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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
View Heights Conv Hosp	12619 S. Avalon Blvd Los Angeles, CA 90061

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45009 Based on observation, interview, and record review, the facility failed to provide a dining experience that maintained or enhanced resident's dignity and respect during mealtimes for facility residents by not ensuring: 1. The dining room offered enough space for all residents to sit down at the same time for mealtimes. 2. All residents sitting at the same table were served food at the same time. 3. All residents received their breakfast at the same time. 4. Residents were not served food on disposable plates and bowls. This deficient practice had the potential to affect Resident's self-esteem and self-worth. Findings: 1. During an observation on 2/11/2025 at 12:16 p.m., in the dining room, staff were observed passing out food trays to residents. Not all residents sitting at the same table received their food trays at the same time. Staff passed out food trays to different residents sitting at different tables, skipping residents. During an observation on 2/11/2025 at 12:22 p.m., in the dining room, residents were observed forming a line at the entrance of the dining room. Residents were in line waiting for a seat to become available. During an observation on 2/12/2025 at 12:07 p.m., in the dining room, an unidentified resident was observed walking into the dining room, looked around the room for a place to sit and stayed standing in the middle of the dining room because there were no empty seats. Certified Nursing Assistant (CNA) 3 asked the resident to stand by the door until there was an available seat for him to use. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/13/2025 at 1216 p.m., in the dining room, an unidentified resident came to the dining room but could not find a seat. CNA 3 told the resident to go back to their room and he would call the resident when there was an available chair. The resident stood standing in the middle of the dining room looking around at all the seated residents. CNA 3 told the resident again to go back to her room and the resident left the dining room. During an interview on 2/13/2025 at 12:18 p.m. with CNA 3 in the dining room, CNA 3 stated the dining room did not have enough space for all residents to sit down and eat together. CNA 3 stated residents must wait until there was an available chair for them. CNA 3 stated residents must wait against the wall while other residents were eating. CNA 3 stated the dining room did not have enough chairs for all residents and that was the reason why residents had to wait to eat. During an interview on 2/14/2025 at 10:35 a.m. with the Director of Nursing (DON), the DON stated the north side of the facility housed 50 residents and the dining room only had 40 chairs to accommodate residents during mealtimes. The DON stated staff sent residents back to their rooms to wait for a seat because the facility's dining room could not accommodate all residents. The DON stated it was an acceptable practice to send residents back to their rooms or have them wait in line because the facility could not accommodate all the residents. The DON stated this practice would make residents feel bad because they were sent away and had to wait to eat. 2. During an observation on 2/1/2025 at 12:20 p.m., in the dining room, staff were observed passing out food trays to residents. Not all residents sitting at the same table received their food trays at the same time. Staff passed out food trays to different residents seated at different tables, skipping residents. During an interview at 2/14/2025 at 10:46 a.m. with the DON, the DON stated there was no particular process for passing out food trays. The DON stated there was no particular order staff followed when passing out trays or where residents were seated during mealtimes. The DON stated it was acceptable to skip some residents seated at the same table and have other residents seated at the same table wait for their food. 3. During an observation on 2/13/2025 at 7:54 a.m., in the kitchen, while preparing breakfast there were no more cooked hashbrowns left. Dietary [NAME] (DC) 2 was observed cooking more hashbrowns which caused a delay in residents receiving their food. During an interview on 2/13/2025 at 8:01 a.m. with DC 2, in the kitchen, DC 2 stated some of the residents received their breakfast late because she ran out of hashbrowns and had to cook more. DC 2 stated she cooked one box of hashbrowns and the hashbrowns ran out while she was plating the breakfast trays. DC 2 stated the hashbrown box contained 118 hashbrowns and the facility had 146 residents. DC 2 stated she knew there was not enough hashbrowns to provide for all the residents. DC 2 stated she waited until she ran out of the hashbrowns before she cooked more hashbrowns which caused the delay. DC 2 stated it was not right to have residents wait for their food. DC 2 stated it was important to have all residents eat at the same time to preserve their dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview ono 2/13/2025 at 2:10 p.m. with the DS, in the kitchen, the DS stated DC 1 and DC 2 informed her they ran out of hashbrowns while plating the food. The DS stated the cooks should have counted the hashbrowns and should have known it was not enough. The DS stated it was not appropriate for cooks to wait until the last minute to cook additional food because it created a delay in residents receiving their food. The DS stated it was important for all residents to receive their food at the same time to provide a homelike environment and for resident's dignity. The DS stated it could potentially had caused residents to become upset and inpatient while waiting for their food. 4. During an observation 2/13/2025 at 7:56 a.m., in the kitchen, DC 2 used disposable plates to serve food to the residents. During an interview on 2/13/2025 at 12:49 p.m., south dining room, residents received their food on disposable bowls. During an interview on 2/13/2025 at 7:58 a.m. with DC 2, in the kitchen, DC 2 stated she was serving residents food on disposable plates because she did not have any more plates. DC 2 stated it was important to serve food on regular plates because it kept the residents' food warm and for their dignity. During an interview on 2/13/2025 at 1:48 p.m. with the Dietary Supervisor (DS), the DS stated residents were served their meals on disposable plates because the facility did not have enough plates for all residents. The DS stated it was not appropriate to serve food on disposable plates because it was not providing a home like environment during mealtimes. The DS stated serving residents food on disposable plates could potentially cause residents to feel bad, feel less than the other residents and it did not respect residents' dignity. During a review of facility's Policy and Procedure (P&P) titled Dining Room Service dated 12/2024, the P&P indicated food would be delivered promptly to assure quality. The P&P indicated meals would be distributed promptly to maintain adequate temperature and appearance. The P&P indicated all individuals should be encouraged to sit in a dining rom chair. During a review of facility's P&P titled Disposable Dishes and Utensils, dated 12/2024, the P&P indicated the facility will use single-service items only in extenuating circumstances (events or situations that make it difficult to do something), such as machine failure and individual resident needs. The P&P indicated single-service articles may be used to serve residents in emergency or isolation. During a review of facility's P&P titled Dignity, dated 12/2024, the P&P indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity and individuality. The P&P indicated treated with dignity meant the resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) prior to administration of psychotropic medication (medications that affect the mind, emotions, and behavior) for three of eight sampled residents (Residents 31, 16, and 347) by failing to: 1. Ensure informed consent was obtained from Resident 31's conservator (a person who has been appointed by the court to make decisions for another person who is deemed incompetent) prior to Resident 31's initial administration of Trazodone (an antidepressant [a medication used to treat depression, which is a mood disorder that causes a persistent feeling of sadness and loss of interest] and a sedative [a medication used to help an individual fall asleep]) on 7/30/2024. 