STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing and Rehabilitation Center	8647 Fenwick Street. Sunland, CA 91040

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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42275 Based on interview and record review, the facility failed to notify a resident ' s physician regarding an increase in episodes of yelling after discontinuing Seroquel (antipsychotic, a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) for one of six sampled residents (Resident 1). This deficient practice had the potential to result in worsening symptoms and negatively affect the delivery of care and services to Resident 1. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 9/7/2023 with diagnoses that included dementia (a progressive state of decline in mental abilities), psychosis, and hemiplegia (one-sided paralysis [complete or partial loss of muscle function]) and hemiparesis (one-sided muscle weakness) following cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 1 was usually able to make self-understood and usually understood others, and Resident 1 ' s cognition (ability to think and make decisions) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene, lower body dressing and sit to stand, and required maximum assistance from staff for oral hygiene, upper body dressing, personal hygiene, lying to sitting on side of bed and transfer. During a review of Resident 1 ' s physician order dated 3/11/2025, the physician order indicated the physician discontinued Resident 1 ' s Seroquel 25 milligram (mg - a unit of measurement) one tablet by mouth at bedtime for psychotic disorder manifested by yelling on 3/11/2025. During a review of Resident 1 ' s Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/2025, the MAR indicated Resident 1 ' s yelling episodes as follows: - On 4/12/2025 3 p.m.-11 p.m. shift: Two episodes of yelling - On 4/16/2025 7 a.m.-3 p.m. shift: Two episodes of yelling (continued on next page)

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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 - Some	- On 4/16/2025 3 p.m.-11 p.m. shift: Two episodes of yelling - On 4/16/2025 11 p.m.-7 a.m. shift: Two episodes of yelling - On 4/17/2025 7 a.m.-3 p.m. shift: Two episodes of yelling - On 4/17/2025 3 p.m.-11 p.m. shift: Two episodes of yelling - On 4/17/2025 11 p.m.-7 a.m. shift: Two episodes of yelling - On 4/18/2025 7 a.m.-3 p.m. shift: Two episodes of yelling - On 4/18/2025 3 p.m.-11 p.m. shift: Two episodes of yelling During a concurrent interview and record review on 5/5/2025 at 10:25 a.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 1 ' s MAR dated 4/2025 for monitoring episodes of yelling and Resident 1 ' s physician order dated 3/11/2025 indicating the discontinuing of Seroquel. LVN 2 stated that the nurses needed to monitor the residents ' behaviors after discontinuing a psychotropic medication (medications capable of affecting the mind, emotions, and behavior) for any behavior changes and should inform the physician if there are any increased behavioral issues for a psychiatric re-evaluation. LVN 2 stated Resident 1 had two episodes of yelling on 4/12/2025 during the 3 p.m.-11 p.m. shift, two episodes of yelling on 4/16/2025 during the 7 a.m.-3 p.m., 3 p.m.-11 p.m., and 11 p.m.-7 a.m. shift, two episodes of yelling on 4/17/2025 during the 7 a.m.-3 p.m., 3 p.m.-11 p.m., and 11 p.m.-7 a.m. shift, and two episodes of yelling on 4/18/2025 during the 7 a.m.-3 p.m. and 3 p.m.-11 p.m. shift. LVN 2 stated LVN 2 was on duty on 4/17/2025 and 4/18/2025 for the 7 a.m.-3 p.m. shifts and marked on Resident 1 ' s MAR that Resident 1 had two episodes of yelling. LVN 2 stated LVN 2 did not notify Resident 1 ' s physician of Resident 1 ' s increased episodes of yelling. During a concurrent interview and record review on 5/5/2025 at 1:45 p.m., with the Director of Nursing (DON), reviewed Resident 1 ' s MAR dated 4/2025 for monitoring episodes of yelling, Resident 1 ' s physician order dated 3/11/2025 indicating the discontinuing of Seroquel, Resident 1 ' s Situation-Background-Assessment-Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) and Change of Condition (COC- a sudden clinically important deviation from a resident ' s baseline in physical, cognitive, behavioral, or functional domains) from 4/12/2025 to 4/18/2025, and Resident 1 ' s progress notes from 4/12/2025 to 4/18/2025. The DON stated that the DON was unable to locate documentation indicating that Resident 1 ' s physician was notified of Resident 1 ' s increased yelling episodes. The DON stated the nursing staff should notify the physician to reevaluate Resident 1 ' s behavioral issues after discontinuing Seroquel on 3/11/2025. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure titled, Change of Condition, last reviewed on 2/26/2025, the policy indicated, It is the policy of this facility that all changes in the resident condition will be documented in the medical record and communicated to the physician and resident/responsible party. Any sudden or serious change in a resident ' s condition manifested by a marked change in physical or mental behavior, will be communicated to the physician as soon as identified. Licensed nurse will use the ' Advanced SBAR Change of Condition Documentation/COC form ' to evaluate the situation, identify problem, gather information on applicable systems and report key items to the physician In addition to the Advanced SBAR Change of Condition Documentation/COC form, licensed and staff will continue to document follow up and the nurse ' s actions in the licensed progress notes as needed.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to protect the resident ' s right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of six sampled residents (Resident 1) when on 4/19/2025, Resident 2 hit Resident 1 ' s face several times with a fist (a person ' s hand when the fingers are bent in toward the palm and held there tightly). This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. Resident 1 sustained hematoma (a type of discoloration [change in skin color] caused by bleeding under the skin) on the left dorsal (on the back) hand, left eye and left nostril, and skin lacerations (or skin cut, a deep cut or tear in the skin) on the nasal septum (the thin wall that separates the right and left sides of the nose), left eye, left lower lip, and left lower chin requiring transfer to General Acute Care Hospital 1 (GACH 1) for further evaluation and suturing (the process of using stitches [known as sutures - typically made from thread-like materials and are used to bring the edges of a wound together to promote healing] to close as wound). Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 9/7/2023, with diagnoses that included cerebral infarction (often referred to as a stroke, death of brain tissue caused by a blockage or disruption of blood flow to the brain) with hemiplegia (severe or complete loss of strength leading to paralysis [loss of ability to move] on one side of the body) and hemiparesis (weakness or inability to move one side of the body), dementia (a progressive state of decline in mental abilities), During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene and lower body dressing, and required maximum assistance from staff for oral hygiene, upper body dressing, personal hygiene, and mobility [movement]. During a review of Resident 1 ' s Situation- Background- Assessment- Recommendation (SBAR- a form that provides a framework for communication between members of the health care team about a resident ' s condition) Communication Form dated 4/19/2025, timed at 6:00 p.m., the SBAR indicated on 4/19/2025 Resident 1 was hit by his roommate (Resident 2) and as a result Resident 1 sustained facial cuts and a cut on his (Resident 1) nose. The SBAR further indicated Resident was observed with a bloody face. The SBAR indicated Resident 1 ' s physician was notified with a new order to transfer Resident 1 to a hospital for further evaluation and treatment. During a review of Resident 1 ' s Physician Order dated 4/19/2025, timed at 11:30 p.m., the Physician Order indicated to transfer Resident 1 to GACH 1 for further evaluation due to cuts on the lip and nose. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Discharge Skin and Body assessment dated [DATE], the Skin and Body Assessment indicated the following skin conditions: 1. Skin cut on left eye area measuring 1.5 centimeters (cm - unit of length) 2. Skin cut on nose area measuring 0.5 cm 3. Skin cut on left side of lip area measuring 0.5 cm 4. Skin cut on left lower chin area measuring 1.5 cm 5. Hematoma on Resident 1 ' s left dorsal hand During a review of Resident 1 ' s Physician Order dated 4/20/2025, timed at 5:24 p.m., the Physician Order indicated to readmit the resident (Resident 1) to the facility. During a review of Resident 1 ' s Skin assessment dated [DATE] (upon Resident 1 ' s return to the facility), the Skin Assessment indicated the following skin conditions: 1. Nasal Septum cut closed with two stitches, measuring 1.5 cm in length and zero cm in width. 2. Left eye cut closed with one stitch, measuring 0.6 cm in length and zero cm in width. 3. Left lower lip cut closed with four stitches, measuring two cm in length and zero cm in width 4. Left lower chin cut closed with two stitches, measuring one cm in length and zero cm in width 5. Left dorsal hand hematoma measuring two cm in length and two cm in width 6. Left eye hematoma measuring three cm in length and five cm in width 7. Left nostril hematoma measuring one cm in length and 0.5 cm in width 8. Left eye bruise (a type of injury where small blood vessels under the skin break, usually due to trauma [serious physical injury] or impact, causing blood to leak into surrounding tissues) with swelling (enlargement or puffiness of a body part due to accumulation of fluid in the tissues that can occur from injury or trauma). During a review of Resident 1 ' s Physician Orders dated 4/20/2025, the Physician Orders indicated the following: 1. Nasal Septum cut with two stitches: Cleanse with normal saline (NS - a saltwater solution used to clean wounds). Pat dry and leave open to air every day shift for laceration for 14 days. 2. Left eye cut with one stitch: Cleanse with NS. Pat dry and leave open to air every day shift for laceration for 14 days. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	3. Left lower lip cut with four stitches: Cleanse with NS. Pat dry and leave open to air every day shift for laceration for 14 days. 4. Left lower chin cut with two stitches: Cleanse with NS. Pat dry and leave open to air every day shift for laceration for 14 days. 5. Left dorsal hand hematoma: Monitor left dorsal hand hematoma for signs and symptoms (s/s - signs are objective findings that can be observed or measured by a healthcare professional, symptoms are subjective experiences reported by the resident) of skin breakdown every shift for 30 days. 6. Left eye hematoma: Monitor left eye hematoma for s/s of skin breakdown every shift for 30 days. 7. Left nostril hematoma: Monitor left nostril hematoma for s/s of skin breakdown every day shift for 30 days. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 4/24/2024 with diagnoses that included age-related cognitive decline (refers to the gradual decline in thinking abilities that can occur as people age) and alcohol dependence (a condition where a person ' s drinking pattern becomes problematic leading to significant health, social or occupational difficulties). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition. The MDS further indicated that Resident 2 required moderate assistance from staff for personal hygiene and upper and lower body dressing, and supervision with toileting hygiene and mobility. During a review of Resident 2 ' s SBAR dated 4/19/2025, timed at 6:00 p.m., the SBAR indicated that on 4/19/2025, Resident 2 exhibited an aggressive behavior towards his (Resident 2 ' s) roommate and hit his (Resident 2 ' s) roommate (Resident 1) in the face causing skin cuts and bleeding from nose. During a review of Resident 2 ' s Physician Order dated 4/19/2025, timed at 6:30 p.m., the Physician Order indicated to arrange Resident 2 ' s transfer to an inpatient psychiatric care (receiving mental health treatment while staying overnight in a hospital or treatment facility) due to sudden onset of aggressive behavior. During a review of Resident 2 ' s Physician Order dated 4/20/2025, timed at 1:10 a.m., the Physician Order indicated to transfer Resident 2 to GACH 1 (same hospital Resident 1 was transferred) instead for evaluation of sudden behavioral changes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/2/2025 at 11:20 a.m. with Resident 1 and Admissions Coordinator 1 (AC 1), in Resident 1 ' s room, Resident 1 stated he does not remember the specific date but recalls his (Resident 1 ' s) former roommate (Resident 2) hit him (Resident 1) on the face (while pointing to Resident 1 ' s left eye, nose and left side of chin). Resident 1 stated that at the time of the incident, he (Resident 1) was calling the nurses to obtain assistance however Resident 2 did not like it and started hitting Resident 1 in the face several times with Resident 2 ' s fist. Resident 1 further stated he was very upset following the incident, during which Resident 1 was hit in the face multiple times by Resident 2 with a fist. Resident 1 stated he (Resident 1) could not express with the right words how he (Resident 1) feels but wanted to press charges against Resident 2. During an interview on 5/2/2025 at 4:42 p.m., with the Director of Nursing (DON), the DON stated that Resident 2 hitting Resident 1 in the face several times with a fist is physical abuse. The DON stated the incident on 4/19/2025 (involving Resident 1 and Resident 2) resulted in actual harm to Resident 1. During a phone interview on 5/5/2025 at 12:41 p.m., with Registered Nurse 2 (RN 2), RN 2 stated that he (RN 2) heard screaming and an agitated voice (a voice that is upset or expressing worry, often showing signs of distress [indicates a condition where a person is in extreme danger and needs urgent help]) coming from the shared room of Resident 1 and Resident 2 while RN 2 was walking through the hallway. RN 2 stated he (RN 2) then entered the shared room of Resident 1 and Resident 2 and observed Resident 1 lying in his (Resident 1 ' s) bed with visible facial bleeding. RN 2 stated Resident 2 was unable to provide an explanation of the incident. During a review of the facility ' s policy and procedure (P&P) titled, Abuse Prevention/Investigation/Reporting and Resolution, last reviewed on 2/26/2025, indicated This facility will protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition), for whom we provide care and treatment against any and all forms of physical, verbal, mental abuse .that are necessary to avoid physical harm, and to attain or maintain physical, mental, and psycho-social well-being of the residents.