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	07/30/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 interview and record review, the facility failed to ensure a resident's responsible party (RP 1) was notified following the resident's involvement in a physical altercation with another resident and of an interdisciplinary team (IDT) conference for one out of three sampled residents (Resident 1). This deficient practice resulted in RP 1 not being informed of Resident 1's physical altercation with Resident 2 on 7/25/2025 nor informed of an IDT conference following the incident on 7/28/2025, placing Resident 1 at risk for uncoordinated care and decisions without input from RP 1.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 readmitted on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), hypertension (high blood pressure), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 5/5/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 was independent with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought) and psychoactive substance abuse (the harmful use of substances that affect mental processes, leading to significant health risks and social consequences). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were intact. The MDS indicated Resident 2 was independent for ADLs. 1. During a review of Resident 1's Change of Condition Note, dated 7/25/2025, the Change of Condition Note indicated on 7/25/2025, Resident 1 walked towards Resident 2 and suddenly hit him on the left side of the face unprovoked. The Change of Condition Note indicated Resident 1's conservator (Responsible Party [RP 1]) was notified on 7/25/2025 at 3:16 p.m. During a review of Resident 1's Progress Notes, dated 7/25, 7/26, 7/27, 7/28, 7/29, and 7/30/2025, the Progress Notes did not indicate a voicemail was left notifying RP 1 of Resident 1's involvement in a physical altercation. There were no notes to indicate attempts to follow up with RP 1 to ensure she was made aware of Resident 1's involvement in a physical altercation. During an interview on 7/30/2025 at 11:41 a.m. with RP 1, RP 1 stated she was never made aware of the physical altercation that involved Resident 1. RP 1 stated that she did not receive any calls or voicemails from the facility regarding the incident that occurred on 7/25/2025. RP 1 stated, To be honest, they (the facility) have not been good at notifying me about any changes or [Resident 1's] plan of care. I always have to call and ask about things. During a concurrent record review and interview on 7/30/2025 at 12:07 p.m. with Registered Nurse (RN) 1, Resident 1's Resident Representative Notification section of the Change of Condition Note, dated 7/25/2025, was reviewed. The Resident Representative Notification section indicated RP 1 was notified of the incident on 7/25/2025 at 3:16 p.m. The Resident Representative Notification section indicated RN 1 signed the completion of the section. RN 1 stated after a change of condition occurred, it was important to notify the resident's RP because it was the RP's right to be aware of any changes that occurred in the resident. RN 1 stated if RP 1 was not successfully contacted, then a voicemail should be left and a follow-up call should occur to ensure the RP was notified. RN 1 stated she recalled, on 7/25/2025, she helped Licensed Vocational Nurse (LVN) 1 with documenting after the incident. RN 1 stated she signed the notification section of the Change of Condition Note because she thought LVN 1 was able to successfully notify RP 1 of the incident. RN 1 stated if LVN 1 was unable to speak to RP 1, then a voicemail should have been left and documented, or LVN 1 should have followed up or endorsed a need for a follow-up for the next shift. RN 1 stated there was no documentation to indicate LVN 1 left a voicemail or followed up. During an interview on 7/30/2025 at 12:21 p.m. with LVN 1, LVN 1 stated the normal process was to notify the resident's RP of any changes of condition. LVN 1 stated she called RP 1's number but was not able to speak with RP 1. LVN 1 stated she left a voicemail, but did not document that a voicemail was left. LVN 1 stated she did not document or follow up to ensure RP 1 was informed of Resident 1's change of condition because the shift was chaotic and that she was very busy. During a concurrent record review and interview on 7/30/2025 12:34 p.m. with the Director of Nursing (DON), Resident 1's Resident Representative Notification section of