

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER New Vista Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>38469</p> <p>Based on observation, interview and record review, the facility failed to ensure a facility staff member provided privacy while doing a blood sugar level check (procedure to check the amount of sugar in the blood) and administered medications for one of three residents (Resident 99).</p> <p>This deficient practice violated the resident's right to privacy which had the potential to affect the resident's sense of self-worth and self-esteem.</p> <p>Findings:</p> <p>During a review of Resident 99's Admission Record, the document indicated the facility admitted the resident on 3/27/2024 with diagnoses including difficulty in walking and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]).</p> <p>During a review of Resident 99's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 7/3/2024, the document indicated that the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated the resident required substantial/maximal assistance with upper body dressing, lower body dressing, putting on and taking off footwear and personal hygiene.</p> <p>During a concurrent observation and interview on 10/9/2024 at 4:24 p.m., with Licensed Vocational 1 (LVN1), observed LVN 1 proceed to Resident 99's bedside and administered two oral medications and used the blood glucose meter (BGM- a small portable device used to measure the amount of sugar in the blood) to obtain Resident 99's blood sugar level. Observed LVN 1 not close the privacy curtain while performing the blood sugar testing and Resident 99 was within sight of their roommate and from the hallway. LVN 1 stated that she should have closed the curtain when administering Resident 99's medication and when checking their blood sugar. LVN 1 stated resident's privacy and dignity must be respected and promoted and not doing so violates their rights of a dignified existence.</p> <p>During a review of the facility's policy and procedure titled, Dignity and Privacy, dated 11/28/2018, the policy indicated, It is the policy of this 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>

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 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>50033</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents' rooms (Resident 45) was within a comfortable temperature range of 71 degrees Fahrenheit (F, unit of temperature) to 81 F.</p> <p>This deficient practice placed Resident 45 at risk for being in an uncomfortable environment due to the temperature being less than 71 F.</p> <p>Findings:</p> <p>During a review of Resident 45's Admission Record, the document indicated the facility originally admitted the resident on 1/27/2020 and readmitted the resident on 5/7/2021 with diagnoses including acute kidney failure (when the kidneys suddenly can't filter waste products from the blood) and gout (a type of arthritis [a condition that causes sudden and severe pain and swelling in the joints]).</p> <p>During a review of Resident 45's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated the resident was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact. The MDS further indicated the resident was dependent on staff for transferring from a bed to a chair and required moderate assistance for toileting and personal hygiene.</p> <p>During an interview on 10/7/2024 at 10:37 a.m., with Resident 45, Resident 45 stated the facility temperature is freezing at night and is also too cold at times during the day.</p> <p>During a concurrent observation and interview on 10/9/2024 at 8:25 a.m., with Environmental Services 1 (EVS 1) in Resident 45's room, EVS 1 took the temperature in the room with an infrared thermometer (or known as a temperature gun- a device that measures an object's temperature from a distance by detecting infrared radiation emitted by the object). The temperature on the floor was 69.1 F and the temperature near the vent on the ceiling was 60.2 F. EVS 1 stated the facility's policy is to keep rooms between 71 and 81 F and the temperature in Resident 45's room should be increased.</p> <p>During an interview on 10/10/2024 at 1:31 p.m., with the Environmental Services Director (ESD), the ESD stated the facility's policy is to keep resident rooms between 71 and 81 F. The ESD stated he has had some complaints that rooms are too cold, so they check room temperatures between 5 and 6 a.m. to make sure temperatures are within range. The ESD stated if a room is at 69.1 F he would adjust the set temperature to make it a little bit higher. The ESD stated the resident could be uncomfortable if the temperature is below the acceptable 71-81 F range.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, reviewed 2/29/2024, the P&P indicated residents are to be provided with a safe, clean, comfortable, and homelike environment which includes comfortable and safe temperature levels between 71 and 81 F.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49947</p> <p>Based on interview and record review, the facility failed to:</p> <p>1. Ensure one of one sampled resident's (Resident 65's) representative (RR 1) was invited and participated in Interdisciplinary Team (IDT - a group of professionals with different areas of expertise who work together to achieve a common goal for the resident) care plan meetings (a written document that summarizes a resident's needs, goals, and care/treatment).</p> <p>This deficient practice denied Resident 65 and RR 1's involvement in planning interventions related to the resident's recent weight loss.</p> <p>2. Ensure the hospice (program that provides care and support for people who are nearing the end of their life and have stopped treatment to cure or control their disease) care provider was invited and included in the development of one of one resident's (Resident 24) care plan.</p> <p>This deficient practice had the potential to result in failure to deliver the necessary care and services.</p> <p>Findings:</p> <p>a. During a review of Resident 65's Admission Record, the document indicated the facility admitted the resident on 9/4/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive group of lung diseases that make it hard to breathe), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), personal history of transient ischemic attack (TIA - a temporary disruption in the blood supply to part of the brain) and cerebral infarction (a serious condition when blood flow to the brain is blocked, causing brain tissue to die).</p> <p>During a review of Resident 65's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition), dated 9/6/2024, the document indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 65's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 9/11/2024, the document indicated the resident needed substantial assistance from staff for toileting, dressing, showering, and personal hygiene, and some assistance for eating.</p> <p>During a review of Resident 65's IDT Weight Management care plans (a written document that summarizes a resident's needs, goals, and care/treatment) dated 9/18/2024, 9/25/2024 and 10/2/2024. The document indicated RR 1 was notified but did not specify if she was invited.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/7/2024 at 12:32 p.m., in Resident 65's room with RR 1, RR 1 stated that Resident 65 had lost over 10 pounds (lbs. - unit to measure for weight) in about a month and the facility did not invite her to the IDT meetings on 9/18/2024, 9/25/2024 and 10/2/2024 addressing Resident 65's weight loss, but only told her what happened during the meeting after the meetings were held. RR 1 further stated, she is Resident 65's wife and should be involved in something so important and her input is invaluable as she knows Resident 65 the best. RR 1 stated she felt disappointed that she was not invited to the three IDT meetings.</p> <p>During an interview on 10/8/2024 at 11:32 a.m., with the Director of Nursing (DON), the DON confirmed by stating the facility did not have the opportunity to invite RR 1 to the IDT meetings on 9/18/2024, 9/25/2024 and 10/2/2024, but the facility should have. The DON stated RR 1's input would have been valuable, and she had the right to attend the meeting.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Development of Resident Care Plan/IDT Meeting, last reviewed on 4/1/2024, the P&P indicated residents and family members are invited to attend the care planning conference and participate in developing and reviewing the care plan.</p> <p>38469</p> <p>b. During a review of Resident 24's Admission Record, the document indicated the facility admitted the resident on 4/7/2023 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]).</p> <p>During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/12/2024, the document indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired and required substantial/maximal assistance from staff for toileting, shower, dressing and for personal hygiene.</p> <p>During a concurrent interview and record review on 10/9/2024 at 10:05 a.m., with Registered Nurse 1 (RN 1) and the Social Services Director (SSD), reviewed Resident 24's Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) Care Conference dated 4/12/2024 and 7/12/2024. The documents indicated that there was no invitation extended to the hospice care team for collaboration in developing Resident 24's care plan. The SSD stated that hospice care team should be part of the care planning process so that everybody in the IDT is on the same page and are aware of the resident's current medical status. The SSD stated that there must be a collaboration of care between facility staff and the hospice care team and updates on the resident's conditions are communicated during this meeting. RN 1 stated that without collaboration, Resident 24 may not be provided with the necessary care and services the resident is entitled to.</p> <p>During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/29/2024, the policy indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Hospice Care Planning, last reviewed on 2/29/2024, the policy indicated the facility will utilize the interdisciplinary team to provide an individualized resident assessment and care planning between the facility and hospice team. This approach will maximize and maintain every resident's comfort, resident requests and family being integrated into the ongoing plan of care. The hospice/facility care plan will be available in the resident's medical record for review as needed .