2. Ensure Resident 31's Verification of Informed Consent were complete and included the frequency (how often) of administration for haloperidol (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]), Depakote (an anticonvulsant medication, a medication used to prevent or treat seizures and can be used to treat behavioral disorders), and Trazodone. 3. Ensure Resident 16's Verification of Informed Consent were complete and included the frequency of administration for Buspirone (an antianxiety medication [a medication used to treat anxiety, which is characterized by feelings of unease, worry, and fear]), Ativan (an antianxiety medication), and Zyprexa (an antipsychotic medication). 4. Ensure Resident 347's Verification of Informed Consent was complete and included the frequency of administration for Zyprexa. These deficient practices resulted in the removal of Residents 31, 16, and 347's conservators' right to make decisions about the care and treatments the residents received in the facility. Findings: 1. During a review of Resident 31's Admission Record (Face Sheet), the Face Sheet indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (a condition with too many fats in the blood). The Face Sheet indicated Resident 31 has a conservator. During a review of Resident 31's Minimum Data Set ([MDS], a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 31's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 31 had hallucinations (when an individual sees, hears, smells, tastes, or feels something that is not there) and delusions (an unshakable belief in something that is untrue). The MDS indicated Resident 31 was independent with eating, toileting, bathing, and dressing. The MDS indicated Resident 31 took antipsychotic, antidepressant, and anticonvulsant medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 31's Order Recap Report, dated 2/1/2024 through 2/28/2025, the Order Recap Report indicated to give Trazodone 50 milligrams (mg, a unit of measurement) by mouth, at bedtime for lack of sleep. The order was initiated on 7/30/2024. During a review of Resident 31's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 7/1/2024 through 7/30/2024, the MAR indicated Resident 31 received the first dose of Trazodone 50mg on 7/30/2024 at 9 p.m. During a concurrent interview and record review on 2/13/2025 at 2:28 p.m., with RN 1, Resident 31's Verification of Informed Consent for Trazodone dated 9/1/2024 at 12/31/2024 were reviewed. RN 1 stated Resident 31 did not have a Verification of Informed Consent for the use of Trazodone prior to Resident 31's initial administration on 7/30/2024. RN 1 stated Resident 31 had two Verification of Informed Consent for Trazodone because the facility was required to renew informed consents for psychotropic medication every six months after the initial informed consent was completed. RN 1 stated the purpose of verifying and obtaining informed consent from Resident 31's conservator prior to the initial administration of Trazodone was to ensure Resident 31's conservator was aware of the indication, risks, and benefits of Trazodone. During an interview on 2/13/2025 at 4:05 p.m., with the Director of Nursing (DON), the DON stated prior to the initial administration of a psychotropic medication, informed consent needed to be obtained and verified. The DON stated without the Verification of Informed Consent for Resident 31's initial administration of Trazodone on 7/30/2024, it would indicate that Resident 31's conservator was not notified of the indication, risks, and benefits. The DON stated without obtaining informed consent, Resident 31's conservator was deprived of the right to ask questions, to request additional education, and to make an informed decision whether Resident 31 should receive Trazodone. 2. During a review of Resident 31's Order Recap Report, dated 2/1/2024 through 2/28/2025, the Order Recap Report indicated to give Trazodone 50 milligrams (mg, a unit of measurement), by mouth, at bedtime for lack of sleep. The initial Order date was 7/30/2024. During a review of Resident 31's Medication Review Report, dated 2/1/2025 through 2/28/2025, the Medication Review Report indicated to: a. Give Depakote Extended Release 1500mg, by mouth, in the evening for mood swings. The Order date was 4/13/2024. b. Inject haloperidol 450mg, intramuscularly (into the muscle), every four weeks, on Thursday, on day shift related to schizophrenia. During an interview on 2/13/2025 at 2:28 p.m., with RN 1, RN 1 stated the facility was required to renew informed consents for psychotropic medication every six months. RN 1 stated when a renewal of informed consent was verified, all aspects of the medication, such as medication name, dosage, frequency, and indication of use, was reviewed with the conservator. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/13/2025 at 2:38 p.m., with RN 1, Resident 31's Verification of Informed Consent for haloperidol dated 6/30/2024 at 12/31/2024 were reviewed. RN 1 stated the Verification of Informed Consent was incomplete and did not indicate the frequency of administration of haloperidol. RN 1 stated a complete Verification of Informed Consent included the frequency of the proposed medication. During a concurrent interview and record review, on 2/13/2025 at 2:39 p.m., with RN 1, Resident 31's Verification of Informed Consent for Depakote dated 6/30/2024 at 12/31/2024 were reviewed. RN 1 stated the Verification of Informed Consent was incomplete and did not indicate the frequency of administration of Depakote. RN 1 stated a complete Verification of Informed Consent included the frequency of the proposed medication. During a concurrent interview and record review on 2/13/2025 at 2:40 p.m., with RN 1, Resident 31's Verification of Informed Consent for Trazodone dated 9/1/2024 at 12/31/2024 were reviewed. RN 1 stated the Verification of Informed Consent was incomplete and did not indicate the frequency of administration of Trazodone. RN 1 stated a complete Verification of Informed Consent included the frequency of the proposed medication. During an interview on 2/13/2025 at 3:46 p.m., with the DON, the DON stated the frequency of a psychotropic medication had to be discussed with the residents' conservator prior to the initial administration and during the six-month renewal. The DON stated the licensed nurses were responsible for indicating the frequency of the psychotropic medication to show the details of the psychotropic medication that were discussed with the resident's conservator. The DON stated the residents' conservator should be aware of all aspects of the medication the resident was receiving in the facility. 3. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and gastroesophageal reflux disease (GERD, a chronic condition that occurred when stomach contents leak into the esophagus [the muscular tube through which food passed from the throat to the stomach]). The Admission Record indicated Resident 16 had a public guardian (responsible for the care of individuals who were no longer able to make decisions or care for themselves). During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 16 had intact cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 16 was independent (resident completed the activity by himself without assistance from a helper) with eating, toileting hygiene, showering/bathing self, chair/bed-to-chair transfer, and walking. The MDS indicated Resident 16 required setup assistance with oral hygiene and personal hygiene. The MDS indicated Resident 16 had hallucinations, delusion, and disorganized thinking (a symptom of some mental health disorders that made it difficult to think clearly and logically). During a review of Resident 16's physician order, dated 8/9/2024, the physician order indicated staff were to give Ativan 1 mg by mouth (PO) every 12 hours as needed (PRN) for agitation for 14 days. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 16's physician orders report, dated 2/1/2025-2/14/2025, the report indicated staff were to give Buspirone HCL 10mg PO three times a day for anxiety. The report indicated a physician order for staff to give Zyprexa 30mg PO at bedtime for paranoia (mental disorder in which a person had an extreme fear and distrust of others). During a review of Resident 16's Ativan 0.25-12mg PO informed consent, dated 8/9/2024, the informed consent did not include the frequency and duration for the Ativan order. During a concurrent record review and interview on 2/14/2025 at 8:45 a.m. with the DON, Resident 16's Ativan 0.25-12mg PO informed consent, dated 8/9/2024, was reviewed. The DON stated there was no frequency of Ativan on the informed consent. During a concurrent record review and interview on 2/14/2025 at 8:45 a.m. with the DON, Resident 16's Buspirone HCL 5-90mg PO informed consent, dated 8/9/2024, was reviewed. The DON stated there was no frequency of Buspirone HCL on the informed consent. During a concurrent record review and interview on 2/14/2025 at 8:45 a.m. with the DON, Resident 16's Zyprexa 1.25-40mg PO informed consent, dated 8/9/2024, was reviewed. The DON stated there was no frequency of Zyprexa on the informed consent. 4. During a review of Resident 347's Admission Record, the Admission Record indicated Resident 347 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 347's diagnoses included schizoaffective disorder, DM, HTN, and stimulant dependence (a substance use disorder that involved continued use of stimulants [a class of drugs that speeded up messages travelling between the brain and body]). The Admission Record indicated Resident 347 had a public guardian. During a review of Resident 347's MDS, dated [DATE], the MDS indicated Resident 347 had intact cognitive skills for daily decision making. The MDS indicated Resident 347 was independent with eating, toileting hygiene, showering/bathing self, chair/bed-to-chair transfer, and walking. The MDS indicated Resident 347 required setup assistance with oral hygiene and personal hygiene. The MDS indicated Resident 347 had hallucinations, delusion, and disorganized thinking. During a review of Resident 347's physician orders report, dated 2/1/2025-2/14/2025, the report indicated staff were to give Zyprexa solution 10mg IM, as needed for psychotic aggression for 14 days. Give 3 times in 24 hours as needed. During a review of Resident 347's Zyprexa solution 1.25-40mg IM PRN informed consent, dated 2/4/2025, the informed consent did not include the frequency and duration for the Zyprexa solution order. During an interview on 2/13/2025 at 10:39 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the purpose of informed consent was to get permission from public guardian before administration of medication, to inform public guardian of medication adverse effect (an unwanted or harmful result from a drug, treatment, or procedure), and to obtain approval from public guardian before starting psychotropic medication. LVN 5 stated staff should include the frequency of medication on the informed consent. (continued on next page)

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	056417	A. Building B. Wing	02/14/2025

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/14/2025 at 8:45 a.m. with the DON, Resident 347's Zyprexa solution 1.25mg-40mg IM PRN informed consent, dated 2/4/2025, was reviewed. The DON stated there was no frequency of Zyprexa IM solution on the informed consent. The DON stated it was not acceptable to have informed consent without the medication's frequency. The DON stated it was important to include the medication frequency, so we were aware of how often to give medication and inform public guardian. During a review of the facility's Policy & Procedure (P&P), titled Informed Consent, approved in 3/2024, the P&P indicated The nature of the procedures to be used in the proposed psychiatric treatment includes their probable frequency and duration. The P&P indicated the facility would verify the resident or his/her representative party has given informed consent to the proposed treatment prior to the administration of psychotherapeutic and antipsychotic medications. 49900

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure the assessment entry on the Minimum Data Set ([MDS], a resident assessment tool) was accurate for one of seven sampled residents (Resident 31) when the MDS did not indicate Resident 31 was on hypoglycemic medication (medication used to lower blood sugar levels). This failure had the potential to negative affect Residents 31's plan of care and delivery of necessary care and services. Findings: During a review of Resident 31's Admission Record (Face Sheet), the Face Sheet indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia, type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (a condition with too many fats in the blood). During a review of Resident 31's Minimum Data Set ([MDS], a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 31's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 31 was independent with eating, toileting, bathing, and dressing. During a review of Resident 31's Order Recap Report, dated 2/1/2024 through 2/28/2025, the Order Recap indicated to: a. Inject Insulin Glargine (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) 24 units, subcutaneously (in the fat tissue), in the morning, related to type 2 diabetes mellitus. The order was started 1/6/2023 and discontinued on 2/7/2025. b. Inject Insulin Glargine 12 units, subcutaneously, in the morning, for type 2 diabetes mellitus. The order was started 2/8/2025. During a concurrent interview and record review on 2/13/2025 at 1:27 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 31's MDS, dated [DATE] was reviewed. The MDSC stated the MDS indicated Resident 31 was not on any hypoglycemic medication. The MDSC stated Resident 31 was on Insulin Glargine for many years and the MDS was inaccurate. The MDSC stated accurate assessment on the MDS was important to ensure Resident 31 received the necessary care and treatment related to the administration of Insulin Glargine. During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, dated 12/2024, the P&P indicated, All personnel who complete any portion of the Resident Assessment must sign and certify the accuracy of that portion of the assessment.

