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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056417 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>08/13/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>View Heights Conv Hosp |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12619 S. Avalon Blvd<br>Los Angeles, CA 90061 |  |

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

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on interview and record review, the facility failed to implement the care plan for two of three sampled residents (Resident 1 and Resident 2), when staff did not monitor Resident 1 and Resident 2 after a physical altercation on 8/6/2024.</p> <p>This deficient practice had the potential for residents to not receive appropriate care, treatment, and services.</p> <p>Findings:</p> <p>1. During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included schizoaffective disorder (a serious mental illness that affected how a person thought, felt, and behaved), tachycardia (heart was beating faster than normal, usually more than 100 beats per minute), hypertension (high blood pressure), and vitamin D deficiency (having inadequate amounts of vitamin D in body).</p> <p>During a review of Resident 1 ' s History &amp; Physical (H&amp;P), dated 9/8/2023, the H&amp;P indicated Resident 1 was alert and oriented.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS]- a standardized resident assessment and care screening tool), dated 7/5/2024, the MDS indicated Resident 1 ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 1 had disorganized thinking (fragmented or illogical thoughts and speech patterns that make it difficult for the individual to communicate effectively). The MDS indicated Resident 1 had no impairment (a loss of part or all of a physical or mental ability) to all extremities, was independent with mobility, and did not require assistance from a helper in walking.</p> <p>During a review of Resident 1 ' s Psychiatric Progress Note, dated 7/24/2024, the note indicated Resident 1 was alert and oriented to person and place. The note indicated Resident 1 had auditory hallucinations (hearing noises without an external stimulus), poor insight (an awareness of underlying sources of emotional, cognitive, or behavioral responses and difficulties in oneself or another person), and poor judgment.</p> <p>During a review of Resident 1 ' s progress notes, dated 8/7/2024, the notes indicated the following:</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>a. At 6:02 AM, Resident is alert and oriented, but no signs of any distress noted at this time. Resident remains stable post victimization. Resident is compliant (the act of following a medical regimen or schedule correctly and consistently, including taking medicines or following a diet) with medication and no adverse reaction noted.</p> <p>b. At 10:19 AM, Resident is alert and oriented, he medication compliant, ate his meals. He remained in his room most of the day.</p> <p>c. At 10:29 PM, Resident is alert and oriented, he medication compliant, ate his meals. He remained in his room most of the day.</p> <p>The progress notes indicated there was no documented assessment of Resident 1 ' s shoulders.</p> <p>During a review of Resident 1 ' s care plan titled, May be at risk for pain related to (r/t) being victimized by a male peer (Resident 2) m/b (manifested by) being hit on the shoulder initiated on 8/7/2024, the care plan indicated the staff ' s interventions included to monitor for Resident 1 for swelling around the shoulder area.</p> <p>During a concurrent telephone interview and record review on 8/13/2024 at 9:57 AM with Registered Nurse Supervisor 2 (RNS 2), Resident 1 ' s care plan titled, May be at risk for pain r/t being victimized by a male peer m/b being hit on the shoulder initiated on 8/7/2024 was reviewed. RNS 2 stated staff monitored Resident 1 ' s shoulders area by talking and checking on Resident 1. RNS 2 stated monitoring required staff to see and check even if Resident 1 said he was okay or alright. RNS 2 stated all interventions should have been documented. RNS 2 stated documentation should be reflected in the progress notes. RNS 2 stated if it was not documented it meant it was not monitored.</p> <p>2. During a review of Resident 2 ' s Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included schizoaffective disorder, stimulant dependence (a substance use disorder characterized by developing a tolerance and need for stimulant drugs [drugs made a person feel more awake, alert, confident or energetic]), and nicotine dependence.</p> <p>During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions making was intact. The MDS indicated Resident 2 had serious mental illness. The MDS indicated Resident 2 had no impairment to all extremities, was independent with mobility, and did not require assistance from a helper in walking.</p> <p>During a review of Resident 2 ' s Psychiatric Progress Note, dated 7/25/2024, the note indicated Resident 2 was alert and oriented to person and place. The note indicated Resident 2 had auditory hallucinations, poor insight, and poor judgment.