</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for one of two sampled resident (Resident 203) by failing to follow the facility's policy and procedure when performing a fingerstick (a procedure in which a finger is pricked with a lancet [a small needle] to draw a tiny drop of blood for testing) to check Resident 203's blood sugar level.</p> <p>This deficient practice had the potential for Resident 203 to have an inaccurate blood sugar test result and not receive the correct amount of insulin glargine (an injection that treats diabetes mellitus [DM - a disorder characterized by difficulty in blood sugar control and poor wound healing]) ordered by the physician, and possibly resulting in serious health complications requiring hospitalization .</p> <p>Findings:</p> <p>During a review of Resident 203's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/20/2023 and readmitted on [DATE] with diagnoses including type two (2) DM and acute (sudden) and chronic respiratory failure (RF -a condition where the lungs fail to effectively exchange gases, resulting in insufficient oxygen intake and/or inadequate removal of carbon dioxide from the blood).</p> <p>During a review of Resident 203's Minimum Data Set (MDS - a resident assessment tool) dated 9/25/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS further indicated that the resident was dependent on staff with toileting hygiene, upper/lower body dressing, and chair/bed-to-chair transfer.</p> <p>During a review of Resident 203's physician order summary report, the order summary report indicated an order dated 10/27/2024, to administer insulin glargine 30 units (unit - used for medication dosage) subcutaneously (SQ - under the skin) one time a day for diabetes in the afternoon and hold if blood sugar below 100 milligrams per deciliter (mg/dl - a unit of measurement).</p> <p>During a concurrent observation and interview on 11/19/2024 at 11:50 a.m., with Licensed Vocational Nurse 6 (LVN 6) in Resident 203's room, observed LVN 6 wipe Resident 203's right hand's fourth finger with an alcohol prep pad (APP - a small, pre-soaked wipe containing a high concentration of alcohol, used to clean and disinfect the skin before giving an injection or treating a minor cut) indicating 70 percent (% - out of each hundred or per one hundred) of isopropyl alcohol (IA - used as a disinfectant). LVN 6 used a lancet to prick Resident 203's finger and wiped the first drop of blood obtained with an APP. LVN 6 wiped the resident's finger with a new APP, obtained the second blood drop and applied the blood to the glucose test strip (a small, disposable plastic strip that measures the amount of glucose in the blood). When LVN 6 was asked if it was appropriate to use the second blood drop as the sample to test Resident 203' blood sugar right after wiping the finger with an APP, LVN 6 stated that she (LVN 6) learned from school to use the second blood drop obtained to test the resident's blood sugar after discarding the first blood drop. LVN 6 was asked if the alcohol was going affect the blood sugar test result, LVN 6 did not answer the question.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/2024 at 2:20 p.m., with the Director of Nursing (DON), the DON stated, if the licensed nurse used an APP to disinfect the resident's finger to obtain a blood sample, they should have waited for the alcohol to dry, otherwise the blood sugar test results would be affected by alcohol.</p> <p>During a review of the facility P&P titled, Obtaining a Fingerstick Glucose (sugar) Level, last reviewed on 2/29/2024, indicated, Obtain a blood sample by using a sterile (completely clean and free from any germs) lancet. Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who required assistance with nail trimming was provided care and services to maintain good personal hygiene for one of one sampled resident (Resident 24).</p> <p>This deficient practice had the potential to result in a negative impact on the resident's self- esteem due to an unkempt appearance.</p> <p>Findings:</p> <p>During a review of Resident 24's Admission Record, the document indicated the facility admitted the resident was admitted on [DATE] with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]).</p> <p>During a review of Resident 24's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/12/2024, the document indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired and required substantial/maximal assistance from staff for toileting, shower, dressing and for personal hygiene.</p> <p>During a review of Resident 24's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) for Activities of Daily Living (ADLs- are activities related to personal care), at risk for skin breakdown dated 8/12/2024, the document indicated an intervention to provide ADL assistance as needed.</p> <p>During a concurrent observation and interview on 10/9/24 at 9:55 a.m., with Registered Nurse 1 (RN 1), observed Resident 24 in bed with long fingernails with jagged edges and few broken nails. RN 1 stated that Certified Nurse Assistants (CNAs) assigned to Resident 24 should check the resident's fingernails and trim it when it's long. RN 1 stated that caring for the resident's fingernails is part of personal hygiene because if the nails are long and the resident scratches themselves, it may cause skin breakdown and can lead to skin tear and infection.</p> <p>A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/29/2024, indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49947</p> <p>Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one of one sampled resident (Resident 65) by not clarifying the rate of two intravenous (IV - medication that is given into a vein) medications.</p> <p>This deficient practice had the potential for Resident 65 to receive a medication error and harm to the resident.</p> <p>Findings:</p> <p>During a review of Resident 65's Admission Record, the document indicated the facility admitted the resident on 9/4/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive group of lung diseases that make it hard to breathe), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), personal history of transient ischemic attack (TIA - a temporary disruption in the blood supply to part of the brain) and cerebral infarction (a serious condition when blood flow to the brain is blocked, causing brain tissue to die).</p> <p>During a review of Resident 65's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition), dated 9/6/2024, the document indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 65's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 9/11/2024, the document indicated the resident needed substantial assistance from staff for toileting, dressing, showering, and personal hygiene, and some assistance for eating.</p> <p>During a review of Resident 65's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Zosyn (antibiotic) 3.375 milligrams (mg - unit of measurement) IV every six hours for seven days, ordered 10/3/2024. - Vancomycin (antibiotic) 1 gram (gm - unit of measurement) IV every 12 hours for seven days, ordered 10/3/2024. <p>There was no rate (how much and how fast to give the medication) listed on either medication order.</p> <p>During a review of Resident 65's IV Therapy Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment), dated 10/3/2024, the document did not indicate a rate for IV Zosyn and vancomycin.</p> <p>During a review of Resident 65's IV Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional) binder, the document did not indicate a rate for IV Zosyn and vancomycin.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469</p> <p>Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcers [an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure]) was set correctly for one of one sampled resident (Resident 41). <p>This deficient practice had the potential to increase the resident's risk of skin breakdown.</p> <ol style="list-style-type: none"> 2. Ensure a resident's deep tissue injury (DTI, a form of pressure ulcer usually presenting with intact skin that is red or purple in color) pressure ulcer on the left and right heels were measured for approximately six weeks for one of two sampled residents (Resident 93). <p>This deficient practice had the potential to not know if Resident 93's DTI was healing or not.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 41's Admission Record, the document indicated the facility admitted the resident on 3/4/2020 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and osteoarthritis (a degenerative joint disease that occurs when the cartilage and bone in the joints break down over time). <p>During a review of Resident 41's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 9/3/2024, the document indicated that Resident 41's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and was dependent on staff for toileting hygiene, shower, upper body dressing, lower body dressing, and personal hygiene.</p> <p>During an observation on 10/8/2024 at 12:03 p.m., with the Director of Nursing (DON), observed Resident 41 in bed using a LALM with a maximum setting range of 320-400 pounds (lbs.).</p> <p>During a concurrent interview and record review on 10/11/2024 at 3:45 p.m., with the DON, reviewed Resident 41's physician orders and Resident 41's current weight. The DON stated that there was no physician's order for the use of LALM and Resident 41 weighed 150 lbs. on 10/6/2024. The DON stated there should be an order when a LALM mattress is used and that they were just being proactive. The DON stated that if the setting is incorrect and the mattress is too firm it can potentially cause a skin breakdown which could led to infection.</p> <p>During a review of the facility's policy and procedure titled, Support Surface Guidelines, last reviewed 2/29/2024, the policy indicated, The purpose of this procedure guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown .</p> <p>34659</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 93's Admission Record, the document indicated the facility admitted the resident on 10/23/2023 and readmitted the resident on 6/10/2024 with diagnoses that included diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 93's MDS dated [DATE], the document indicated the resident was severely impaired (never/rarely made decisions) in cognition with skills required for daily decision making. The MDS indicated that Resident 93 was dependent (helper does all the effort) with toileting, dressing, and personal hygiene. The MDS indicated Resident 93 had one or more unhealed pressure ulcers.