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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** 47286 Based on interview and record review, the facility failed to ensure a care plan for addressing the behavior of self-isolation, for which Cymbalta (a medication used to treat depression) was administered, was developed for one of five sampled residents (Resident 3). This deficient practice placed Resident 3 at risk of receiving unnecessary doses of Cymbalta, and subsequent side effects associated with psychotropic medications (a drug or other substance that affects how the brain works) such as nausea, drowsiness, agitation, and headache. Cross-reference F-tag F758. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's admitting diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). Resident 3 did not have diagnoses of depression (a common mental health condition characterized by a persistent low mood, loss of interest or pleasure in activities, and other symptoms that can significantly interfere with daily life) or anxiety (a common emotional state characterized by feelings of unease, worry, fear, and apprehension). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 3 did not have cognitive impairments (problems with thinking, learning, or memory). The MDS indicated Resident 3 did not exhibit physical or verbal behaviors (e.g., physical aggression towards others and/or verbal aggression/threats towards others). The MDS indicated Resident 3 did not reject care. The MDS indicated Resident 3 could eat independently and was independent with mobility while in and out of bed. During a review of Resident 3's physician orders, dated 3/21/2024, the order indicated Resident 3 was to receive Cymbalta 30 milligrams (mg, a unit of dose measurement), every morning, for depression manifested by self-isolative behavior. During an interview, on 2/13/2025 at 11:23 a.m., with the Director of Nursing (DON), DON stated Resident 3 did not have a care plan to address or treat the self-isolative behavior the Cymbalta was ordered for on 3/21/2024. The DON stated there were non-pharmacologic interventions staff could attempt to address self-isolative behavior, prior to initiating psychotropic medications. The DON stated non-pharmacological interventions included counseling, group activities, and outdoor fitness programs. The DON stated non-pharmacological interventions should always be attempted before psychotropic medications, and stated these interventions would be documented in a care plan. The DON stated Resident 3 should have a care plan for self-isolative behavior to monitor if non-pharmacological interventions were effective in addressing the behavior to allow for a decrease or discontinuation of the Cymbalta. (continued on next page)

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	02/14/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Care Plan Guidelines, dated 12/2024, the P&P indicated the purpose of a care plan was to identify needs and develop a comprehensive, standardized plan of care for each resident that includes individualized & measurable objectives and timetables to meet the resident's psychiatric, psychosocial, and medical needs. During a review of the facility's P&P titled Psychotropic Medication Use, dated 12/2024, the P&P indicated facility staff were to take a holistic approach to behavior management that involved a thorough assessment of the underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. The P&P indicated psychotropic medications would be used to address behaviors only if the nondrug approaches and interventions were attempted prior to their use.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 documented medication administration accurately for one of 18 sampled residents (Resident 56), in accordance with professional standards. This failure had the potential to delay Resident 56 in reaching her care goals due to the documentation of medication that was not given. Findings: During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 56's admitting diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated 11/13/2024, the MDS indicated Resident 56 did not have cognitive impairments (problems with thinking, learning, or memory). The MDS indicated Resident 56 was independent to eat, and independent with mobility. During a review of Resident 56's physician order, dated 10/14/2024, the order indicated Resident 56 was to receive 0.25 milligrams (mg, a unit of measuring medication dosage) of Ozempic (a prescription injectable medication used to treat type 2 diabetes mellitus [a disorder characterized by difficulty in blood sugar control and poor wound healing] in adults) in the morning every 7 days. During a review of Resident 56's Medication Administration Record (MAR), dated 2/1/2025 to 2/28/2025, the MAR indicated Resident 56 received scheduled weekly doses of Ozempic on 2/4/2025 and 2/11/2025. During a concurrent observation and interview, on 2/12/2025 at 11:36 a.m., of the South Station Medication Cart, with LVN 2 Resident 56's Ozempic injection pen was observed. LVN 2 stated the Ozempic injection pen was opened 11/5/2024 and stated the injection pen was empty. During a concurrent observation and interview, on 2/12/2025 at 11:39 a.m., of the South Station Medication fridge, with LVN 2, a sealed and unopened Ozempic injection pen was observed. LVN 2 stated the Ozempic injection pen belonged to Resident 56 and was sealed and unused. During a concurrent observation and interview, on 2/12/2025 at 1:04 p.m., of the South Station Medication Cart, with LVN 1, Resident 56's Ozempic injection pen was observed. LVN 1 stated the Ozempic injection pen in the cart was opened 2/12/2025 but was dated as opened on 2/11/2025. LVN 1 stated she administered Resident 56's Ozempic dose on 2/12/2025 (1 day after the scheduled dose). LVN 1 stated Resident 56 originally refused the medication, then changed her mind and later agreed to receive the scheduled dose. LVN 1 stated she forgot to administer the dose after Resident 56 changed her mind. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/12/2025 at 1:07 p.m., with LVN 1, Resident 56's MAR dated 2/1/2025 to 2/28/2025 was reviewed. LVN 1 stated the MAR indicated Resident 56's Ozempic dose was ordered for and documented as administered on 2/11/2025. LVN 1 stated Resident 56's Ozempic dose, scheduled for 2/11/2025, was administered on 2/12/2025. LVN 1 stated medications should not be documented as administered until they are given. During an interview on 2/13/2025 at 11:54 a.m., with the Director of Nursing (DON), the DON stated licensed nursing staff were to document administration of medications on the MAR right after the medication is administered. The DON stated medications should not be documented as administered before they are given. During a review of the facility policy and procedure (P&P) titled Documentation of Medication Administration, dated 2024, the P&P indicated documentation of medication administration was to be done at the time medications are given.

