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	06/25/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's orthostatic blood pressures (blood pressures taken to help healthcare providers determine if the body is struggling to regulate blood pressure when moving to an upright position) were obtained for one of four sampled residents (Resident 1) according to the facility's established procedure for a resident who suffered a recent fall with injury. This failure had the potential to prevent identification of orthostatic hypotension (a drop in blood pressure when standing up) as a contributing factor to Resident 1's fall, delayed clinical interventions to reduce dizziness, and placed Resident 1 at risk for subsequent falls with injury. Findings: 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) and obesity (complex, chronic disease characterized by an excessive amount of body fat). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 4/20/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 was independent for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician Orders, dated 1/4/2024, the Physician Orders indicated to monitor and record orthostatic blood pressures (blood pressures taken to help healthcare providers determine if the body is struggling to regulate blood pressure when moving to an upright position) laying, sitting, and standing every evening shift every four weeks on Tuesdays for orthostatic hypotension (a drop in blood pressure when standing up) monitoring. During a review of Resident 1's General Acute Care Hospital (GACH) Emergency Department (ED) Note, dated 6/20/2026, the ED Note indicated, on 6/20/2026, Resident 1 presented to the ED with a closed head injury prior to arrival. The GACH ED note indicated Resident 1 suffered a slip and fall injury in the hallway at the facility. The GACH ED Note indicated Resident 1 sustained dental fractures (broken bone) and a fracture to the right-hand pinky finger. During a review of Resident 1's Morse Fall Scale (rapid, widely used clinical tool to assess a patient's risk of falling), dated 5/31/2026, the fall scale indicated Resident 1 was at moderate risk for a fall. During an interview on 6/25/2026 at 9:15 a.m. with Registered Nurse (RN) 1, RN 1 stated obtaining orthostatic blood pressures was imperative to detect orthostatic hypotension. RN 1 stated Resident 1 required diligent orthostatic blood pressure monitoring because the resident was known to be prescribed multiple psychotropic medications (mood altering medications), which increased her risk for dizziness and falls. During a concurrent interview and record review on 6/25/2026 at 3:36 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Monitoring Medication Administration Record (MAR) and Medication Administration Audit Report, dated 6/2026, were reviewed. The Medication Administration Audit Report indicated Resident 1's blood pressures were obtained in the following order on 6/23/2026: sitting at 10:34 p.m., standing at 10:39 p.m., and lying at 10:59 p.m. LVN 1 stated his usual practice when obtaining orthostatic blood pressure measurements was to assess the resident in the sitting position first, followed by the standing position, and lastly in the lying position. LVN 1 (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed he followed this same sequence when obtaining Resident 1's orthostatic blood pressure measurements on 6/23/2026. During a concurrent interview and record review on 6/25/2026 at 3:50 p.m. with LVN 1, the facility's lesson plan for orthostatic blood pressure measuring, dated 5/22/2026, was reviewed. The lesson plan indicated licensed nurses were instructed to obtain orthostatic blood pressure measurements in the lying, sitting, and standing positions. LVN 1 stated he had not obtained Resident 1's orthostatic blood pressure measurements in the correct sequence and stated the incorrect technique could result in undetected orthostatic hypotension, delayed appropriate clinical intervention, and placed Resident 1 at increased risk for falls, especially because Resident 1 was receiving psychotropic medications. During a review of the facility's Policy & Procedure (P&P) titled, Falls Management System, revised 12/2025, the P&P indicated the facility was to provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs. During a review of the facility's P&P titled, Monitoring of Vital Signs, dated 12/2025, the P&P indicated the facility was to ensure optimum resident assessment and to ensure optimum monitoring of resident change of condition.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure orthostatic blood pressure measurements (blood pressures taken to help healthcare providers determine if the body is struggling to regulate blood pressure when moving to an upright position) were accurately documented for one of three sampled residents (Resident 2). This failure had the potential to result in the delayed identification of orthostatic hypotension (a drop in blood pressure when standing up), delayed clinical interventions to reduce dizziness, and placed Resident 2 at risk for subsequent falls with injury.Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), hypoosmolality (an excess of total body water relative to electrolytes), hypertension (high blood pressure), and diabetes (poor blood sugar control). During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 5/26/2026, the MDS indicated Resident 2's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 2 was entirely independent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's Physician Orders, dated 8/9/2024, the Physician Orders indicated to monitor and record orthostatic blood pressures (blood pressures taken to help healthcare providers determine if the body is struggling to regulate blood pressure when moving to an upright position) laying, sitting, and standing, every evening shift every four weeks on Tuesdays, for orthostatic hypotension (a drop in blood pressure when standing up) monitoring. During a review of Resident 2's Change of Condition Note, dated 5/9/2026, the note indicated, on 5/9/2026, Resident 2 suffered a witnessed fall. During a review of Resident 2's Morse Fall Scale, dated 5/27/2026, the fall scale indicated Resident 2 was at moderate risk for falls. During a concurrent interview and record review on 6/25/2026 at 2:33 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 2's Monitoring Medication Administration Record (MAR) and Medication Administration Audit Report, dated 6/2026, were reviewed. The MAR and audit report indicated Resident 2's orthostatic blood pressures in the lying, sitting, and standing positions was documented as 139/85 millimeters of mercury ([MM Hg]-unit of measurement that describes the amount of force blood uses to get through the vessels of the body [normal range of 120-129 [top number] and 80-84 [bottom number]) for all three measurements. The audit report indicated Resident 2's orthostatic vital signs (three values) were recorded at 6:47 p.m. LVN 2 stated the facility's standard practice was to document orthostatic vital signs as they were obtained. LVN 2 stated she performed Resident 2's orthostatic blood pressure assessment but inadvertently entered the same blood pressure values for all three positions without verifying the recorded measurements. LVN 2 acknowledged the documentation was inaccurate and stated orthostatic vital signs should be documented accurately to ensure the assessment reflected the resident's actual condition. LVN 2 stated inaccurate documentation of orthostatic blood pressures could result in failure to identify orthostatic hypotension, delayed clinical evaluation, or medical adjustments, and placed the resident at risk for falls. During a review of the facility's Policy & Procedure (P&P) titled, Charting and Documentation, dated 1/2025, the P&P indicated the facility was to ensure all services provided to the resident would be documented in the resident's medical record. During a review of the facility's P&P titled, Monitoring of Vital Signs, dated 12/2025, the P&P indicated the facility was to ensure optimum resident assessment and to ensure optimum monitoring of resident change of condition. During a review of the facility's Charge Nurse Job Description (undated), the job description indicated the charge nurse was to perform routine charting duties as required and in accordance with established charting documentation policies and procedures.