</p> <p>During a review of Resident 93's physician's orders, the document indicated an order to cleanse the left and right heel with normal saline (salty solution) and pat dry; apply betadine (a topical antiseptic [chemical used for preventing infection in an injury]), cover with dry dressing and wrap with kerlix (gauze used for wrapping dressings) for 30 days and re-assess every day shift for DTI for 30 days, dated 9/11/2024.</p> <p>During a review of Resident 93's Skin Only Evaluation and Weekly Wound Reports from 7/19/2024 to 8/29/2024, the document indicated Resident 93 had a left and right heel DTI, but there was no indication of the length, width, or depth of the wounds.</p> <p>During a concurrent interview and record review on 10/11/2024 at 10:46 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 93's Skin Only Evaluation and Weekly Wound Reports from 7/19/2024 to 8/29/2024. RN 1 was unable to display any records with Resident 93's left and right heel wound measurements. RN 1 stated it is important to document wound measurements so the licensed nurses and physician can know if a wound is healing and if not to change the treatment plan.</p> <p>During an interview on 10/11/2024 at 12:14 p.m., with the DON, the DON stated it is important to document wound measurements to assess if a wound is healing and if not to change the treatment plan.</p> <p>During a review of the facility's policy and procedure titled, Pressure Injury and Non-Pressure Injury Assessment Procedure, last reviewed 2/29/2024, the policy indicated descriptive documentation of all pressure ulcer and non-pressure ulcers must be done at least weekly and whenever there is a change in the appearance of the wound. The policy and procedure indicated description must include: location of pressure sore, size, color of wound bed, presence or absence of exudate (fluid that leaks), odor if present, stage, depth of the wound, tissue evolved, and description of necrotic tissue (dead tissue) if present.</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** 38469</p> <p>Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure that a 24-inch television was bolted or anchored on the television stand for one of three residents (Resident 8). <p>This deficient practice had the potential for the television to fall over and cause injury to the resident.</p> <ol style="list-style-type: none"> 2. Ensure a resident's medication was not left unattended at the bedside for one of three sampled residents (Resident 83). <p>This deficient practice had the potential for other residents to enter the room and take another resident's medication and could experience adverse side effects (undesired harmful effect resulting from a medication or other intervention).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 8's Admission Record, the document indicated the facility admitted the resident on 8/20/2022 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). <p>During a review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/30/2024, indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired and required supervision from staff for toileting, shower, dressing and for personal hygiene.</p> <p>During a concurrent observation and interview on 10/09/2024 at 10:24 a.m., with Registered Nurse 1 (RN1), observed in Resident 8's room, a 24-inch television placed on top of a drawer stand facing Resident 8's bed. Observed the television not bolted or anchored as it swayed and tilted when grasped. RN 1 stated that the way the television is placed on the stand, without it being bolted, can easily topple during earthquakes or if accidentally hit by a body part of the resident when the resident is wheeling himself in the room.</p> <p>During a review of the facility's policy and procedure titled, Accident Prevention, last reviewed on 2/29/2024, indicated, The facility will protect the resident's environment to remain free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents .</p> <p>34659</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>2. During a review of Resident 83's Admission Record, the document indicated the facility admitted the resident on 4/28/2023 with diagnoses that included diabetes mellitus, polyneuropathy (disease or dysfunction of one or more peripheral nerves [nerves located outside of the brain and spinal cord], typically causing numbness or weakness), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 83's MDS dated [DATE], the document indicated the resident was cognitively intact with skills required for daily decision making. The MDS indicated that Resident 83 was independent with eating and oral hygiene. The MDS indicated Resident 83 was diagnosed with schizophrenia (mental disorder in which people interpret reality abnormally).</p> <p>During a review of Resident 83's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Gabapentin (nerve pain medication) oral capsule 100 milligrams (mg, a unit of measurement), give one capsule by mouth at bedtime for nerve pain, dated 7/15/2024. - Lexapro (medication for depression) oral tablet 10 mg, give one tablet by mouth at bedtime for depression manifested by expression of sadness, dated 6/30/2024. - Metformin (medication for type 2 diabetes) oral tablet 500 mg, give one tablet by mouth two times a day for diabetes mellitus, dated 8/13/2024. - Seroquel (medication for schizophrenia) oral tablet 25 mg, give 0.5 tablet by mouth at bedtime for schizophrenia manifested by hearing voices affecting activities of daily living (ADLs - activities related to personal care), dated 9/21/2024. <p>During a review of Resident 83's Self Administration of Medication Assessment, dated 10/7/2024, the document indicated the interdisciplinary team (a group of health care professionals who work together for a resident's goals) determined it is not safe for the resident to self-administer drugs.</p> <p>During a concurrent observation and interview on 10/7/2024 at 9:18 a.m., with Resident 83, observed a plastic cup containing four pills on his bedside table. Resident 83 stated a nurse left the medications yesterday. Resident 83 stated he does not take his medications because his stomach hurts.</p> <p>During a concurrent observation and interview on 10/7/2024 at 9:20 a.m., with Licensed Vocational Nurse 2 (LVN 2), observed the plastic cup with four pills at Resident 83's bedside. LVN 2 stated the pills were: gabapentin, Lexapro, metformin, and Seroquel. LVN 2 stated medications are not to be left at a resident's bedside because there are wandering residents in the facility who could enter the room and take them. LVN 2 stated she worked the 3 p.m. to 11 p.m. shift the previous day but Resident 83 took the medications she gave him.</p> <p>During an interview on 10/7/2024 at 9:25 a.m., with the Director of Nursing (DON), LVN 2 showed the pill cup to DON. The DON stated she did not know why the medications were left at the bedside or which staff left them.</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>During a concurrent interview and record review on 10/11/2024 at 12:14 p.m., with the DON, reviewed the facility's policy and procedure titled, Medication Administration, last reviewed on 2/29/2024. The DON stated, according to the policy, medications are administered at the time they are prepared. The DON stated, according to policy, residents are allowed to self-administer medications when specifically authorized by the attending physician. The DON stated it is important not to leave medications at the bedside because other residents could come into the room and take them. The DON stated medications should not be left at the bedside because a resident could collect them over time and then take many at one time.</p> <p>During a review of the facility's policy and procedure titled, Medication Administration, last reviewed 2/29/2024, the policy indicated medications are administered at the time they are prepared. The policy and procedure indicated residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49947</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, interview and record review, the facility failed to obtain the weight of one of one sampled resident (Resident 65) according to the facility's policy and procedure (P&P).</p> <p>This deficient practice had the potential for a delay in care and services and undetected weight loss.</p> <p>Findings:</p> <p>During a review of Resident 65's Admission Record, the Admission Record indicated the facility admitted Resident 65 on 9/4/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive group of lung diseases that make it hard to breathe), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), transient ischemic attack (TIA - a temporary disruption in the blood supply to part of the brain) and cerebral infarction (a serious condition when blood flow to the brain is blocked, causing brain tissue to die).</p> <p>During a review of Resident 65's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition), dated 9/6/2024, indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 65's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/11/2024, it indicated the resident needed substantial assistance from staff for toileting, dressing, showering, and personal hygiene, and some assistance for eating.</p> <p>During a review of Resident 65's electronic medical record in regards to weights and Resident 65's Monthly Record of Vital Signs (measurements of the body's most basic functions) and Weights and Weekly Weights for 9/2024, the document did not indicate Resident 65's weight on 9/5/2024, the next day following the resident's admission to the facility. The weight that was first entered was as follows:</p> <p>- 9/8/2024 171 pounds (lbs. - unit of weight measurement).</p> <p>During a review of the Restorative Nurse Aid (RNA, a program designed to ensure each resident maintains their physical and functional abilities) Weight Log folder, the log indicated Resident 65's initial admission weight on 9/4/2024 of 170 lbs. The log did not indicate a weight on 9/5/2024.</p> <p>During a concurrent interview and record review on 10/9/2024 at 10:00 a.m., with Registered Nurse 4 (RN 4), reviewed Resident 65's electronic medical record in regards to weights, Resident 65's Monthly Record of Vital Signs and Weights for 9/2024, Weekly Weights for 9/2024, and RNA Weight Log. RN 4 confirmed by stating there was no weight entered for Resident 65 on their second day following admission to the facility, on 9/5/2024. RN 4 stated it should not have been missed because an accurate assessment is very important to provide the best care for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0692</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 10/9/2024 at 10:20 a.m., with the Director of Nursing (DON), the DON confirmed by stating that Resident 65's electronic medical record in regards to weights, Resident 65's Monthly Record of Vital Signs and Weights for 9/2024, Weekly Weights for 9/2024, and RNA Weight Log did not indicate Resident 65's weight on their second day following admission to the facility. The DON stated it is extremely important that the facility follows the P&P because there is a potential for inaccuracies that can delay proper care.</p> <p>During a review of the facility's P&P titled, Weight Assessment and Intervention, reviewed on 4/1/2024, the policy indicated the nursing staff will measure residents' weight on admission, the next day, and weekly for two weeks thereafter. The policy further indicated the weights shall be recorded in the weight record book or notebook and in the individual's medical record.</p>

