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	07/17/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (continued on next page)

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

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the lump (abnormal bumps or swellings on or under the skin) at the back of neck of one of four residents (Resident 1), was assessed timely and reported to the resident's physician. This deficient practice had the potential to result in the delay of care and services necessary to treat Resident 1's back of neck lump and had the potential to cause worsening condition of the lump. Findings:During a concurrent observation and interview on 7/17/2025 at 9:30 a.m. with Resident 1, Resident 1 stated he had a lump (mass) at the back of his neck. The lump was observed like the size of a pea, did not look swollen and was not red. Resident 1 stated a family member (FM)1 saw the lump and probably informed the nurse.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 (a mental illness that can affect thoughts, mood, and behavior), alcohol dependence (a chronic disease in which a person craves drinks that contain alcohol and is unable to control his or her drinking), and nicotine dependence (a chronic, compulsive need to use nicotine despite negative consequences.) During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/14/2025, the MDS indicated Resident 1 had intact cognition. The MDS indicated Resident 1 was independent with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, and mobility. During a review of the County Case Management (CM) e-mail sent to the facility's Registered Nurse (RN) 2 dated 6/16/2025 timed 2:27 p.m., the County CM email indicated notification to RN 2 regarding FM 1's request to have a nurse check Resident 1's bump on the middle of the neck. During a review of Resident 1's Progress Notes dated 6/16/2025 to 7/15/2025, the progress notes did not indicate a nurse had assessed Resident 1's bump on the middle of the neck when requested by the FM 1 as indicated in the County CM email on 6/16/2025. The progress notes did not indicate RN 2 responded and provided update to the County CM as requested in the email dated 7/15/2025. During a review of the County CM e-mail dated 7/15/2025 timed 10:27 a.m., the County CM email indicated a requested update regarding Resident 1's neck. During an interview on 7/17/2025 at 1:00 p.m. with RN 2, RN 2 stated the County CM's email dated 6/16/2025, with the FM 1's request to assess Resident 1's lump in the middle of neck was received. RN 2 stated Resident 1's neck was checked but there was nothing observed in the resident's front neck. RN 2 stated Resident 1's back side of his neck was not assessed. RN 2 stated she did not document Resident 1's assessment in the resident's progress notes. RN 2 stated she did not notify the doctor nor replied to the County CM's e-mails, because there was nothing in Resident 1's neck. RN 2 acknowledged that the County CM's email was received on 7/15/2025 following up updates about Resident 1's lump on the back of his neck. RN 2 stated she went to Resident 1's room and assessed Resident 1's back of neck and observed a small bump. RN 2 stated the consequence when the resident's skin was not properly assessed, or concerns ignored was putting the resident at risk to sustain skin infections. RN 2 stated Resident 1's FM inquiry was not addressed, and the County CM's email was not replied. During an interview on 7/17/2025 at 2:47 p.m. with the Director of Nursing (DON), the DON stated residents' skin were checked by the Certified Nursing Assistants (CNA) on shower schedules and by the nurses daily. The DON stated when the family representative requested for residents to be assessed, the nurses should go and assess the resident. The DON stated after RN 2 assessed Resident 1's back of neck, RN 2 should have informed the doctor and Resident 1's County CM. The DON stated if there were no documentation in the resident's clinical records about the findings, it meant the nurses did not acknowledge the FM's concerns, and the assessment was never done. The DON stated the risk of Resident 1 not receiving the proper assessment could cause worsening condition of Resident 1's back of neck lump. During a review of the facility's undated policy and procedure (P&P) titled, Resident Assessment, the P&P indicated a registered nurse should conduct and coordinate all comprehensive assessment, to identify the resident's care needs. During a review of the P&P titled Charting and Documentation, dated 1/2025, the P&P indicated all services provided to the residents should be documented in resident's medical record. The P&P indicated treatments or services performed to the resident should be documented on the resident's medical record.