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	08/05/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit one of three sampled residents (Resident 1) to return to the facility after Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) for psychiatric (the branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) evaluation. This deficient practice subjected Resident 1 to an unnecessary prolonged hospitalization, violated Resident 1's rights to return to their facility, and has the potential to result in Resident 1's displacement in an unfamiliar facility requiring adjusting to new surroundings.During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 4/12/2025 with diagnoses that included difficulty walking, alcohol abuse (a pattern of alcohol use that involves problems controlling your drinking, being preoccupied with alcohol or continuing to use alcohol even when it causes problems), alcohol dependence (condition where a person experiences a strong compulsion to drink alcohol and is unable to control their drinking despite negative consequences) with withdrawal (symptoms that may occur when a person who has been drinking too much alcohol on a regular basis suddenly stops drinking alcohol), unspecified psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) not due to substance or known physiological condition, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), poisoning by fentanyl (used to treat severe pain) or fentanyl analogs, accidental (unintentional), unsheltered homelessness. During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool) dated 6/5/2024, the MDS indicated that Resident 1 was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impaired and was dependent from staff for transfer, dressing, toilet use, personal hygiene, and bathing.During a review of Resident 1's physician order, the physician order indicated an order to transfer via 5150 (a 72-hour hold [temporary detention] for mental health evaluation) to GACH 1, dated 7/31/2025 timed 1:42 p.m.During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Communication Form dated 7/31/2025, the SBAR indicated Resident 1 was physically aggressive towards staff. Danger to others evidenced by physical assault to staff.During a review of Resident 1's Nurses Notes dated 7/31/2025 timed 1:42 p.m., the Nurses Notes indicated Resident 1 placed on hold for danger to others escorted by law enforcement to GACH 1 psychiatric unit.During a review of Resident 1's GACH 1 Emergency Documentation note dated 7/31/2025 timed 6:27 p.m., the Emergency Documentation note indicated that psychiatry (psych- a branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) is not accepting hold. During a review of Resident 1's GACH 1 Emergency Documentation note dated 7/31/2025 timed 8:48 p.m., facility will not be taking resident, resident cannot be transferred to Psych Emergency Department (ED) for further management given patient will not be on a hold.During a review of Resident 1's GACH 1 Psych ED Consultation note dated 7/31/2025 timed 5:21 p.m., the Psych ED Consultation note indicated Resident 1 wants to go back to the facility and continue physical rehabilitation. The Psych ED Consultation note indicated the facility denied that Resident 1 made any threats. Does not want Resident 1 to come back to the facility because Resident 1 gets agitated and Resident 1 leaves during the day. Hold Not accepted. Legal: No hold.During a review of Resident 1's GACH 1 History and Physical (H&P) report dated 8/1/2025 timed 2:48 a.m., the H&P indicated Resident 1 was evaluated by psychiatry and does not meet criteria for hold. No acute psychiatric concerns. Placement: Facility declines for resident to return to previous arrangement. Pending placement.During a review of the facility's census (daily list indicating resident names with corresponding room numbers) dated 7/31/2025 (census for 8/1/2025), 8/1/2025 (census for 8/2/2025), 8/2/2025 (census for 8/3/2025), 8/3/2025 (census for 8/4/2025, and 8/4/2025 (census for 8/5/2025), the facility's census indicated that there was three available male beds (room [ROOM NUMBER]-B and room [ROOM NUMBER] A/B) in the facility. During an interview on 8/5/2025 at 2:41 p.m., with the GACH Social Worker (GACH SW), the GACH SW stated that on 7/31/2025, Resident 1 was seen by a psychiatrist in the GACH ED. The GACH SW stated Resident 1 did not meet the criteria for a 5150 hold. The GACH SW stated the emergency room physicians determined Resident 1 was cleared to be discharged on 7/31/2025 and go back to the facility. The GACH SW stated there was no reason for Resident 1 to be in the GACH. The GACH SW stated that she spoke to the Director

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide the resident and/or the resident's responsible party with a notice for bed hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) prior to transferring to General Acute Care Hospital 1 (GACH 1) for one of three sampled residents (Resident 1).This deficient practice had the potential to deprive the resident and/or the resident's responsible party the right to be informed of their rights regarding bed holds. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 4/12/2025 with diagnoses that included difficulty walking, alcohol abuse (a pattern of alcohol use that involves problems controlling your drinking, being preoccupied with alcohol or continuing to use alcohol even when it causes problems), alcohol dependence (condition where a person experiences a strong compulsion to drink alcohol and is unable to control their drinking despite negative consequences) with withdrawal (symptoms that may occur when a person who has been drinking too much alcohol on a regular basis suddenly stops drinking alcohol), unspecified psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) not due to substance or known physiological condition, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), poisoning by fentanyl (used to treat severe pain) or fentanyl analogs, accidental (unintentional), unsheltered homelessness. During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool) dated 6/5/2024, the MDS indicated that Resident 1 was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impaired and was dependent from staff for transfer, dressing, toilet use, personal hygiene, and bathing.During a review of Resident 1's physician order, the physician order indicated an order to transfer via 5150 (a 72-hour hold [temporary detention] for mental health evaluation) to GACH 1, dated 7/31/2025 timed 1:42 p.m.During a concurrent interview and record review on 8/5/2025 at 8:52 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 1's physician orders and progress notes dated 7/31/2025. RN 1 stated that there is no documented evidence that Resident 1 was informed or given a bed hold on 7/31/2025 when he was transferred to GACH 1. RN 1 stated that Resident 1 does not have a bed hold order. RN 1 continued to state that a physician's order is needed for bed holds. During a concurrent interview and record review on 8/5/2025 at 9:19 a.m., with the Director of Nursing (DON), reviewed Resident 1's physician orders and progress notes dated 7/31/2025. The DON stated that Resident 1 was transferred to GACH 1 on 7/31/2025 and Resident 1 does not have an order for a bed hold. When asked if residents need an order for bed hold, the DON stated that she was not sure and had to check the facility's policy. The DON stated that a bed hold is important to ensure that a resident who is transferred to the hospital has a bed to come back to if the resident comes back to the facility within seven days of transfer. During a review of the facility's policy and procedure (P&P) titled, Discharge Process, dated 5/14/2025, the P&P indicated before the facility transfers a resident to an acute hospital or the resident goes on a therapeutic leave, the facility will provide written information to the resident and their representative that specifies the following: the duration of the state bed hold policy during which the resident is permitted to return and resume residence; the information in the notice described above.