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<p>F 0694</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>49947</p> <p>Based on interview, and record review, facility staff (Registered Nurse 3 [RN 3]) failed to monitor and provide peripheral (away from the center of the body) intravenous (IV- into a vein) line care to one of one sampled resident (Resident 65) on 10/6/2024, when Resident 65 complained of pain to the IV site on the left forearm.</p> <p>This deficient practice resulted in RN 3 continuing to use Resident 65's IV site on the left forearm on 10/6/2024 to administer IV medication further causing Resident 65 to experience untreated pain to the IV site.</p> <p>Findings:</p> <p>During a review of Resident 65's Admission Record, the Admission Record indicated the facility admitted Resident 65 on 9/4/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive group of lung diseases that make it hard to breathe), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), transient ischemic attack (TIA - a temporary disruption in the blood supply to part of the brain) and cerebral infarction (a serious condition when blood flow to the brain is blocked, causing brain tissue to die).</p> <p>During a review of Resident 65's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition), dated 9/6/2024, the H&P indicated Resident 65 did not have the capacity to understand and make decisions. The H&P also indicated Resident 65 was admitted to the General Acute Care Hospital (GACH) for cholecystitis (inflammation of the gallbladder [a small digestive organ]) status post (s/p- medical term that refers to a patient's condition after a specific event, treatment, or diagnosis) cholecystectomy (surgical procedure to remove the gallbladder).</p> <p>During a review of Resident 65's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 9/11/2024, the MDS indicated Resident 65 needed substantial assistance from staff for toileting, dressing, showering, and personal hygiene, and some assistance for eating.</p> <p>During a review of Resident 65's physician's orders, the physician orders indicated the following:</p> <ol style="list-style-type: none"> 1. Zosyn (antibiotic) 3.375 milligrams (mg - unit of measurement) IV every six hours for seven days for wound infection, ordered 10/3/2024. 2. Vancomycin (antibiotic) one (1) gram (gm - unit of measurement) IV every 12 hours for seven days for wound infection, ordered 10/3/2024. <p>During a review of Resident 65's Type of Line form (documentation form for the insertion of IV lines) undated, the Type of Line form indicated that on 10/3/2024 at 6:00 p.m., Resident 65 had a left forearm IV line inserted.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 65's Type of Line form undated, the Type of Line form indicated that on 10/7/2024 at 10:30 a.m., Resident 65's left forearm IV access site was discontinued (removed) due to the IV line being infiltrated (a complication of IV therapy that occurs when IV fluid or medication leaks out of the vein and into the surrounding tissue causing swelling and pain).</p> <p>During a concurrent observation and interview on 10/7/2024 at 12:20 p.m., with Resident 65's wife (RR 1) in Resident 65's room, observed Resident 65's left forearm. RR 1 pointed to Resident 65's left foreman covered with a bandage and stated that the IV that was previously on Resident 65's left forearm was infiltrated from 10/6/2024 and had to be removed. RR 1 stated that RR 1 informed RN 3 on 10/6/2024 about Resident 65's left forearm IV access site having blood and fluid on the outside of the IV insertion site and causing Resident 65 pain, but RN 3 never checked Resident 65's left forearm IV site. RR 1 stated that Registered Nurse 4 (RN 4) removed Resident 65's left forearm IV access on 10/7/2024 because the IV access was causing Resident 65 pain.</p> <p>During an interview on 10/7/2024 at 12:30 p.m., with Resident 65, Resident 65 stated that his (Resident 65) IV access on the left forearm began to cause Resident 65 pain starting on 10/6/2024. Resident 65 stated that he (resident 65) informed RN 3 about the pain to the left forearm IV access site, but RN 3 did not provide any intervention for the pain in Resident 65's left forearm IV access site. Resident 65 stated that RN 3 even continued administering Resident 65's IV antibiotic Zosyn despite the pain at the IV access site on the left forearm.</p> <p>During an interview on 10/7/2024 at 12:35 p.m., with RN 4, RN 4 stated she (RN 4) had to remove the IV access on Resident 65's left forearm on 10/7/2024 during the 7 a.m.-3 p.m. shift because it was painful to Resident 65 and was no longer patent (patency refers to when the IV line is open and not clogged).</p> <p>During an interview on 10/7/2024 at 3:35 p.m., with RN 3, RN 3 stated that on 10/6/2024, Resident 65 complained of pain to the left forearm IV access site. RN 3 stated that he (RN 3) noted that Resident 65's IV access site to the left forearm had blood around the outside of the tubing. RN 3 stated that he (RN 3) did not check the patency of Resident 65's IV access to the left forearm and did not address Resident 65's complaint of pain to the left for arm access site. RN 3 stated that he (RN 3) continued to utilize Resident 65's left forearm IV access on 10/6/2024 at 6 p.m. to infuse the physician ordered antibiotic Zosyn despite Resident 65's complaint of pain; and despite not checking the patency of Resident 65's IV access. RN 3 stated he (RN 3) should have not increased the rate of the Zosyn administration and should have checked for placement and infiltration.</p> <p>During an interview on 10/10/2024 at 11:45 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses must address any pain the residents are experiencing are reporting immediately.</p> <p>During an interview on 10/11/2024 at 2:00 p.m., with the Medical Records Assistant (MRA), the MRA stated they do not have a policy regarding IV medication administration and peripheral IVs.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>42275</p> <p>Based on observation, interview, and record review, the facility failed to provide respiratory care services consistent with professional standards of practice by failing to ensure that a resident received continuous oxygen per the physician's order for one of two sampled residents (Resident 203).</p> <p>This deficient practice had the potential to result in complications from receiving more oxygen than required and can negatively impact Resident 203's well-being.</p> <p>Findings:</p> <p>During a review of Resident 203's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/20/2023 and readmitted the resident on 10/26/2024 with diagnoses that included type two (2) diabetes mellitus (DM - a chronic condition that affects the way the body processes blood glucose [sugar]) and acute (sudden) and chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood).</p> <p>During a review of Resident 203's Minimum Data Set (MDS - a resident assessment tool) dated 9/25/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS further indicated that the resident was dependent on staff with toileting hygiene, upper/lower body dressing, and chair/bed-to-chair transfer.</p> <p>During a review of Resident 203's Order Summary Report, the Order Summary Report indicated an order to provide oxygen at two (2) liters per minute (LPM - a unit of measurement) via nasal cannula (NC - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) routinely for hypoxia (a severe deficiency of oxygen in the blood and tissues) every shift, ordered 11/15/2024.</p> <p>During a concurrent observation, interview, and record review on 11/19/2024 at 12 p.m., with Licensed Vocational Nurse 6 (LVN 6), reviewed Resident 203's physician orders. Observed with LVN 6, Resident 203 lying in bed with 4.5 LPM of oxygen. LVN 6 stated that Resident 203's physician order was to administer 2 LPM of oxygen and stated the staff did not follow the physician's order. LVN 6 further stated that LVN 6 did not check Resident 203's oxygen setting rate until the time of this observation and did not check Resident 203's oxygen setting rate since starting her (LVN 6) morning shift at around 7 a.m.</p> <p>During an interview on 11/21/2024 at 4:14 p.m., with the Director of Nursing (DON), the DON stated that it was unsure who increased Resident 203's oxygen setting level to 4.5 LPM on 11/19/2024. The DON stated the licensed nurses should check the oxygen setting levels to follow the physician's order whenever entering residents' room with oxygen therapy and monitor the residents closely.</p> <p>During a review of the facility's policy and procedure titled, Oxygen Use, last reviewed on 2/29/2024, the policy indicated, The purpose of this procedure is to provide the guidelines for safe oxygen administration Verify that there is a physician's order for this procedure.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>50033</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 63) was assessed for pain per shift as ordered by the physician.