STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056417	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
View Heights Conv Hosp	12619 S. Avalon Blvd 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, facility staff failed to ensure one of four sampled residents (Resident 2) was monitored for verbal and physical aggression, as ordered by the physician. This deficient practice created the risk for Resident 2, who hit another resident in the face on 4/16/2025, to commit repeat physical aggression towards other facility residents with possible physical injury and psychosocial harm. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and was most recently readmitted on [DATE]. Resident 1 ' s admitting diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/9/2025, the MDS indicated Resident 1 did not have impaired cognition (difficulties with thinking, learning, remembering, and making decisions). The MDS indicated Resident 1 was independent with mobility while in and out of bed. 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 admitting diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 occasionally exhibited hallucinations and delusions, and occasionally exhibited disorganized thinking (e.g., unclear or illogical flow of ideas). The MDS indicated Resident 2 had cognitive impairments. The MDS indicated Resident 2 was independent with mobility while both in and out bed and had no impairments to her upper or lower extremities. During a review of Resident 2 ' s Change of Condition (COC) assessment, dated 4/16/2025, the COC indicated that on 4/16/2025, Resident 2 hit Resident 1 without provocation. The COC further indicated Resident 2 verbalized a desire to hit someone again and was tearing her clothing. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s physician order, dated 4/23/2025, the physician order indicated staff were to monitor Resident 2 for verbal and physical aggression and document the number of episodes. During an interview on 4/28/2025 at 9:05 a.m., with Resident 1, Resident 1 stated Resident 2 hit her in the face while they were walking in the hallway, and stated she did not know why Resident 2 hit her. Resident 1 stated she sustained pain after being hit and stated she took pain medication. During an interview on 4/28/2025 at 9:25 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 2 had a history of aggressive behavior towards others and could become agitated very quickly. During an interview on 4/28/2025 at 10:28 a.m., with CNA 2, CNA 2 stated Resident 2 was aggressive with both staff and residents. CNA 2 stated Resident 2 was a safety risk to others and stated, I even get scared of her sometimes. During a concurrent interview and record review on 4/28/2025 at 12:01 p.m., with the Director of Nursing (DON), Resident 2 ' s physician orders were reviewed. The DON stated Resident 2 had orders to be monitored for verbal and physical aggression, and staff were to document the number of episodes. The DON stated staff were to document on Resident 2 ' s behavior monitoring flowsheet. During a concurrent interview and record review, on 4/28/2025 at 12:04 p.m., with the DON, Resident 2 ' s behavior monitoring flowsheet, dated 4/2025, was reviewed. The DON stated the behavior monitoring flowsheet did not indicate staff were monitoring Resident 2 for verbal and/or physical aggression. The DON stated the purpose of the monitoring was to identify escalating behaviors and prevent additional incidents of aggression and abuse towards other residents. The DON stated monitoring was required to ensure the safety of the other facility residents. During a review of the facility ' s policy and procedure (P&P) titled Preventing Resident Abuse, revised 2023, the P&P indicated staff were to monitor residents with needs and behaviors that may lead to conflict. During a review of the facility ' s P&P titled High Risk Safety Monitoring, revised 2024, the P&P indicated it was the facility ' s policy to monitor the status of residents who are at risk for unsafe behavior. The P&P indicated the licensed nurse was to monitor the resident at frequent intervals for safety and document all actions taken in the clinical record.