</p> <p>During a record review of Resident 2 ' s care plan titled, Had episode of physical aggression m/b hitting peer on the shoulder, unprovoked ., revised on 8/7/2024, the care plan indicated staff ' s interventions included to administer PRN (as needed) medications as ordered, and monitor/document for side effects (an unwanted or undesirable effect of a drug) and effectiveness. The care plan indicated Resident 2 was placed on 1:1 monitoring for safety precautions.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a record review of Resident 2 ' s care plan titled, At risk for pain r/t hitting a male peer (Resident 2) with a closed fist, revised on 8/7/2024, the care plan indicated staff ' s interventions included to monitor for any swelling on the hand or fist area.</p> <p>During a review of Resident 2 ' s Progress Notes, dated 8/7/2024, the notes indicated the following:</p> <p>a. At 1:49 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>b. At 4:55 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>c. At 7:04 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>d. At 9:53 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>e. At 11:13 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>The notes indicated no documented monitoring for the side effects of Zyprexa (an antipsychotic medication used to treat several mental health conditions) nor assessment of Resident 2 ' s hand or fist area.</p> <p>During a review of Resident 2 ' s One-to-One (1:1, close supervision) Monitoring sheet, dated 8/7/2024, the 1:1 monitoring sheet indicated there was no documentation on 8/7/2024 at 10 PM.</p> <p>During a concurrent telephone interview and record review with RNS 2 on 8/13/2024 at 9:57 AM, Resident 2 ' s care plan titled, Had episode of physical aggression m/b hitting peer on the shoulder, unprovoked . revised on 8/7/2024, was reviewed. RNS 2 stated he was unable to see documentation of monitoring and effectiveness for the PRN administration of Zyprexa. RNS 2 stated the monitoring should have been documented in the Medication Administration Record (MAR). RNS 2 stated he was unable to tell if Zyprexa was effective for Resident 2 from the MAR or progress notes. RNS 2 stated the effectiveness of Zyprexa should be documented in the progress notes. RNS 2 stated if it was not documented it meant it was not monitored. RNS 2 stated lack of monitoring affected the quality of care of the resident. RNS 2 stated the facility did not implement what was indicated on the care plan.</p> <p>During a concurrent telephone interview and record review on 8/13/2024 at 11:05 AM with the Director of Nursing (DON), Resident 2 ' s care plan titled, At risk for pain r/t hitting a male peer with a closed fist, revised on 8/7/2024, was reviewed. The DON stated she was unable to locate any documentation regarding Resident 2 ' s hand or fist area in Resident 2 ' s notes. The DON stated it should be documented. The DON stated even if the area was clean, staff still needed to document.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a concurrent telephone interview and record review on 8/13/2024 at 11:05 AM with the DON, Resident 2 ' s care plan titled, Episode of physical aggression m/b hitting peer on the shoulder, unprovoked . revised on 8/7/2024, was reviewed. The DON stated the 1:1 monitoring sheet should be completed and the risk of not completing was a safety hazard. The DON stated if it was not documented it meant it was not done. The DON stated interventions on the care plans should be implemented.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled Care Plans-Comprehensive (of large scope; covering or involving much; inclusive), revised 2020, the P&amp;P indicated each resident's comprehensive care plan has been designed to identify the professional services that are responsible for each element of care and aid in preventing or reducing declines in the resident's functional status and/or functional levels.</p> |  |  |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on interview and record review, the facility failed to provide services that met professional standards of quality for two of three sampled residents (Resident 1 and Resident 2) when:</p> <ol style="list-style-type: none"> <li>1. Staff did not document one-to-one (1:1, close supervision) monitoring was performed for Resident 2 at 10 PM on 8/7/2024.</li> <li>2. Staff documented the same assessments for Resident 2 over different time periods on 8/7/2024 and 8/8/2024. Staff documented the same assessments for Resident 1 over different time periods on 8/7/2024.</li> <li>3. Staff did not update Resident 1 and Resident 2's vital signs (measurements of the body's most basic functions) when there was a change in the resident's condition on 8/6/2024.</li> </ol> <p>These deficient practices had the potential to result in serious harm such as another episode of aggression towards others, and a delay of necessary treatments.</p> <p>Findings:</p> <p>1a. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included schizoaffective disorder (a serious mental illness that affected how a person thought, felt, and behaved), stimulant dependence (a substance use disorder characterized by developing a tolerance and need for stimulant drugs [drugs made a person feel more awake, alert, confident or energetic]), and nicotine dependence.