</p> <p>This deficient practice had the potential for Resident 63 to experience undetected pain.</p> <p>Findings:</p> <p>During a review of Resident 63's Admission Record, the document indicated the facility originally admitted the resident on 1/12/2022 and readmitted the resident on 6/5/2023 with diagnoses including but not limited to meningitis (a serious infection that causes inflammation of the meninges [the membranes that protect the brain and spinal cord]), intraspinal abscess (an enclosed collection of pus within the spine) and granuloma (a collection of immune cells that forms in response to chronic inflammation), paraplegia (paralysis [complete or partial loss of function and feeling in a body part] of the legs and lower body), and perineural cyst (fluid-filled sacs that form on nerves at the base of spine).</p> <p>During a review of Resident 63's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 6/16/2024, the document indicated Resident 63 had the capacity to understand and make decisions.</p> <p>During a review of Resident 63's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 9/9/2024, the document indicated the resident had intact cognition (refers to mental activities including thinking, reasoning, understanding, learning, and remembering) and required at least moderate assistance from staff for most activities of daily living (ADLs- activities related to personal care).</p> <p>During a review of Resident 63's physician's orders, the document indicated the following active orders:</p> <ol style="list-style-type: none"> 1. Hydrocodone-acetaminophen (medication used for moderate to severe pain) 5-325 milligrams (mg, a unit of measurement) give one tablet every six hours as needed for severe pain (8-10, numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 7/1/2024. There was no other current pain medication ordered. 2. Assess pain every shift using the pain rating scale: 0=no pain, 1-4=mild pain, 5-7=moderate pain, 8-10=severe pain, ordered 7/1/2024. <p>During a review of Resident 63's care plan (a document that summarizes a resident's health conditions, treatments, and care needs) for alteration in comfort due to pain related to back problems, being bedfast (confined to bed), wheelchair-bound, and having two stage IV pressure injuries (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), last revised 9/2024, the care plan indicated the following interventions:</p> <ol style="list-style-type: none"> 1. Assess location, characteristics, onset, duration, frequency, quality, and intensity of pain. <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Administer pain medication as indicated: hydrocodone-acetaminophen 5-325 mgs every six hours as needed for severe pain.</p> <p>During a concurrent interview and record review on 10/10/2024 at 1:00 p.m., with Registered Nurse 1 RN 1, reviewed Resident 63's Medication Administration Records (MARs - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/2024 and 8/2024. The MARs indicated there were no pain assessments documented on 7/2/2024 7 a.m.-3 p.m. shift and 11 p.m.- 7 a.m. shift, 7/2/2024 11 p.m.- 7 a.m. shift, 7/3/2024 7 a.m.-3 p.m. shift, 7/4/2024 11 p.m.- 7 a.m. shift, 8/9/2024 11 p.m.- 7 a.m. shift, 8/10/2024 11 p.m.- 7 a.m. shift, and 8/25/2025 3 p.m.- 11 p.m. shift. RN 1 stated those could have been missed, but Resident 63 will always tell staff when he is in pain. RN 1 stated Resident 63's pain assessment should be documented each shift as that is what is ordered by the physician.</p> <p>During an interview on 10/10/2024 at 3:17 p.m., with the Director of Nursing (DON), the DON stated all pain assessments should be completed so they can assess if the resident is having pain and if pain medications are working or not.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, reviewed 2/29/2024, the P&P indicated the resident should be provided optimal comfort through a pain control plan that is mutually established with the resident, family, and members of the health care team. The P&P further indicated the resident's pain should be assessed and documented, and the resident should receive medication as the physician ordered.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34659</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 13) received their trazadone (medication used to treat major depressive disorder [mood disorder that causes a persistent feeling of sadness and loss of interest]) as ordered by the physician.</p> <p>This had the potential for Resident 13 to not receive adequate sleep and to suffer depression.</p> <p>Findings:</p> <p>During a review of Resident 13's Admission Record, the document indicated the facility admitted the resident on 7/27/2017 and readmitted the resident on 12/18/2022 with diagnoses that included depression.</p> <p>During a review of Resident 13's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/29/2024, the document indicated the resident was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated that Resident 13 was independent with eating and oral hygiene.</p> <p>During a review of Resident 13's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) titled, Adverse Reaction (undesired harmful effect resulting from a medication or other intervention) related to use of Antidepressants, initiated 11/22/2023, the document indicated a goal that the resident will be able to sleep at least six to eight hours at night for 90 days. The care plan indicated an intervention to administer medication as ordered: trazadone 150 mg, one tab by mouth at bedtime for insomnia.</p> <p>During a review of Resident 13's physician's orders, the document indicated an order for trazadone oral tablet 150 milligrams (mg, a unit of measurement), give one tablet by mouth at bedtime for insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep) manifested by sleeplessness, ordered 7/1/2024, clarified 8/30/2024, and ordered again on 9/14/2024.</p> <p>During a review of Resident 13's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 8/2024, the document indicated on 8/24/2024, Resident 13's trazadone was not given but was documented with a code 6 which means: other, see progress notes.</p> <p>During a review of Resident 13's Nursing Progress Notes, dated 8/24/2024, the document indicated a note: waiting for pharmacy to deliver.</p> <p>During a review of Resident 13's Delivery Record for the medication trazadone, the document indicated Resident 13's trazadone was delivered on 8/25/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 13's MAR dated 9/2024, the document indicated the medication trazadone was not given on 9/24/2024, as indicated by a licensed nurses initials and the date circled. The MAR indicated a note documented on the back of the MAR that Resident 13's trazadone was unavailable on 9/24/2024, that pharmacy was called and will be sent.</p> <p>During a review of Resident 13's Delivery Record for the medication trazadone, the document indicated Resident 13's trazadone was delivered on 9/25/2024.</p> <p>During an interview on 10/7/2024 at 10:10 a.m., with Resident 13, Resident 13 stated there were two days he did not receive his trazadone. Resident 13 stated he could not sleep those nights.</p> <p>During a concurrent interview and record review on 10/9/2024 at 9:13 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 13's MARs dated 8/2024 and 9/2024. RN 1 stated the pharmacy is notified at least three days in advance before a medication supply will be empty. RN 1 stated trazadone is not in their emergency kit (e-kit, contains certain medications that could be taken if needed immediately) and could not have been taken from the e-kit to be given to Resident 13 on 8/24/2024 and 9/24/2024 when the documentation indicated the trazadone was not given and available. RN 1 stated it is important for Resident 13 to get his medication because he would not get enough sleep and could negatively affect the resident.</p> <p>During a review of the facility's policy and procedure titled, Medication Administration, last reviewed 2/29/2024, the policy indicated medications are administered in accordance with written orders of the attending physician .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given .If a dose of a regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>50033</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses monitored for side effects while a resident received apixaban (an anticoagulant- medications that prevent and treat blood clots [gel-like clumps of blood] in the heart and blood vessels) for one of three sampled residents (Resident 101).</p> <p>This deficient practice had the potential to result in Resident 101 experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from the anticoagulant including bleeding from the gums or nose, having blood in the stool, and unusual bruising.</p> <p>Findings:</p> <p>During a review of Resident 101's Admission Record, the document indicated the facility admitted the resident on 4/20/2024 with diagnoses including cerebral infarction (an obstruction of blood flow in the brain that leads to tissue damage) and hemiplegia (total paralysis [complete or partial loss of muscle function] of the arm, leg, and trunk on the same side of the body).</p> <p>During a review of Resident 101's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition) dated 4/21/2024, the H&P indicated Resident 101 can make his needs known but cannot make medical decisions. The H&P further indicated Resident 101 is currently using anticoagulants long-term.</p> <p>During a review of Resident 101's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Apixaban five milligram (mg, unit of measurement) tablet, give one tablet twice a day for blood clot prevention, dated 4/19/2024. - Monitor for gum bleeding, nose bleeding, unusual bruising, coughing up blood, blood-stained mucus, melena (black stool) each shift and notify the doctor for any symptoms present due to anticoagulant use, dated 4/20/2024. <p>During a review of Resident 101's care plan (a document that summarizes a resident's health conditions, treatments, and care needs) titled, At risk for bleeding/signs of active bleeding related to the use of apixaban ., dated 4/23/2024, the care plan indicated interventions to assess for bleeding/signs of active bleeding and monitor for overt bleeding.