STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta View Post Acute	831 S Lake Street Los Angeles, CA 90057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to ensure a care plan was developed for Resident 2 ' s Central Venous Catheter (CVC-is a thin, flexible tube that's inserted into a vein to give fluids, blood, and/or medications). This failure had the potential to negatively affect the delivery of care and services. Findings: During a review of Resident 2 ' s Admission Record dated 1/13/25, it was indicated that Resident 2 was readmitted . to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), muscle weakness, and pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 2 ' s History and Physical (H&P), dated 10/25/24, indicated the resident can not make own medical decisions but can make needs known. During a review of Resident 2 ' s Minimum Data Set (MDS, an assessment tool) dated 10/21/24, indicated the resident was rarely/never understood and had short- and long-term memory problems with severely impaired cognition (mental action of understanding, reasoning, thinking, judgment, thought) and was dependent on staff for mobility, eating, dressing, bathing, and personal hygiene. During a review of Resident 2 ' s Admission Nursing Risks Evaluation/assessment dated [DATE] indicated that Resident 2 had an intravenous (IV, inside the vein) central line on the left upper chest. During a concurrent interview and record review on 1/13/15 at 4:00 pm with the Director of Nursing (DON), Resident 2 ' s care plans were reviewed. DON verified there was no care plan for the CVC. and stated it was important for the care plan to be in place to know the goals and perspective plan of care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P), Goals and Objectives, Care Plans reviewed November 2024, the P&P indicated care plans shall incorporate goals and objectives that lead to the resident ' s highest obtainable level of independence . care plan goals and objectives are defined as the desired outcome for a specific resident problem . Care plan goals and objectives are derived from information contained in the resident ' s comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to ensure Resident 2 ' s Central Venous Catheter (CVC, a thin, flexible tube that's inserted into a vein to give fluids, blood, and/or medications) care was documented, indicating it was done in the Intravenous (IV, inside the vein) Administration Record (IVAR). This failure resulted in the documentation not being complete and therefore unable to tell if the care was completed. Findings: During a review of Resident 2 ' s Admission Record dated 1/13/25, it was indicated that Resident 2 was readmitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), muscle weakness, and pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 2 ' s History and Physical (H&P), dated 10/25/24 indicated the resident cannot make their own medical decisions but can make their needs known. During a review of Resident 2 ' s Minimum Data Set (MDS, an assessment tool) dated 10/21/24, indicated the resident was rarely/never understood and had short- and long-term memory problems with severely impaired cognition (mental action of understanding, reasoning, thinking, judgment, thought) and was dependent on staff for mobility, eating, dressing, bathing, and personal hygiene. During a review of Resident 2 ' s Admission Nursing Risks Evaluation/assessment dated [DATE] indicated that Resident 2 had an intravenous (IV, inside the vein) central line on the left upper chest. During a review of Resident 2 ' s IV Administration Record (IVAR) dated December 2024, indicated a task of IV central line: monitor site every shift for signs/symptoms of infection and/or infiltration every shift for prevention. Starting on night shift 12/21/24 (three shifts a day; day, evening, and night) no entries made until 12/31/24 when new order entered. Review of the same IVAR indicated a task of IV central line measure external catheter length on admission, with each dressing change and as needed every day shift every Wednesday for prevention, with entry for Wednesday 12/25/24 missing. IV Central line: change transparent dressing on admission and weekly and as needed every day shift every Wednesday for prevention for 12 weeks entry for Wednesday 12/25/24 missing. During a concurrent interview and record review on 1/13/15 at 4:00 pm with the Director of Nursing (DON), Resident 2 ' s IVAR was reviewed. DON verified there was entries for the central line on the dates above and stated I don ' t know why the Registered Nurses did not document the care I know they did it, there is one on every shift, maybe there was something wrong with the way the order was entered that it did not come up on their tasks to do, that is possible since when the order recap was done on 12/31/24 the care is documented from then on. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P), Goals and Objectives, Care Plans reviewed November 2024, the P&P indicated care plans shall incorporate goals and objectives that lead to the residents highest obtainable level of independence . car plan goals and objectives are defined as the desired outcome for a specific resident problem . care plan goals and objectives are derived from information contained in the resident ' s comprehensive assessment.