455</p> <p>Based on observation, interview, and record review, for two of 18 residents (Residents 69 and 44), the facility failed to:</p> <ol style="list-style-type: none"> 1. Provide hand hygiene to Resident 69 prior to meals. 2. Label tube feeding (nutrition in a liquid form) according to facility policy and procedures for Resident 44. <p>These deficient practices had the potential to cause infection and cross contamination with infectious agents such as blood, body fluids, secretions and excretions (visible and invisible) for Residents 69 and 44.</p> <p>Findings:</p> <p>1. A review of Resident 69's Admission record indicated Resident 69 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included hyperlipidemia (a condition where there are high levels of lipids, or fats, in the blood), lack of coordination, encephalopathy (is a disturbance of brain function), hypertension (HTN-High blood pressure) and blindness to the left and right eye.</p> <p>A review of the History and Physical report completed on 9/13/2024, indicated Resident 69 did not have the capacity for medical decision making due to encephalopathy.</p> <p>A review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 11/21/2024, indicated Resident 69's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 69 was independent with eating and oral hygiene, toileting hygiene, shower bathing and upper and lower dressing, personal hygiene, and was ambulatory.</p> <p>During a facility tour on 12/2/2024 Resident 69 was observed standing up by the side of his bed, using the urinal and placing it back on the bed side rail and then getting back in bed. Resident 69. A long wooden walking stick was also observed at the head of Resident 69's bed.</p> <p>During a concurrent dining observation and interview on 12/03/24 at 12:20 PM Resident 69 was observed seated up at the edge of the bed with feet to the ground, Resident 69's bedside table was observed with a lunch tray meal and was placed in front of the Resident. Resident 69 was observed touching tray and food with free hands to feel for the food placement layout with his free hands. Resident 69 was observed eating food with free hands and not utilizing the spoons and utensils on his tray and eating independently. Resident 69's bedside side rail was observed to have a urinal with some urine in it. Resident 69 was asked if staff had explained to him the tray layout and/or offered assistance with hand washing. Resident 69 responded no to both questions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview of 12/3/24 at 12:45 PM, Certified Nurse Assistant (CNA) 1 stated, Resident 69 is independent with eating. CNA 1 stated she did not offer and/or see the resident wash his hands before eating with his bare hand. CNA 1 stated eating with bare hands without washing them can place the resident at risk for spread of bacteria and is an infection control issue.</p> <p>During an interview on 12/05/24 at 4:01 PM, the Director of Nursing (DON) stated Resident 69 should have been helped with hand washing before eating food with his free hands, for sanitation, infection control, prevention of disease.</p> <p>A review of facility policy and procedures titled infection control dated 7/12/2024 indicated, standard precautions (a set of practices that healthcare workers use to prevent the spread of infections) will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions, excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes.</p> <p>45528</p> <p>Cross reference F693</p> <p>2. A review of Resident 44's Admission Record indicated the facility admitted Resident 44 on 1/10/2020 and readmitted Resident 44 on 11/8/2024 with diagnoses including Dependent on respiratory ventilator (a medical device to help support or replace breathing), dysphagia (difficulty swallowing), and hypertension (HTN -high blood pressure).</p> <p>A review of Resident 44's MDS dated [DATE], indicated Resident 44 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 44 was dependent on staff for activities of daily living.</p> <p>During an observation on 12/2/2024, at 9:12 A.M., in Resident 44's room, the tube feeding bottle was observed hanging from Resident 44's feeding pole without a label (date and time hang) on the feeding formular bottle, water bag and tubing.</p> <p>During a concurrent observation and interview on 12/2/2024 at 9:20 A.M., with the Licensed vocational nurse 1(LVN 1), in Resident 44's room, the tube feeding formular bottle, water bag and tubing was observed hanging from Resident 44's feeding pole without a label with resident's name, type of feeding formular, rate, time or nurses initials. LVN 1 stated, the tube feeding formular bottle, water bag and tubing were not labeled with date and time, no label on the feeding bag that shows everything the time it was hang, who hang it, when it was hang. The label needs to be on the feeding, water and tube so the nurses can know when the feeding was hang to prevent infection, it is part of infection control practices.