</p> <p>During a concurrent interview and record review on 10/11/2024 at 10:54 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 101's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 7/2024 and 8/2024. Resident 101's MARs indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident 101 was not monitored for the side effects of anticoagulants on 7/1/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/2/2024 11 p.m.-7 a.m. shift, 7/3/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/4/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/5/2024 11 p.m.-7 a.m. shift, 7/12/2024 11 p.m.-7 a.m. shift, 8/9/2024 11 p.m.-7 a.m. shift, 8/25/2024 3 p.m.-11 p.m. shift, and 8/31/2024 11 p.m.-7 a.m. shift.</p> <p>RN 1 stated when a resident is on an anticoagulant, licensed nurses should be monitoring for side effects like bruising and bleeding and documenting this on the MAR every shift. RN 1 stated if this is not done the resident could have side effects from the apixaban and they won't be able to evaluate the medication effectively.</p> <p>During an interview on 10/11/2024 at 1:35 p.m. with the Director of Nursing (DON), the DON stated Resident 101 should be monitored for the side effects of apixaban including signs of bleeding and excessive bruising. The DON stated they need to monitor for all potential side effects to effectively communicate about the medication with the doctor.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Anticoagulation Use, last reviewed on 2/29/2024, the P&P indicated nursing staff will monitor for signs of bleeding (e.g. bleeding gums, bruising, bloody stools) and report to the physician.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses monitored for changes in behavior and side effects while a resident received 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 five sampled residents (Resident 101).</p> <p>This deficient practice had the potential to lead to Resident 101 to have unnoticed changes in behavior and experience adverse side effects (undesired harmful effect resulting from a medication or other intervention) including tardive dyskinesia (a movement disorder which causes involuntary and repetitive movements, including those of the face, mouth, tongue, arms, or legs) and cognitive impairment (decreased mental status [ability to understand and make decisions]).</p> <p>Findings:</p> <p>During a review of Resident 101's Admission Record, the document indicated the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized anxiety disorder (a mental health condition that causes excessive fear, worry, and feelings of dread and uneasiness).</p> <p>During a review of Resident 101's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition), dated 4/21/2024, the H&P indicated Resident 101 can make his needs known but cannot make medical decisions.</p> <p>During a review of Resident 101's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Seroquel 50 milligram (mg, unit of measurement) tablet, give one tablet three times a day for schizophrenia manifested by agitation, dated 7/1/2024. - Monitor resident each shift for changes in behavior, dated 7/1/2024. - Monitor resident each shift for Parkinsonism symptoms (tremors, drooling, rigidity) and tally by hashmark, dated 7/5/2024. - Monitor resident each shift for akathisia (inability to sit still/restlessness) and tally by hashmark, dated 7/1/2024. - Monitor resident each shift for tardive dyskinesia and tally by hashmark, dated 7/1/2024. - Monitor resident each shift for cognitive impairment and tally by hashmark, dated 7/1/2024. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 101's care plan (a document that summarizes a resident's health conditions, treatments, and care needs) titled, .at risk for adverse reactions related to use of antipsychotic medications due to schizophrenia manifested by agitation, dated 4/23/2024, the care plan indicated to observe for adverse reactions, signs and symptoms of tardive dyskinesia, monitor behavior each shift, and evaluate effectiveness of medications.</p> <p>During a concurrent interview and record review on 10/11/2024 at 10:54 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 101's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 7/2024 and 8/2024. The MARs indicated the following for each physician order:</p> <ul style="list-style-type: none"> - Resident 101 was not monitored for changes in behavior on 7/1/2024 11 p.m.-7 a.m. shift, 7/2/2024 11 p.m.-7 a.m. shift, 7/3/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/4/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/5/2024 11 p.m.-7 a.m. shift, 7/12/2024 11 p.m.-7 a.m. shift, 8/9/2024 11 p.m.-7 a.m. shift, and 8/25/2024 3 p.m.-11 p.m. shift. - Resident 101 was not monitored for Parkinsonism symptoms on 7/5/2024 11 p.m.-7 a.m. shift, 7/12/2024 11 p.m.-7 a.m. shift, 8/9/2024 11 p.m.-7 a.m. shift, and 8/25/2024 3 p.m.-11 p.m. shift. - Resident 101 was not monitored for akathisia on 7/1/2024 11 p.m.-7 a.m. shift, 7/2/2024 11 p.m.-7 a.m. shift, 7/3/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/4/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/5/2024 11 p.m.-7 a.m. shift, 7/12/2024 11 p.m.-7 a.m. shift, 8/9/2024 11 p.m.-7 a.m. shift, and 8/25/2024 3 p.m.-11 p.m. shift. - Resident 101 was not monitored for tardive dyskinesia on 7/1/2024 11 p.m.-7 a.m. shift, 7/2/2024 11 p.m.-7 a.m. shift, 7/3/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/4/2024 7 a.m.-3 p.m. shift and 11 p.m.-7 a.m. shift, 7/5/2024 11 p.m.-7 a.m. shift, 7/12/2024 11 p.m.-7 a.m. shift, 8/9/2024 11 p.m.-7 a.m. shift, and 8/25/2024 3 p.m.-11 p.m. shift. - Resident 101 was not monitored for cognitive impairment on 7/5/2024 11 p.m.-7 a.m. shift, 7/12/2024 11 p.m.-7 a.m. shift, 8/9/2024 11 p.m.-7 a.m. shift, and 8/25/2024 3 p.m.-11 p.m. shift. <p>RN 1 stated Resident 101 should have been monitored for behavior and for antipsychotic side effects and that these would only be documented in the MAR. RN 1 stated if this monitoring is not done, they may not be able to tell if the antipsychotic is effective. RN 1 stated they also may not be able to tell if the resident is having side effects or not and may not be able to evaluate the medication effectively.</p> <p>During an interview on 10/11/2024 at 1:35 p.m., with the Director of Nursing (DON), the DON stated Resident 101 should be monitored for his behavior and the side effects of his antipsychotic medication to be able to communicate effectively with the physician and to see if a reduction in the dose of the antipsychotic medication is needed.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Psychotropic (medications capable of affecting the mind, emotions, and behavior) Medication Policy, reviewed on 2/29/2024, the P&P indicated the facility will regularly review psychotropic medications for continued need, appropriate dosage, side effects, and risks and/or benefits. The P&P further indicated nursing staff will monitor psychotropic drug use daily noting any adverse effects.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49947</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from significant medication error by failing to administer an intravenous (IV - medication through a vein) medication at a rate (how much and how fast) prescribed by the physician to one of one sampled resident (Resident 65).</p> <p>This deficient practice had the potential to cause an adverse reaction (undesired harmful effect resulting from a medication or other intervention).</p> <p>Findings:</p> <p>During a review of Resident 65's Admission Record, the Admission Record indicated the facility admitted Resident 65 on 9/4/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive group of lung diseases that make it hard to breathe), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), transient ischemic attack (TIA - a temporary disruption in the blood supply to part of the brain) and cerebral infarction (a serious condition when blood flow to the brain is blocked, causing brain tissue to die).</p> <p>During a review of Resident 65's History and Physical (H&P- a comprehensive assessment of a resident's medical history and current condition), dated 9/6/2024, the H&P indicated Resident 65 did not have the capacity to understand and make decisions. The H&P also indicated Resident 65 was admitted to the General Acute Care Hospital (GACH) for cholecystitis (inflammation of the gallbladder [a small digestive organ]) status post (s/p- medical term that refers to a patient's condition after a specific event, treatment, or diagnosis) cholecystectomy (surgical procedure to remove the gallbladder).</p> <p>During a review of Resident 65's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 9/11/2024, the MDS indicated Resident 65 needed substantial assistance from staff for toileting, dressing, showering, and personal hygiene, and some assistance for eating.</p> <p>During a review of Resident 65's physician's orders, the physician orders indicated an order for Zosyn (antibiotic) 3.375 milligrams (mg - unit of measurement) IV every six hours for seven days for wound infection, ordered 10/3/2024.</p> <p>During a review of Resident 65's IV Therapy Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment), dated 10/3/2024, the document did not indicate a rate for IV Zosyn.</p> <p>During a review of Resident 65's IV Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional) binder, the document did not indicate a rate for IV Zosyn.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/7/2024 at 12:20 p.m., with Resident 65's wife (RR 1), in Resident 65's room, RR 1 stated Registered Nurse 3 (RN 3) was Resident 65's nurse on the 3 p.m.-11 p.m. shift on 10/6/2024. Per RR 1, RN 3 did not check the IV for patency (free flowing/unobstructed) but rather increased the dial-a-flow (DAF - medical device used to regulate the flow of fluids through an IV that is not attached to a pump). RR 1 stated she then asked RN 3, pointing at the DAF, and asked why is it at a rate of 150 milliliters (ml- unit of measurement) per hour (ml/hr) and if it should it be 100 ml/hr. Per RR 1, RN 3 stated, These DAF never work properly, they are always too slow, that's why it is higher at 150.</p> <p>During an interview on 10/7/2024 at 12:35 p.m., with RN 4, in Resident 65's room, when asked about the IV Zosyn rate, RN 4 stated the rate is 100 ml/hr. RN 4 further stated nurses must follow the directions and may not adjust the rate without a physician's order because it can harm the resident by creating discomfort or infiltration at the IV site.