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to implement its policy and procedures (P&P) for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act by failing to report to the State Survey Agency (SSA) an allegation of physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) within two (2) hours of the incident for one of six sampled residents (Resident 1). This deficient practice resulted in a delay in an onsite inspection by the SSA to ensure the safety of the other residents and had the potential to result in unidentified abuse. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 9/7/2023, with diagnoses that included cerebral infarction (often referred to as a stroke, death of brain tissue caused by a blockage or disruption of blood flow to the brain) with hemiplegia (severe or complete loss of strength leading to paralysis [loss of ability to move] on one side of the body) and hemiparesis (weakness or inability to move one side of the body), dementia (a progressive state of decline in mental abilities), During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene and lower body dressing, and required maximum assistance from staff for oral hygiene, upper body dressing, personal hygiene, and mobility [movement]. During a review of Resident 1 ' s Situation- Background- Assessment- Recommendation (SBAR- a form that provides a framework for communication between members of the health care team about a resident ' s condition) Communication Form dated 4/19/2025, timed at 6:00 p.m., the SBAR indicated on 4/19/2025 Resident 1 was hit by his roommate (Resident 2) and as a result Resident 1 sustained facial cuts and a cut on his (Resident 1) nose. The SBAR further indicated Resident was observed with a bloody face. The SBAR indicated Resident 1 ' s physician was notified with a new order to transfer Resident 1 to a hospital for further evaluation and treatment. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 4/24/2024 with diagnoses that included age-related cognitive decline (refers to the gradual decline in thinking abilities that can occur as people age) and alcohol dependence (a condition where a person ' s drinking pattern becomes problematic leading to significant health, social or occupational difficulties). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition. The MDS further indicated that Resident 2 required moderate assistance from staff for personal hygiene and upper and lower body dressing, and supervision with toileting hygiene and mobility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s SBAR dated 4/19/2025, timed at 6:00 p.m., the SBAR indicated that on 4/19/2025, Resident 2 exhibited an aggressive behavior towards his (Resident 2 ' s) roommate and hit his (Resident 2 ' s) roommate (Resident 1) in the face causing skin cuts and bleeding from nose. During a review of the Communication Result Report (CRR) sent by the facility to the SSA dated 4/19/2025, the CRR indicated that the facility reported the alleged physical abuse to the SSA via the facsimile (known as fax - the telephonic transmission of scanned-in printed material) on 4/19/2025 at 7:52 p.m. (approximately three [3] hours and 12 minutes after being informed of the incident). During a phone interview on 5/5/2025 at 1 p.m., with Registered Nurse 2 (RN 2), RN 2 was asked about the time of the alleged physical abuse that occurred on 4/19/2025 in the shared room of Resident 1 and Resident 2. RN 2 was informed that Resident 1' s SBAR indicated that the physician was notified of the alleged resident abuse on 4/19/2025 at 5 p.m. RN 2 stated that the incident probably occurred at around 4:40 p.m., then RN 2 called to notify the Director of Nursing (DON) about 20 minutes later after the incident happened and after providing first aid to Resident 1. During a concurrent interview and record review on 5/5/2025 at 1:33 p.m., with the DON, reviewed the CRR dated 4/19/2025 timed 7:52 pm. The DON stated that the DON received the first phone call from RN 2 on 4/19/2025 at 5:45 p.m., which was missed then another phone call from the Administrator on 4/19/2025 at 5:57 p.m. The DON reviewed Resident 1 ' s SBAR dated 4/19/2025 which indicated that the physician was notified for the alleged resident abuse on 4/19/2025 at 5 p.m., but the DON stated that RN 2 called the DON right away when the incident happened at 5:45 p.m., so, if counted from the time 5:45 p.m., the facility should have been reported in two (2) hours by 7:45 p.m. on 4/19/2025 but the facility reported seven (7) minutes late from the required time of reporting. During a review of the facility ' s P&P titled, Abuse Prevention/Investigation/Reporting and Resolution, last reviewed on 2/26/2025, the policy indicated, All alleged violations involving abuse, neglect (failure to provide adequate care or services), exploitation (deliberate misplacement, exploitation [taking advantage of a resident], or wrongful, use of a resident's belongings or money without the resident's consent), or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. To the state licensing/certification agency responsible for surveying/licensing the facility; An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or,