</p> <p>During a concurrent observation and interview on 12/2/2024 at 9:25 A.M., with the Registered Nurse Supervisor 1(RNS 1), in Resident 44's room, the tube feeding formular bottle, water bag and tubing was observed hanging from Resident 44's feeding pole without a label with resident's name, type of feeding formular, rate, time or nurses initials. RNS 1 stated, tube feeding, water bag, and tubing need to be changed and labeled for infection control reasons.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/5/2024, at 1:33 P.M., with the Director of Nursing (DON), the DON stated tube feeding set needs to have a label on it with the resident's name, room number, name of the formula, rate, date, and the nurse initials that hang it. DON stated the label ensures that the resident is being given the right feeding formular, the label should match the physician orders, the date because there is a certain amount of time to infuse the formular and for infection control purposes.</p> <p>A review of the facility's policy and procedures titled, Enteral Feeding reviewed 7/12/2024, indicated, The facility will remain current in and follow accepted best practices in enteral nutrition .</p> <p>4. On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order .</p>

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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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528</p> <p>Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) before administering an influenza vaccine (flu vaccine -an injection that helps prevent the flu and its complications) for one of five sampled residents (Resident 41). Resident 41 received the Influenza vaccine on 11/4/2024 and the consent for Influenza vaccine was obtained on 11/8/2024.</p> <p>This deficient practice violated the responsible party's (RP) right to be notified in order to make an informed choices for Resident 41 to receive or not to receive the influenza vaccine.</p> <p>Finding:</p> <p>A review of Resident 41's Admission Record indicated the facility admitted Resident 41 on 6/30/2022 and readmitted Resident 41 on 4/1/2024 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage).</p> <p>A review of Resident 41's Minimum Data Set (MDS - a resident assessment tool) dated 10/31/2024, indicated Resident 41 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 41 was dependent on staff for activities of daily living.</p> <p>A review of Resident 41's medication administration record (MAR) dated 11/4/2024, indicated, administer flu vaccine 0.5 millimeters (ml-unit of measure in liquid) intramuscular (IM -into the muscle).</p> <p>During a concurrent interview and record review, on 12/5/2024, at 1:43 P.M., with the Infection Preventionist Nurse (IPN), Resident 41's MAR dated 11/4/024 and Immunization consent form dated 11/8/2024 were reviewed. The MAR indicated influenza vaccine was administered on 11/4/2024 and the immunization consent form indicated date of 11/8/2024. IPN stated Resident 41 received the Influenza vaccine on 11/4/2024 and the consent for Influenza vaccine was obtained on 11/8/2024 from Resident 41's RP. IPN stated informed consent should have been obtained prior to the influenza vaccine being given because if the vaccination is given before the consent, it takes away the choice to make a decision whether to get it or not.</p> <p>During an interview on 12/5/2024, at 2:26 P.M., with the Director of Nursing (DON), the DON stated informed consent for vaccinations needs to be obtained upon admission and before giving the vaccination. The DON stated the informed consent is to get permission from the resident and honor the resident's rights.</p> <p>A review of the facility's policy and procedures (P&P) titled, Influenza vaccine reviewed 7/12/2024, indicated, Procedure:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER New Vista Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1516 Sawtelle Blvd. Los Angeles, CA 90025	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. A consent for vaccination or declination to receive to receive the vaccine will be obtained each year from the patient (or medical decision maker of the patient) and from the employees.</p> <p>A review of the facility's P&P titled, Informed Consent -psychotropic Medication/medical devices/[NAME] procedure reviewed 7/12/2024, indicated, Informed Consent -psychotropic Medication/medical devices/[NAME] procedures:</p> <p>a. Make decisions with regard to his/her medical condition.</p> <p>b. Accept or refuse proposed treatment.</p>		