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	056417	A. Building B. Wing	02/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure quality of care was provided for two of three sampled residents (Residents 31 and 16) by failing to: 1. Clarify the monitoring of Resident 31's blood glucose (amount of sugar in the blood) prior to the administration of Insulin Glargine (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). This deficient practice resulted in Resident 31's blood glucose being unmonitored prior to being administered Insulin Glargine on 2/8/2025, 2/9/2025, 2/10/2025, 2/11/2025, and 2/12/2025. This deficient practice also had the potential to result in Resident 31 becoming hypoglycemic (a condition when the blood sugar level drops too low) and symptomatic with dizziness, shakiness, and confusion. 2. Implement Resident 16's physician order for wound treatment to the right scalp. This deficient practice had the potential to increase the risk of infection for Resident 16, and placed the resident at risk for fever, pain, and worsening skin condition. Findings: 1. During a review of Resident 31's Admission Record (Face Sheet), the Face Sheet indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (a condition with too many fats in the blood). During a review of Resident 31's Minimum Data Set ([MDS], a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 31's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 31 was independent with eating, toileting, bathing, and dressing. The MDS indicated Resident 31 was receiving hypoglycemic medication (medication used to lower blood sugar levels). During a review of Resident 31's Order Recap Report, dated 2/1/2024 through 2/28/2025, the Order Recap indicated to: a. Inject Insulin Glargine (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) 24 units (unit of measurement), subcutaneously (in the fat tissue), in the morning, related to type 2 diabetes mellitus. The order recap indicated the order was started 1/6/2023 and discontinued on 2/7/2025. b. Inject Insulin Glargine 12 units, subcutaneously, in the morning, for type 2 diabetes mellitus. The order recap indicated the order was started 2/8/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 11:08 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated prior to administering Insulin Glargine to a resident, the licensed nurse was responsible for checking the resident's blood glucose. LVN 1 stated after checking the resident's blood glucose, Insulin Glargine would immediately be administered. During a concurrent interview and record review on 2/13/2025 at 11:10 a.m., with LVN 1, Resident 31's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 2/1/2025 through 2/28/2025, was reviewed. LVN 1 stated Resident 31's order for Insulin Glargine was decreased from 24 units to 12 units on 2/8/2025. LVN 1 stated the MAR did not prompt LVN 1 to check Resident 31's blood glucose, on 2/8/2025, 2/9/2025, 2/10/2025, 2/11/2025, and 2/12/2025, prior to administering 12 units of Insulin Glargine. LVN 1 stated when Resident 31's Insulin Glargine order was changed, the option to check Resident 31's blood glucose was not included. LVN 1 stated when Resident 31 was receiving 24 units of Insulin Glargine, the MAR always prompted the licensed nurse to check Resident 31's blood glucose level. LVN 1 stated she was confused why Resident 31's order did not include blood glucose monitoring. During a concurrent interview and record review on 2/13/2025 at 11:15 a.m., with LVN 1, Resident 31's Blood Sugars, dated 2/1/2025 through 2/13/2025 were reviewed. LVN 1 stated Resident 31's Insulin Glargine was scheduled for administration at 8 a.m. LVN 1 stated the Blood Sugars did not indicate Resident 31's blood glucose was checked on 2/8/2025, 2/9/2025, 2/10/2025, 2/11/2025, and 2/12/2025 between 7 a.m. and 9 a.m. During an interview on 2/13/2025 at 11:18 a.m., with LVN 1, LVN 1 stated Resident 31's order for Insulin Glargine should have been clarified with Resident 31's physician because the order did not include blood glucose monitoring prior to administering Insulin Glargine. LVN 1 stated Resident 31's order for Insulin Glargine should have been clarified on 2/8/2025 prior to the first administration. LVN 1 stated Insulin Glargine affected Resident 31's blood glucose over a long period of time, however, checking Resident 31's blood glucose on administration was still important. LVN 1 stated if Resident 31's blood glucose was low (normal blood glucose level between 70 milligrams [mg, unit of measurement] per deciliter [dL, unit of measurement] [mg/dL] and 100 mg/dL), administering medication that decreased blood glucose could be very harmful. LVN 1 stated Resident 31 could experience hypoglycemic symptoms such as shakiness, dizziness, and confusion. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, revised 10/2019, the P&P indicated, [The purpose of the policy is to] provide guidelines for the safe administration of insulin to residents with diabetes . The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin. During a review of the facility's P&P titled, Physician's (Prescriber's) Orders, revised 12/2022, the P&P indicated, Incomplete, unreadable, ambiguous, or confusing orders will be clarified with the prescriber prior to medication administration by the nurse or prior to pharmacy dispensing. 49900 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and gastroesophageal reflux disease (GERD, a chronic condition that occurred when stomach contents leak into the esophagus [the muscular tube through which food passed from the throat to the stomach]). The Admission Record indicated Resident 16 had a public guardian (responsible for the care of individuals who were no longer able to make decisions or care for themselves). During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 had intact cognitive skills for daily decision making. The MDS indicated Resident 16 was independent with eating, toileting hygiene, showering/bathing self, chair/bed-to-chair transfer, and walking. The MDS indicated Resident 16 required setup assistance with oral hygiene and personal hygiene. The MDS indicated Resident 16 had hallucinations (a false perception of a sight, sound, smell, taste, or touch that seems real but was not), delusion (having false or unrealistic beliefs), and disorganized thinking (a symptom of some mental health disorders that made it difficult to think clearly and logically). During a review of Resident 16's Admission Screening/History, dated 2/11/2025, the form indicated Resident 16 was readmitted to facility with diagnosis of closed head injury and scalp laceration (deep cut). The form indicated Resident 16 had four staples to the right side of the scalp. During a review of Resident 16's physician order, dated 2/11/2025, the order indicated staff were to cleanse the wound with soap and water daily. During a review of Resident 16's care plan titled Has head injury with scalp laceration, initiated on 2/11/2025, the care plan indicated the goal was for Resident 16 to remain free of infection. The care plan interventions indicated to assess Resident 16 every shift for any signs of infection. During a concurrent observation and interview on 2/12/2025 at 8:29 a.m. with Resident 16, in Resident 16's room, Resident 16's right scalp was observed with dried blood and four staples. Resident 16 stated he fell on [DATE]. Resident 16 stated since his fall no staff had cleansed his scalp. Resident 16 stated his right scalp was only cleansed in the hospital before placing the staples. During a concurrent observation and interview on 2/13/2025 at 10:36 a.m. with Resident 16, in Resident 16's room, Resident 16's right scalp was observed with dried blood and four staples. Resident 16 stated no staff cleansed his scalp. During a concurrent record review and interview on 2/13/2025 at 11:08 a.m. with LVN 4, Resident 16's MAR, dated from 2/1/2025 to 2/28/2025, was reviewed. LVN 4 stated the physician order to cleanse Resident 16's wound was not transcribed to the MAR. LVN 4 stated the order should be on the MAR. LVN 4 stated Resident 16 might have an infection, fever, headache, and pain if the wound was not cleansed per the order. During an interview on 2/13/2025 at 3:06 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated Resident 16 had the potential for an infection, pain, and swelling if the wound was not cleansed according to the physician order. (continued on next page)

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	056417	A. Building B. Wing	02/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P, titled Physician (Prescriber's) Orders, approved in 1/2023, the P&P indicated The order will be added to the Medication Administration record or Treatment record. For those facilities with Electronic Medical Records (EMR), the noting and transcription will be done electronically.

