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	04/15/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physicians and residents' conservators (a person or organization legally appointed to manage the affairs, finances, or property of someone deemed incapable of doing so) of a change of condition following a resident's allegation of sexual abuse for three of three sampled residents (Resident 1, Resident 2, and Resident 3), after Resident 1 alleged Resident 2 and Resident 3 sexually abused her. These deficient practices limited the involvement of Resident 2 and Resident 3's conservators in care decisions and had the potential to result in a delay in timely safety interventions, placing residents at risk for harm. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/18/2026, the MDS indicated Resident 1's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 was able to carry out activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) independently. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition (process of thinking) was intact. The MDS indicated Resident 2 was able to carry out ADLs independently. c. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE]. Resident 3's diagnoses included schizoaffective disorder. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 was able to carry out ADLs independently. During a review of the facility's SOC 341 Form (a required document for mandated reporters-and recommended for the public-to report known or suspected physical, financial, emotional, or neglectful abuse of individuals aged 65 or older or dependent adults), dated 4/14/2026, the form indicated, on 4/14/2026, Resident 1 reported that she was raped (unlawful sexual penetration (vaginal, anal, or oral) committed against a person's will, without consent, or using force, coercion, or threat) by her roommates (Resident 2 and Resident 3) on 4/13/2026 or 4/14/2026. The form did not indicate Resident 2 and 3's physician or conservators were notified. During a concurrent interview and record review on 4/15/2026 at 11:44 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's and Resident 3's Progress Notes and Change of Condition Notes, dated 4/13/2026 through 4/15/2026, were reviewed. The Progress Notes and Change of Condition Notes did not indicate Resident 2 and 3's physician nor Resident 2 and 3's conservators were notified of Resident 1's allegation of rape involving Resident 2 and Resident 3. LVN 1 stated the facility's standard process required the initiation of a Change of Condition Note to ensure physician notification, and notification of the residents' conservators following such an allegation. LVN 1 stated these notifications were important to ensure awareness of the serious allegation and to maintain (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	resident safety. LVN 1 stated that in the absence of the Change of Condition documentation, physician and conservator notification were not completed, which had the potential to place other residents at risk for harm. During an interview on 4/15/2026 at 12:03 p.m. with Resident 3's conservator (Conservator 1), Conservator 1 stated she did not receive any emails or calls from the facility regarding the allegation of sexual misconduct made against Resident 3. During an interview on 4/15/2026 at 12:55p.m. with Registered Nurse (RN) 1, RN 1 stated on 4/14/2026, she was the assigned nurse for Resident 1, Resident 2, and Resident 3 when the allegation was reported. RN 1 stated she did not notify Resident 2 and 3's physician or conservators because she did not believe that the allegation was substantiated (found to be true). During an interview on 4/15/2026 at 1:19 p.m. with the Director of Nursing (DON), the DON stated for any allegation of sexual abuse, licensed nursing staff were expected to initiate a Change of Condition Note to ensure the physician and conservators were notified following the allegation for all residents involved, including the alleged perpetrators. The DON stated this was necessary to ensure resident safety and address potential changes in the residents' mental or physical condition. The DON stated the lack of physician and conservator notification for Resident 2 and Resident 3 had the potential to lead to a delay in interventions. During a review of the facility's Policy and Procedure (P&P) titled, Reporting of Unusual Occurrences, revised 1/2025, the P&P indicated the facility was to ensure the physician was notified of unusual occurrences that affect or potentially affect the care and services to residents. During a review of the facility's P&P titled, Change in a Resident's Condition, revised 12/2025, the P&P indicated the facility was to ensure the physician and conservator were notified of changes in the resident's medical or mental condition. The P&P indicated the nurse supervisor or charge nurse would notify the conservator when the resident was involved in any incidents or when a change in psychosocial status has occurred. The P&P indicated notifications would be made within the assigned shift of a change occurring in the resident's mental condition or status.

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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	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** Based on interview and record review, the facility failed to develop and implement interventions for two of three sampled residents (Resident 2 and Resident 3), after Resident 1 alleged Resident 2 and Resident 3 sexually abused her. These deficient practices resulted in a delay of the implementation of safety measures and monitoring for Resident 2 and Resident 3, which placed residents at risk for harm.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/18/2026, the MDS indicated Resident 1's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 was able to carry out activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) independently. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 was able to carry out ADLs independently. c. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE]. Resident 3's diagnoses included schizoaffective disorder. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 was able to carry out ADLs independently. During a review of the facility's SOC 341 Form (a required document for mandated reporters - and recommended for the public - to report known or suspected physical, financial, emotional, or neglectful abuse of individuals aged 65 or older or dependent adults), dated 4/14/2026, the form indicated, on 4/14/2026, Resident 1 reported that she was raped (to force someone to have sexual intercourse or other penetration without consent) by her roommates (Resident 2 and Resident 3) on 4/13/2026 or 4/14/2026. The form did not indicate Resident 2 and Resident 3 received additional monitoring. During a concurrent interview and record review on 4/15/2026 at 1:19 p.m. with the Director of Nursing (DON), all of Resident 2 and Resident 3's Care Plans, dated in 2026, were reviewed. The care plans did not indicate a care plan with interventions was developed following Resident 1's allegation of rape against Resident 2 and Resident 3. The DON stated care plans should have been developed and implemented to ensure immediate safety interventions. The DON stated the lack of care plan development had the potential to place residents at harm. During a review of the facility's policy and procedure (P&P) titled, Care Plans Guidelines, revised 12/2024, the P&P indicated the facility was to ensure care plans were revised as changes in the resident's condition dictate.