</p> <p>During a review of Resident 2's Minimum Data Set ([MDS]- a standardized resident assessment and care screening tool), dated 5/12/2024, the MDS indicated Resident 2's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 2 had no impairment on all extremities, was independent with mobility, and did not require assistance from a helper in walking. The MDS indicated Resident 2 had serious mental illness.</p> <p>During a review of Resident 2's Psychiatric Progress Note, dated 7/25/2024, the note indicated Resident 2 was alert and oriented to person and place. The note indicated Resident 2 had auditory hallucinations (hearing noises without an external stimulus), poor insight (an awareness of underlying sources of emotional, cognitive, or behavioral responses and difficulties in oneself or another person), and poor judgment.</p> <p>During a review of Resident 2's Change In Condition form dated 8/6/2024, the form indicated on 8/6/2024 at approximately 5:00 PM, Resident 2 was seen (by unidentified staff) hitting a male peer (Resident 1) on the shoulder area unprovoked.</p> <p>During a review of Resident 2's 1:1 monitoring sheet, dated 8/7/2024, the 1:1 monitoring sheet indicated there was no documentation on 8/7/2024 at 10 PM.</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 - Some</p>                    | <p>During an interview with Certified Nurse Assistant (CNA) 1 on 8/8/2024 at 12:06 PM, CNA 1 stated Resident 2 was on 1:1 monitoring because of the resident ' s aggressive behavior toward Resident 1. CNA 1 stated 1:1 monitoring meant staff assigned to the resident needed to be always with the resident. CNA 1 stated the staff assigned for 1:1 monitoring needed to document on 1:1 monitoring sheet. CNA 1 stated assigned staff needed to document every hour where the resident was and what the resident was doing.</p> <p>During a concurrent of interview and record review on 8/8/2024 at 3:23 PM with the Director of Nursing (DON), Resident 2 ' s 1:1 monitoring sheet, dated 8/7/2024 was reviewed. The 1:1 monitoring sheet indicated incomplete documentation at 10:00 PM. The DON stated it should be completed and the risk of not completing was of safety hazard.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled Resident-Resident Abuse Policy, dated 2023, the P&amp;P indicated the facility would document in the resident record all interventions and their effectiveness when a resident was observed in a physical, sexual, or verbal altercation or confrontation with another resident.</p> <p>1b. During a review of Resident 2 ' s Progress Note, dated 8/7/2024, the note indicated the following:</p> <p>a. At 8:33 AM, Resident was calm all day and has not created any commotion (an agitated disturbance). He is medication compliant (the act of following a medical regimen or schedule correctly and consistently, including taking medicines or following a diet), and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>b. At 10:43 AM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>c. At 11:45 AM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>d. At 1:49 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>e. At 4:55 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>f. At 7:04 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>g. At 9:53 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>h. At 11:13 PM, Resident was calm all day and has not created any commotion. He is medication compliant, and he ate his meals. He was in his room all day with 1:1 employee.</p> <p>During a review of Resident 2 ' s Progress Notes, dated 8/8/2024, the notes indicated the following:</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 - Some</p>                    | <p>a. At 4:33 AM, Resident is alert and oriented but no signs of any distress noted and no aggressive or abnormal behavior observed at this time. Resident is compliant with medication regimen and no adverse reaction (harmful effects suspected to be caused by a medicine) noted.</p> <p>b. At 5:47 AM, Resident is alert and oriented but no evidence of any distress noted and no aggressive or abnormal behavior observed at this time. Resident is compliant with medication regimen and no adverse reaction noted.</p> <p>During a concurrent interview and record review on 8/8/2024 at 2:42 PM with the DON, Resident 2 ' Progress Notes dated 8/7/2024 was reviewed. The DON stated it was not appropriate to document the same assessment at different times. The DON stated nurses should document what they observed such as the behaviors the resident presented and any symptoms during the shift. The DON stated it was important to document properly so the facility could identify concerns and be aware of the resident ' s accurate condition.</p> <p>During a concurrent telephone interview and record review on 8/13/2024 at 9:57 AM with Registered Nurse Supervisor (RNS) 2, Resident 2 ' s Progress Notes dated 8/7/2024 were reviewed. RNS 2 stated it was not the right way to document. RNS 2 stated nurses should document the specific assessment of the resident of what the nurse saw. RNS 2 stated the same thing should not be documented repeatedly. RNS 2 stated it affected the resident ' s quality of care negatively.