</p> <p>During a concurrent interview and record review on 10/7/2024 at 3:35 p.m., with RN 3, reviewed Resident 65's IV MAR dated 10/2024 and confirmed by stating there was no rate for the Zosyn order. RN 3 reviewed Resident 65's paper and electronic medical record in regards for the rate of the Zosyn order and stated there was no rate for Zosyn. RN 3 then stated Zosyn does not have a rate but must be infused (method of delivering fluids or drugs into the bloodstream through a vein) over an hour. RN 3 stated the Zosyn administered by him on 10/6/2024 was running slow and dialed up the DAF to 150 ml/hr. RN 3 further stated DAFs do not work properly, they have a flaw to them, and he always dials the rate up. RN 3 confirmed that he dialed up the Zosyn to 150 ml/hr. RN 3 then confirmed by stating that the rate is on the Zosyn IV bag label at 100 ml/hr. RN 3 stated that he should not have increased it without a new order and the rate should be in the IV MAR and electronic MAR to avoid errors and harm to the resident.</p> <p>During a concurrent interview and record review on 10/8/2024 at 11:20 a.m., with RN 5, reviewed Resident 65's physician's orders and IV MAR dated 10/2024. RN 5 confirmed by stating Resident 65's physician's orders and IV MAR did not indicate a rate for IV Zosyn. RN 5 stated this could cause confusion and a medication error.</p> <p>During a concurrent observation and interview on 10/8/2024 at 11:29 a.m., with RN 5, observed Resident 65's IV medication bag labels for Zosyn. RN 5 stated the rate is on the IV bag itself and IV Zosyn had a rate of 100 ml/hr over one hour. When asked why the rate is on the IV bag only, RN 5 stated he was not sure and that it has always been that way. RN 5 further stated it can be confusing and cause a medication error.</p> <p>During an interview on 10/10/2024 at 11:45 a.m., with the Director of Nursing (DON), the DON confirmed by stating there was no rate for Zosyn in either Resident 65's medical record, physician order, IV therapy care plan, or IV MAR. The DON stated the practice of using the IV medication bag as a reference for the rate could cause confusion and medication errors. The DON stated that licensed nurses may not change the IV rate without a physician's order because it can cause pain and a medication error.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Medication Administration, last reviewed 2/29/2024, the policy indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .Prior to administration, the medication and dosage schedule on the resident's medication administration (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule .Medications are administered in accordance with written orders of the attending physician.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469</p> <p>Based on observation, interview and record review, the facility failed to ensure a multi-dose vial (contain more than one dose of medication) of Aplisol (used in a skin test to help diagnose tuberculosis [TB, a contagious bacterial infection that can affect the lungs and other parts of the body]) found in one of three medication rooms (Medication Room A), was labeled with an open date.</p> <p>This deficient practice had the potential for the multi-dose of Aplisol to become expired and loss its potency and had the potential for it to be administered to multiple residents and lead to an inaccurate test result.</p> <p>Findings:</p> <p>During a concurrent medication cart inspection and interview on [DATE] at 4:24 p.m., with Registered Nurse 2 (RN 2), observed Medication Room A (MR A). Observed an opened Aplisol multi-dose vial unlabeled with an open date. RN 2 stated that upon opening a multi-dose vial, licensed nurses have to label it with an open date and discard after 28 or 30 days. RN 2 stated that the purpose of dating is to ensure the multi-dose vial is not used beyond its discard date.</p> <p>During an interview on [DATE] at 4:50 p.m., with Registered Nurse 1 (RN 1), RN1 stated that multi-dose vials can be used for multiple residents but needs to be labeled with an open date so the nurses will know when to discard it. RN 1 stated that using an expired Aplisol may not give an accurate result of the resident's health status which can lead to undetected residents who can be carrier of the contagious TB.</p> <p>During a review of the facility-provided Aplisol package insert (a document included in the package of a medication that provides information about that drug and its use), dated ,d+[DATE], the document indicated under section Dosage and Administration, that vials in use for more than 30 days should be discarded.</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>49947</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices in the facility's kitchen by failing to:</p> <ol style="list-style-type: none"> 1. Ensure a scooper was not left inside of a large container of cornstarch. 2. Ensure an unpackaged container of lentils was not left open to air. <p>These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) for 104 of 109 residents who received food from the kitchen.</p> <p>Findings:</p> <p>During a concurrent initial kitchen tour observation and interview on 10/7/2024 at 8:35 a.m., with the Dietary Manager (DM), in the dry food storage area of the facility's kitchen, observed a scooper left inside a large container of cornstarch. The DM opened the container of cornstarch and removed the scooper, stating it should not be left in there. The DM further explained no scoop should ever be left in any food storage container as it can cause bacteria growth and harm the residents. Observed a large unpackaged container of lentils left open. The DM pointed to the open container of unpackaged lentils and stated the lid should be on the container and it should not be left open because debris can fall inside and contaminate it.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Storage of Canned and Dry Goods, last reviewed on 4/1/2024, the policy indicated foods shall be received and stored in a manner that complies with safe food handling practices .opened containers must be dated and sealed or covered during storage.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure five of seven sampled residents (Resident 37, Resident 43, Resident 63, Resident 65, and Resident 81) were placed on enhance barrier precautions (EBP-a method of using personal protective equipment [PPE - equipment designed to protect the wearer from injury or the spread of illness or infection such as gloves and gowns] to reduce the spread of pathogens between residents in skilled nursing facilities). <p>This deficient practice had the potential to increase the risk of spreading infection to other residents.</p> <ol style="list-style-type: none"> 2. Ensure an employee was wearing a hairnet while in the kitchen and handling food and two employees were not wearing dangly jewelry and watches while cooking and handling food. <p>These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) to 104 of 109 residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1.a. During a review of Resident 37's Admission Record, the document indicated the facility admitted the resident on 11/29/2022 with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain). The Admission Record indicated Resident 37 had a gastrostomy tube (G-Tube, a plastic tube inserted into a resident's stomach to administer nutrition and medications for one who has swallowing problems). <p>During a review of Resident 37's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/8/2024, the document indicated the resident was severely impaired in cognition (with skills required for daily decision making. The MDS indicated that Resident 37 was dependent (helper does all the effort) with toileting, dressing, and personal hygiene.</p> <p>During a review of Resident 37's physician's orders, the document indicated the following orders:</p> <p>Clean the G-Tube with normal saline (a saltwater solution), pat dry, and cover with a dry dressing every day shift, dated 6/29/2024.</p> <p>During a review of Resident 37's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) for G-Tube, updated 5/9/2024, the document indicated Resident 37 has a G-Tube with a goal that the resident will remain free of signs and symptoms of infection at the G-Tube site. The care plan indicated an intervention to assess insertion site for redness and inflammation.</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 - Some</p>	<p>During an observation on 10/8/24 at 11:22 a.m., with the Infection Preventionist (IP), observed Resident 37's room without EBP signs posted on the door or wall before entering the room.</p> <p>During a concurrent interview and record review on 10/9/2024 at 11:12 a.m., with the IP, reviewed the Resident EBP Assessment Record. The IP stated the residents indicated on the EBP Assessment Record should have EBP signs posted before entering the room. The IP stated he was aware of EBP since approximately 7/2024. The IP stated residents with indwelling devices such as catheters, G-Tubes, and wounds should be placed on EBP. The IP stated Resident 37 should have been on EBP since 7/2024. The IP stated the importance of posting EBP signs is to identify residents who are on EBP precautions and to prevent potential spreading of infection to other residents.</p> <p>1.b. During a review of Resident 43's Admission Record, the document indicated the facility admitted the resident on 9/7/2022 and readmitted the resident on 9/5/2024 with diagnoses that included neuromuscular dysfunction of bladder (urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem).</p> <p>During a review of Resident 43's MDS dated [DATE], the document indicated the resident was cognitively intact with skills required for daily decision making. The MDS indicated that Resident 43 had an indwelling urinary catheter (tube inserted into the body to drain urine for those having the inability to urinate).</p> <p>During a review of Resident 43's physician's orders, the document indicated the following orders:</p> <p>Check the suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) for cloudiness, blood, mucus, and sediments (particles in the urine that could be indicative of infection), dated 7/2/2024.