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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** 49900 Based on observation, interview, and record review, the facility failed to conduct an Interdisciplinary Care Team (IDT, a group of healthcare professionals who worked together to provide care for residents in a nursing home) conference after a witnessed fall on 12/19/2024 for one of seven residents (Resident 112). This deficient practice had the potential to increase the possibility of recurrent falls for Resident 112. Findings: During a review of Resident 112's Admission Record, the Admission Record indicated Resident 112 was admitted to the facility on [DATE]. Resident 112's diagnoses included schizophrenia (a mental illness that was characterized by disturbances in thought), insomnia (trouble falling asleep or staying asleep), and Post-Traumatic Stress Disorder (PTSD - a disorder in which a person had difficulty recovering after experiencing or witnessing a traumatic event). The Admission Record indicated Resident 112 had a public guardian (responsible for the care of individuals who were no longer able to make decisions or care for themselves). During a review of Resident 112's MDS, dated [DATE], the MDS indicated Resident 112 had intact cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 112 was independent (resident completed the activity by himself without assistance from a helper) with eating, toileting hygiene, showering/bathing self, and all mobility while in and out of bed. The MDS indicated Resident 112 required setup assistance with oral hygiene and personal hygiene. The MDS indicated Resident 112 experienced hallucinations (a false perception of a sight, sound, smell, taste, or touch that seems real but was not), delusions (having false or unrealistic beliefs), and disorganized thinking (a symptom of some mental health disorders that made it difficult to think clearly and logically). The MDS indicated Resident 112 reported it was very important to have family or a close friend involved in discussions about Resident 112's care while in the facility. During a review of Resident 112's Change in Condition (COC) Evaluation form, dated 12/19/2024, the COC indicated on 12/19/2024 at approximately 7:45 a.m., Resident 112 had a witnessed fall while walking to the dining room for breakfast because he lost balance. During a concurrent record review and interview on 2/14/2025 at 8:45 a.m. with the DON, Resident 112's IDT records, dated from 7/7/2024 to 12/31/2024, was reviewed. The DON stated there was no IDT conference conducted for the fall on 12/19/2024. The DON stated the facility conducted an IDT conference to find out what exactly happened to the resident, the cause of the incident, and the contributing factors to the incident. The DON stated the IDT normally happened within 7 days of an incident to prevent recurrence of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/14/2025 at 8:45 a.m. with the DON, the facility's Policy & Procedure (P&P), titled Fall Management System, approved in 4/2023, was reviewed. The P&P indicated When a resident sustains a fall . The investigation and appropriate interventions will be initiated at the time of the fall and reviewed by Nursing Management following the next morning stand-up meeting and QA (quality assurance, a system that evaluated and improved patient care) Meeting. The DON stated facility did not have a specific policy stating when the IDT conference should conduct after a fall, but the QA meeting included the IDT team and was held quarterly and should address Resident 112's fall on 12/19/2024.

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	056417	A. Building B. Wing	02/14/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered for two of 18 sampled residents (Resident 56 and Resident 49) when: 1. Licensed Vocational Nurse (LVN) 1 administered five doses of Ozempic (a prescription injectable medication used to treat type 2 diabetes mellitus [DM, a disorder characterized by difficulty in blood sugar control and poor wound healing] in adults) to Resident 56 from an Ozempic injection pen that was 35 days beyond its use by date. 2. LVN 1 administered Metformin (a medication used to treat high blood sugar levels caused by DM) to Resident 49 greater than one hour before the scheduled administration time. These failures created the potential for Resident 56 to not achieve the desired weight loss the Ozempic was indicated for, due to decreased effectiveness of the expired medication. These failures also created the potential for Resident 49 to sustain gastric distress (a group of uncomfortable symptoms related to the digestive system, typically characterized by abdominal pain, nausea, vomiting, and/or diarrhea) related to the administration of Metformin on an empty stomach. Findings: 1. During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 56's admitting diagnoses included obesity (a chronic condition characterized by an excessive accumulation of body fat). During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 56 did not have cognitive impairments (problems with thinking, learning, or memory). The MDS indicated Resident 56 was independent to eat, and independent with mobility. During a review of Resident 56's physician order, dated [DATE], the order indicated Resident 56 was to receive 0.25 milligrams (mg, a unit of measuring medication dosage) of Ozempic every seven days for obesity. During a concurrent observation and interview, on [DATE] at 11:36 a.m., of the North Station Medication Cart, with LVN 2, Resident 56's Ozempic injection pen was observed. LVN 2 stated the Ozempic injection pen was opened [DATE] and stated the injection pen was empty. LVN 2 stated the Ozempic injection pen originally contained enough medication for eight administrations. LVN 2 stated there were no other Ozempic injection pens indicated for Resident 56 in the cart. During a concurrent observation and interview on [DATE] at 11:39 a.m., of the North Station medication storage room refrigerator, with LVN 2, a sealed Ozempic injection pen was observed. LVN 2 stated the Ozempic injection pen belonged to Resident 56 and had not been opened or used. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on [DATE] at 1:04 p.m., with LVN 1, Resident 56's Ozempic injection pen, with open date [DATE], was observed. LVN 1 stated the packaging indicated the injection pen was to be discarded 56 days after opening. LVN 1 stated the injection pen was opened on [DATE], and the injection pen should have been discarded on [DATE]. LVN 2 stated she used Resident 56's new Ozempic injection pen from the South Station refrigerator to administer Resident 56's Ozempic dose on [DATE]. During a review of Resident 56's MAR, dated [DATE] to [DATE], the MAR indicated Resident 56 received four administrations of Ozempic on [DATE], [DATE], [DATE], and [DATE] from the expired Ozempic injection pen opened [DATE]. During a review of Resident 56's MAR, dated [DATE] to [DATE], the MAR indicated Resident 56 received one administration of Ozempic on [DATE] from the expired Ozempic injection pen opened [DATE]. During an interview on [DATE] at 11:54 a.m., with the Director of Nursing (DON), the DON stated the Ozempic injection pen, including any unused doses, were to be discarded after 56 days. The DON stated licensed nursing staff should not administer medication from an injection pen past its use by date. The DON stated a new injection pen should be opened and used. The DON stated using an Ozempic injection pen beyond its use by date created the potential for complications. The DON stated the medication could have lost its potency (the intensity of effect produced for a given drug dose). The DON stated Resident 56's Ozempic was indicated for obesity, and stated administration of Ozempic beyond its use by date could result in Resident 56 not having the desired outcome of weight loss. 2. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was admitted on [DATE]. Resident 49's admitting diagnoses included DM. During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 did not have cognitive impairments. The MDS indicated Resident 49 was independent to eat, and independent with mobility. During a review of Resident 49's physician order, dated [DATE], the order indicated Resident 49 was to receive 1000 mg of Metformin two times a day with meals or immediately after meals. During a review of Resident 49's MAR, dated [DATE] to [DATE], the MAR indicated Resident 49 was to receive two scheduled Metformin doses at 8:00 a.m. and 6:00 p.m. every day. During an observation on [DATE] at 4:25 p.m., at the North Nurse's Station, LVN 1 was observed administering 1000 mg of Metformin to Resident 49. Resident 49 took the medication with a cup of water. During an interview on [DATE] a 9:49 a.m., with the DON, the DON stated medications were to be administered at the ordered time but could also be administered up to one hour before or one hour after the ordered time. The DON stated the earliest time Resident 49's scheduled 6:00 p.m. Metformin dose could be administered was 5:00 p.m. The DON stated the Metformin administration on [DATE], at 4:25 p.m., was too early and not acceptable. The DON stated dinner was not served until 5:00 p.m., and the Metformin should have been administered at 5:00 p.m. with dinner, or immediately after Resident 49 ate dinner. The DON stated administration of Metformin with an empty stomach could cause avoidable gastric distress. (continued on next page)

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	056417	A. Building B. Wing	02/14/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's job description for a LVN, titled Charge Nurse Job Description, undated, the job description indicated LVNs were to prepare and administer medications as ordered by the physician. The job description also indicated LVNs were to dispose of drugs as required, and in accordance with established procedures. During a review of the facility's policy and procedure (P&P) titled Administration of Medications - Medication Pass, dated ,d+[DATE], the P&P indicated medications could be administered up to one (1) hour before or up to one (1) hour after the designated administration time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 47679 Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 3 and Resident 31) were free from unnecessary medications when: 1. Staff failed to monitor for the presence of self-isolating behaviors for Resident 3, and ensure a gradual dose reduction (GDR, stepwise tapering of a medication dose) was attempted for her Cymbalta (a medication used to treat depression and anxiety), which was initiated in March 2024. 2. Staff failed to provide behavior manifestations for hallucinations of Resident 31's use of haloperidol (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]). These deficient practices had the potential for Resident 3 to suffer unwanted adverse effects from continued administration of Cymbalta including excessive sedation, heart problems, and tremors (involuntary, rhythmic shaking movements that can affect various parts of the body, such as the hands, arms, legs, head, or voice), resulted in the facility indicating the use of haloperidol to treat only Resident 31's diagnosis and not behaviors of schizophrenia (a mental illness that is characterized by disturbances in thought) and had the potential to result in the licensed nurses being to monitor Resident 31's behaviors related to schizophrenia. Findings: 1. During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's admitting diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). Resident 3 did not have diagnoses of depression or anxiety. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 3 did not have cognitive impairments (problems with thinking, learning, or memory). The MDS indicated Resident 3 did not exhibit physical or verbal behaviors (e.g., physical aggression towards others and/or verbal aggression/threats towards others). The MDS indicated Resident 3 did not reject care. The MDS indicated Resident 3 was independent with most activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 3's physician orders, dated 3/21/2024, the order indicated Resident 3 was to receive Cymbalta 30 milligrams (mg, a unit of dose measurement) every morning for depression manifested by self-isolative behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Psychotropic Monthly Summary assessments, dated 6/1/2024, 9/2/2024, 12/1/2024, and 1/2/2025, the assessments indicated Resident 3 was assessed for her use of Cymbalta for depression, for the previous months. The assessments indicated Resident 3 did not exhibit any depression for the months of 5/2024, 8/2024, 11/2024. During a review of Resident 3's Psychotropic Monthly Summary assessments, there were no documented assessments for the months of 3/2024, 4/2024, 7/2024, 9/2024, or 10/2024. During a concurrent interview and record review, on 2/13/2025 at 11:23 a.m., with the Director of Nursing (DON), Resident 3's physician orders and Psychotropic Monthly Summaries dated 3/2024 to current, were reviewed. The DON stated the Psychotropic Monthly Summaries were based on the resident's behaviors from the prior month, and stated it was based on monitoring conducted by staff. The DON stated there was no documentation in Resident 3's electronic medical record (EMR) that indicated staff were monitoring Resident 3 for depression or self-isolation. The DON stated the current documentation present in Resident 3's EMR indicated she was participating in group meetings and activities and was not displaying self-isolative behaviors, and did not indicate a continued need for Cymbalta. The DON stated if the behavior the medication was ordered for was not present, a GDR should be completed to ensure the medication was discontinued if no longer needed. The DON stated a GDR had not been attempted since Resident 3's Cymbalta was started in 3/2024. The DON stated that prolonged administration of Cymbalta, if no longer indicated, could cause Resident 3 to experience unwanted side effects including excessive sedation, heart problems, and tremors. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 12/2024, the P&P indicated all ordered psychotropic medications (drugs that alter mood, thoughts, emotions, and behavior) were to be used to treat behaviors, and there must be a clinical indication. The P&P indicated the psychotropic medication should be used at the lowest dose possible to achieve the desired effect. The P&P indicated all residents on psychotropic medications were to be monitored for their efficacy. The P&P indicated staff were to monitor the resident's behavior for residents receiving psychotropic medications. 2. During a review of Resident 31's Face Sheet, the Face Sheet indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia, type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (a condition with too many fats in the blood). During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 31 had hallucinations (when an individual sees, hears, smells, tastes, or feels something that is not there) and delusions (an unshakable belief in something that is untrue). The MDS indicated Resident 31 was independent with eating, toileting, bathing, and dressing. The MDS indicated Resident 31 took an antipsychotic medication. During a review of Resident 31's Medication Review Report dated 2/1/2025 through 2/28/2025, the Medication Review Report indicated to inject haloperidol 450 mg, intramuscularly (into the muscle) every four weeks on Thursday, on the day shift for schizophrenia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 2:36 p.m., with Registered Nurse (RN) 1, RN 1 stated the resident's physician was responsible for providing the indication of use of the psychotropic medications. RN 1 stated indicating the manifested behaviors was important, so the licensed nurses were aware of the behaviors the resident was being treated for. RN 1 stated Resident 31 was treated with haloperidol but without the behavior manifested indicated, it seemed Resident 31 was being treated solely for