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 42275 Based on interview and record review, the facility failed to monitor and provide ongoing assessment of a resident ' s behavioral health needs, as to whether the interventions are improving and stabilizing the resident ' s status or causing adverse consequences after discontinuing Seroquel (antipsychotic, a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) for one of six sampled residents (Resident 1). This deficient practice had the potential to negatively affect Resident 1 ' s psychosocial (the mental, emotional, social, and spiritual aspects of a person ' s life) well-being. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 9/7/2023 with diagnoses that included dementia (a progressive state of decline in mental abilities), psychosis, and hemiplegia (one-sided paralysis [complete or partial loss of muscle function]) and hemiparesis (one-sided muscle weakness) following cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 1 was usually able to make self-understood and usually understood others, and Resident 1 ' s cognition (ability to think and make decisions) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene, lower body dressing and sit to stand, and required maximum assistance from staff for oral hygiene, upper body dressing, personal hygiene, lying to sitting on side of bed and transfer. During a review of Resident 1 ' s physician order dated 3/11/2025, the physician order indicated the physician discontinued Resident 1 ' s Seroquel 25 milligram (mg - a unit of measurement) one tablet by mouth at bedtime for psychotic disorder manifested by yelling on 3/11/2025. During a review of Resident 1 ' s Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/2025, the MAR indicated Resident 1 ' s yelling episodes as follows: - On 4/12/2025 3 p.m.-11 p.m. shift: Two episodes of yelling - On 4/16/2025 7 a.m.-3 p.m. shift: Two episodes of yelling - On 4/16/2025 3 p.m.-11 p.m. shift: Two episodes of yelling - On 4/16/2025 11 p.m.-7 a.m. shift: Two episodes of yelling - On 4/17/2025 7 a.m.-3 p.m. shift: Two episodes of yelling (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing and Rehabilitation Center	8647 Fenwick Street. Sunland, CA 91040

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/17/2025 3 p.m.-11 p.m. shift: Two episodes of yelling - On 4/17/2025 11 p.m.-7 a.m. shift: Two episodes of yelling - On 4/18/2025 7 a.m.-3 p.m. shift: Two episodes of yelling - On 4/18/2025 3 p.m.-11 p.m. shift: Two episodes of yelling During a concurrent interview and record review on 5/2/2025 at 2:30 p.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 1 ' s Nurses ' Weekly Progress Notes (NWPN) completed after Resident 1 ' s Seroquel was discontinued on 3/11/2025. The MDSC stated that Resident 1 ' s NWPN were done on 3/17/2025, 3/24/2025, 3/31/2025, 4/7/2025, and 4/29/2025. The MDSC stated Resident 1 ' s NWPNs were missing for the third and fourth week of 4/2025. The MDSC stated that the licensed nursing staff should monitor and document the resident ' s emotional conditions or psychosocial needs at least once a week at a minimum, especially after discontinuing psychotropic medications. During a concurrent interview and record review on 5/2/2025 at 3 p.m., with the Director of Nursing (DON), reviewed Resident 1 ' s physician order for Seroquel and stated that it was discontinued on 3/11/2025. The DON stated the nursing staff still needed to monitor Resident 1 ' s behaviors to see if the resident was okay without the psychotropic medications (medications capable of affecting the mind, emotions, and behavior). The DON stated that with increased episodes of behavioral issues, the nurses should notify the physician. During a concurrent interview and record review on 5/5/2025 at 10:25 a.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 1 ' s MAR dated 4/2025 for monitoring episodes of yelling and Resident 1 ' s physician order dated 3/11/2025 indicating the discontinuing of Seroquel. LVN 2 stated that the nurses needed to monitor the residents ' behaviors after discontinuing a psychotropic medication for any behavior changes and should inform the physician if there are any increased behavioral issues for a psychiatric re-evaluation. During a review of the facility ' s policy and procedure titled, Behavioral Management, last reviewed on 2/26/2025, the policy indicated, It is the policy of this facility to ensure that when a resident displays mental or psychosocial adjustment difficulties, he/she receives appropriate treatment and services to correct the identified problems in order to obtain or maintain the highest practical physical, mental, and psychosocial well-being Documentation Requirements Licensed nurses ' weekly progress notes may reflect the effectiveness of the psychotropic medication and reduction program in place, and any side effects experienced by the resident and intervention taken.