</p> <p>During a review of Resident 43's Care Plan for Neuromuscular Dysfunction of Bladder, initiated 9/6/2024, the document indicated a goal that the resident will remain free of signs and symptoms of urinary infection for 90 days. The care plan indicated an intervention to provide suprapubic catheter care as ordered.</p> <p>During a concurrent observation and interview on 10/8/2024 at 10:42 a.m., with Treatment Nurse 1 (TN 1), observed Certified Nursing Assistant 1 (CNA 1) provide care to Resident 43 wearing gloves but not wearing a gown. TN 1 stated she does not wear a gown when providing wound care to Resident 43.</p> <p>During an observation on 10/8/24 at 11:22 a.m., with the IP, observed Resident 43's room without EBP signs posted on the door or wall before entering the room.</p> <p>During an interview on 10/8/2024 at 2 p.m., with CNA 1, CNA 1 stated he knew Resident 43 was on EBP even though there was not an EBP sign posted on the door leading into the room. CNA 1 stated he forgot to wear a gown earlier when he was observed providing Resident 43 care earlier that day.</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 - Some</p>	<p>During a concurrent interview and record review on 10/9/2024 at 11:12 a.m., with the IP, reviewed the Resident EBP Assessment Record. The IP stated the residents indicated on the EBP Assessment Record should have EBP signs posted before entering the room. The IP stated he was aware of EBP since approximately 7/2024. The IP stated residents with indwelling devices such as catheters, G-Tubes, and wounds should be placed on EBP. The IP stated Resident 43 should have been on EBP since 7/2024. The IP stated the importance of posting EBP signs is to identify residents who are on EBP precautions and to prevent potential spreading of infection to other residents.</p> <p>1.c. During a review of Resident 63's Admission Record, the document indicated the facility admitted the resident on 1/12/2022 and readmitted the resident on 6/5/2023 with diagnoses that included neuromuscular dysfunction of bladder and presence of a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body).</p> <p>During a review of Resident 63's MDS dated [DATE], the document indicated the resident was cognitively intact with skills required for daily decision making. The MDS indicated that Resident 63 had an indwelling urinary catheter and colostomy.</p> <p>During a review of Resident 63's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Provide suprapubic catheter care every day shift, dated 7/1/2024. - Provide colostomy care daily every day shift, dated 7/1/2024. <p>During a review of Resident 63's Care Plan for Neuromuscular Dysfunction of Bladder, initiated 6/7/2023, the document indicated a goal that the resident will remain free of signs and symptoms of urinary infection for 90 days. The care plan indicated an intervention to monitor for signs and symptoms of urinary tract infection.</p> <p>During a review of Resident 63's Care Plan for Colostomy, initiated 6/7/2023, the document indicated a goal that the resident will maintain effective pattern of bowel functioning for 90 days. The care plan indicated an intervention to perform colostomy care as needed.</p> <p>During an observation on 10/8/24 at 11:22 a.m., with the IP, observed Resident 63's room without EBP signs posted on the door or wall before entering the room.</p> <p>During a concurrent interview and record review on 10/9/2024 at 11:12 a.m., with the IP, reviewed the Resident EBP Assessment Record. The IP stated the residents indicated on the EBP Assessment Record should have EBP signs posted before entering the room. The IP stated he was aware of EBP since approximately 7/2024. The IP stated residents with indwelling devices such as catheters, G-Tubes, and wounds should be placed on EBP. The IP stated Resident 63 should have been on EBP since 7/2024. The IP stated the importance of posting EBP signs is to identify residents who are on EBP precautions and to prevent potential spreading of infection to other residents.</p> <p>1.d. During a review of Resident 65's Admission Record, the document indicated the facility admitted the resident on 9/4/2024 with diagnoses that included cerebral infarction.</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 - Some</p>	<p>During a review of Resident 65's MDS dated [DATE], the document indicated the resident was cognitively intact with skills required for daily decision making. The MDS indicated Resident 65 required maximum assistance (helper does more than half the effort) with toileting.</p> <p>During a review of Resident 65's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Clean the cholecystectomy site (a surgical procedure that removes the gallbladder [small digestive organ]), clean with normal saline, pat dry and apply mupirocin ointment (ointment to treat skin infections) twice a day for 14 days, dated 10/3/2024. <p>During a review of Resident 65's Care Plan for Cholecystectomy Tube, initiated 10/10/2024, the document indicated a goal that there will be no signs and symptoms of infection daily through the next review date. The care plan indicated a goal to perform cholecystectomy care as ordered.</p> <p>During an observation on 10/8/24 at 11:22 a.m., with the IP, observed Resident 65's room without EBP signs posted on the door or wall before entering the room.</p> <p>During a concurrent interview and record review on 10/9/2024 at 11:12 a.m., with the IP, reviewed the Resident EBP Assessment Record. The IP stated the residents indicated on the EBP Assessment Record should have EBP signs posted before entering the room. The IP stated he was aware of EBP since approximately 7/2024. The IP stated residents with indwelling devices such as catheters, G-Tubes, and wounds should be placed on EBP. The IP stated Resident 65 should have been on EBP since 9/2024. The IP stated the importance of posting EBP signs is to identify residents who are on EBP precautions and to prevent potential spreading of infection to other residents.</p> <p>1.e. During a review of Resident 81's Admission Record, the document indicated the facility admitted the resident on 4/22/2023 with diagnoses that included pedestrian on foot injured in collision with car (foot injury from being hit by a car).</p> <p>During a review of Resident 81's MDS dated [DATE], the document indicated the resident was cognitively intact with skills required for daily decision making. The MDS indicated Resident 81 was dependent on staff for toileting and showering.</p> <p>During a review of Resident 81's physician's orders, the document indicated the following orders:</p> <ul style="list-style-type: none"> - Left thigh wound to cleanse with normal saline, pat dry, and dressing change every day shift every other day for trauma wound for 21 days, dated 10/2/2024. <p>During a review of Resident 81's Care Plan for Left Upper Thigh wound, initiated 7/1/2024, the document indicated the wound will heal without complication daily. The care plan indicated an order to apply treatment as ordered.</p> <p>During an observation on 10/8/24 at 11:22 a.m., with the IP, observed Resident 81's room without EBP signs posted on the door or wall before entering the room.</p> <p>(continued on next page)</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 10/9/2024 at 11:12 a.m., with the IP, reviewed the Resident EBP Assessment Record. The IP stated the residents indicated on the EBP Assessment Record should have EBP signs posted before entering the room. The IP stated he was aware of EBP since approximately 7/2024. The IP stated residents with indwelling devices such as catheters, G-Tubes, and wounds should be placed on EBP. The IP stated Resident 81 should have been on EBP since 7/2024 due to their wound. The IP stated the importance of posting EBP signs is to identify residents who are on EBP precautions and to prevent potential spreading of infection to other residents.</p> <p>During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, revised 4/1/2024, the document indicated EBP is used to prevent the spread and transmission of multi-drug resistant organisms (MDRO- bacteria that have become resistant to certain antibiotics [medication to treat bacterial infections] between residents in skilled nursing facilities) to residents in long-term care facilities. The policy and procedure indicated EBPs use gown and gloves are applied prior to performing the high contact resident activity as opposed to before entering the room. The policy and procedure indicated high contact resident care activities requiring the use of gown and gloves for EBPs include device care such as urinary catheter, feeding tube, and wound care.</p> <p>49947</p> <p>2. During an initial kitchen tour observation on 10/7/2024 at 8:13 a.m., near the stove and tray-line area, the Dietary Manager was observed handling food without wearing a hairnet.</p> <p>During an interview on 10/7/2024 at 8:16 a.m., with the DM, the DM stated it was the facility's policy to always wear a hairnet while handling food in the kitchen. The DM further stated he should always wear his hairnet while in the kitchen but forgot. The DM stated that without a hairnet, hair debris can fall in the food and can cause cross-contamination; possibly causing residents to become ill.</p> <p>During an initial kitchen tour observation on 10/7/2024 at 8:22 a.m., near the stove area, observed [NAME] 1 (CK 1) handling and cooking food with two dangly bracelets, one that was metal, and the other was red fabric material.</p> <p>During an interview on 10/7/2024 at 8:16 a.m., with CK 1, CK 1 stated that she forgot to remove the bracelets prior to the start of her shift. CK 1 stated she is aware of the dress code policy, and they are not supposed to wear dangly jewelry because it could be dangerous by touching the food and cause an infection with a resident.</p> <p>During an interview on 10/7/2024 at 8:32 a.m. with the DM, the DM stated employees in the kitchen are provided training on the dress code while at work and with the exception on a wedding band, jewelry shall not be worn while handling food. The DS further stated it is an infection control issue because the jewelry can touch the food and cause cross contamination.</p> <p>A review of facility's policy and procedure (P&P) titled, Dress Code for Women and Men (Kitchen), revised on 4/1/2024, the P&P indicated staff working in the kitchen must wear a hairnet that completely covers the hair and no excessive dangly jewelry, just wedding bands only.</p>		