</p> <p>1c. During a review of Resident 2 ' s Change in Condition form, dated 8/6/2024, the form indicated Resident 2 had a change in condition on 8/6/2024 around 5:00 PM. The form indicated Resident 2 ' s vital signs were as follows:</p> <p>At 7:42 AM, blood pressure of 106/76 millimeters of mercury (mmHg, unit of measurement) (normal reference range [NRR] less than 120/80 mm/Hg).</p> <p>At 7:42 AM, respirations (rate of breathing) of 18 (NRR 12-20 breaths per minute).</p> <p>At 7:42 AM, oxygen saturation (level of oxygen circulating in the blood) was 99 percent (%) (NRR, 92-100%).</p> <p>At 8:08 PM, Resident 2 ' s pulse was 90 beats per minute (NRR 60-100).</p> <p>At 7:44 PM, temperature was 97 degrees Fahrenheit.</p> <p>During a concurrent telephone interview and record review on 8/13/2024 at 11:05 AM with the DON, Resident 2 ' s Change In Condition form dated 8/6/2024 was reviewed. The DON stated vital signs should be taken after the assessment of the residents. The DON stated the nurses should update the vital signs on the form. The DON stated it was important to update the vital signs in the resident ' s chart to assess the resident, and to notify the MD if there were any changes. The DON stated if it was not done properly, it would delay care to residents.</p> <p>During a telephone interview on 8/13/2024 at 9:57 AM, with RNS 2, RNS 2 stated if it was not documented meant it is not monitored. RNS 2 stated it affected the quality of care to the residents.</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 - Some</p> | <p>2a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder, tachycardia (heart was beating faster than normal, usually more than 100 beats per minute), hypertension (high blood pressure), and vitamin D deficiency (having inadequate amounts of vitamin D in body).</p> <p>During a review of Resident History &amp; Physical (H&amp;P), dated 9/8/2023, the H&amp;P indicated Resident 1 was alert and oriented.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated Resident 1 ' s cognitive skills for daily decisions making was moderate impaired. The MDS indicated Resident 1 had disorganized thinking (fragmented or illogical thoughts and speech patterns that make it difficult for the individual to communicate effectively). The MDS indicated Resident 1 had no impairment to all four extremities, was independent with mobility, and did not require assistance from a helper in walking.</p> <p>During a review of Resident 1 ' s Psychiatric Progress Note, dated 7/24/2024, the note indicated Resident 1 was alert and oriented to person and place. The note indicated Resident 1 had auditory hallucinations, poor insight, and poor judgment.</p> <p>During a review of Resident 1 ' s Progress Notes, dated 8/7/2024, the notes indicated the following:</p> <p>a. At 10:19 AM, Resident is alert and oriented, he medication compliant, ate his meals. He remained in his room most of the day.</p> <p>b. At 10:29 PM, Resident is alert and oriented, he medication compliant, ate his meals. He remained in his room most of the day.</p> <p>2b. During a review of Resident 1 ' s Change In Condition form, dated 8/6/2024, the form indicated had a change in condition on 8/6/2024 around 5:00 PM. The form indicated Resident 1 ' s most recent vital signs were as follows on 8/6/2024 at 8:58 AM:</p> <p>a. Blood pressure 116/72 mmHg.</p> <p>b. Pulse was 96 beats per minute.</p> <p>c. Respiration was 18 breaths per minute.</p> <p>d. Temperature was 96.1 degrees Fahrenheit.</p> <p>e. Oxygen saturation 96%.</p> <p>The form indicated there were no additional documented vital signs taken after 8/6/2024 at 8:58 AM.</p> <p>During a telephone interview on 8/13/2024 at 11:05 AM with the DON, the DON stated vital signs should be taken after the assessment of the residents. The DON stated the nurses should update the vital signs on the form. The DON stated it was important to update the vital signs in the resident ' s chart to assess the resident, and to notify the MD if there were any changes. The DON stated if it was not done properly, it would delay care to residents.</p> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056417   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>08/13/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>View Heights Conv Hosp   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12619 S. Avalon Blvd<br>Los Angeles, CA 90061 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During a review of the facility ' s P&amp;P titled Change in a Resident's Condition, dated 1/2022, the P&amp;P indicated the nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status including all five vital signs.</p> <p>During a review of the facility ' s P&amp;P titled Charting and Documentation, dated 4/2023, the P&amp;P indicated all observations, medications administered, services performed, etc. must be documented in the resident ' s clinical records.</p> <p>During a review of the facility ' s P&amp;P titled Monitoring of Vital Signs, dated 1/2024, the P&amp;P indicated residents with special needs or problems may warrant more frequent monitoring of vital signs. The P&amp;P indicated all vital signs will be documented on the Vital Signs Sheet in the permanent health record.</p> |  |  |