having schizophrenia, which was not appropriate. RN 1 stated the order should have been clarified over the years with Resident 31's physician so the licensed nurses could better monitor and care for Resident 31. During an interview on 2/13/2025 at 4:08 p.m., with the DON, the DON stated psychotropic medication were used to treat specific behaviors and symptoms manifested by a diagnosis. The DON stated a diagnosis alone was not an appropriate indication to administer psychotropic medication. The DON stated Resident 31's order for haloperidol was active since 1/4/2018 and was not clarified since then. The DON stated although Resident 31 had manifested behaviors due to his schizophrenia, those specific behaviors were not indicated on the order. The DON stated it was important to clarify the manifested behaviors that were being treated, so the licensed nurses were aware of the specific behaviors and to be able to assess if the medication treatment was effective. During a review of the facility's P&P titled, Psychotropic Medication Use, revised 10/2019, the P&P indicated, Psychotropic medications to treat behaviors will be used appropriately to address specific underlying or psychiatric causes of behavioral symptoms . All medications used to treat behaviors must have clinical indication and be used in the lowest possible doses to achieve the desired therapeutic effect.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to dispose of medication for one of 18 sampled residents (Resident 56) when: 1. An Ozempic (a prescription injectable medication used to treat type 2 diabetes mellitus [DM, a disorder characterized by difficulty in blood sugar control and poor wound healing] in adults) injection pen was kept in the North Station medication cart beyond its use-by date of 12/31/2024. 2. Licensed Vocational Nurse (LVN) 1 failed to label an Ozempic injection pen with the correct open date. These failures created the potential for Resident 56 to receive Ozempic with reduced potency and effectiveness, possibly causing a delay in the effectiveness of the ordered therapy. Findings: During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 56's admitting diagnoses included obesity (a chronic condition characterized by an excessive accumulation of body fat). During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated 11/13/2024, the MDS indicated Resident 56 did not have cognitive impairments (problems with thinking, learning, or memory). The MDS indicated Resident 56 was independent to eat, and independent with mobility. During a review of Resident 56's physician order, dated 10/14/2024, the order indicated Resident 56 was to receive 0.25 milligrams (mg, a unit of measuring medication dosage) of Ozempic every seven days for obesity. During a concurrent observation and interview, on 2/12/2025 at 11:36 a.m., of the North Station Medication Cart, with LVN 2, Resident 56's Ozempic injection pen was observed. LVN 2 stated the Ozempic injection pen was opened 11/5/2024 and stated the injection pen was empty. LVN 2 stated the Ozempic injection pen originally contained enough medication for eight administrations. LVN 2 stated there were no other Ozempic injection pens indicated for Resident 56 in the cart. During a concurrent observation and interview on 2/12/2025 at 11:39 a.m., of the North Station medication storage room refrigerator, with LVN 2, a sealed Ozempic injection pen was observed. LVN 2 stated the Ozempic injection pen belonged to Resident 56 and had not been opened or used. During a review of Resident 56's Medication Administration Records (MAR), dated 1/1/2025 to 1/31/2025 and 2/1/2025 to 2/28/2025, the MARs indicated Resident 56 received a total of five doses of Ozempic from the Ozempic injection pen opened 11/5/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 2/12/2025 at 1:04 p.m., with LVN 1, Resident 56's Ozempic injection pens, with open dates of 11/5/2024 and 2/11/2025, were observed. LVN 1 stated the packaging indicated the injection pens were to be discarded 56 days after opening. LVN 1 stated the injection pen opened on 11/5/2024 should have been discarded on 12/31/2024. LVN 1 stated the Ozempic injection pen dated 2/11/2025 was opened on 2/12/2025. LVN 1 stated the open date should be accurate and the open date of 2/11/2025 was not correct. During an interview on 2/13/2025 at 11:54 a.m., with the Director of Nursing (DON), the DON stated the Ozempic injection pen, including any unused doses, were to be discarded after 56 days. The DON stated licensed nursing staff should not administer medication from an injection pen past its use by date. The DON stated a new injection pen should be opened and used. The DON stated the medication could have lost its potency (the intensity of effect produced for a given drug dose). The DON stated Resident 56's Ozempic was indicated for obesity, and stated administration of Ozempic beyond its use by date could result in Resident 56 not having the desired outcome of weight loss. During a review of the facility's job description for a LVN, titled Charge Nurse Job Description, undated, the job description indicated LVNs were to dispose of drugs as required, and in accordance with established procedures.

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	056417	A. Building B. Wing	02/14/2025

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 45009 Based on observation, interview and record review, the facility did not provide a diet that met the nutritional needs for all facility residents by: 1. Not ensuring residents received a breakfast that offered a nutritional value. 2. Not ensuring a system was in place to ensure meal substitutes and alternatives provided were of equal or nutritive value for all facility residents. These deficient practices had the potential to impact resident's nutritional status and could result in all residents sustaining undesired weight loss and malnutrition. Findings: 1. During an observation on 2/13/2025 at 7:11 a.m. in the kitchen, a mc muffin sandwich without meat was served to the residents. The mc muffin sandwich contained only scrambled eggs. During an interview on 2/13/2025 at 7:20 a.m. with Dietary Supervisor (DS), the DS stated they were serving a vegetarian mc muffin sandwich for breakfast. The DS stated the mc muffin sandwich did not come with meat and that made it a vegetarian sandwich. During an interview on 2/13/2025 at 7:39 a.m. with Dietary [NAME] (DC) 2, DC 2 stated she was a serving a sandwich with scrambled eggs for breakfast. DC 2 stated the sandwich was supposed to have sausage but she did not have any sausage in the kitchen. DC 2 stated this had happened before where the kitchen did not have any sausage for resident meals. DC 2 stated it was important to serve residents a meal that provided a nutritious value. During a concurrent interview and record review on 2/13/2025 at 8:36 a.m. with DS, Cooks Spreadsheet, dated 2/13/2025 was reviewed. The [NAME] Spreadsheet indicated residents had to receive a mc muffin sandwich with sausage meat. DS stated she did not know the sandwich had to have meat. The DS stated she was supposed to check on the food that was served to the residents but she did not. The DS stated she did not notice the mc muffin sandwiches did not have sausage. The DS stated it was important to provide all residents with the correct nutrition to prevent weight loss. 2. During a concurrent interview and record review, on 2/12/2025 at 1:27 p.m., with the Registered Dietician (RD), the facility document titled Nutritional Breakdown, dated Winter 2024 to 2025, was reviewed. The RD stated the document provided nutritional data for various diets (i.e., regular [no modifications], vegetarian, low-fat, etc.), but did not indicate the nutritional data for any specific menu items, including those being served to facility residents. The RD stated she would need to check if the facility had a nutritional analysis available that provided nutritional data for the menus being served in the facility. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/12/2025 at 2:10 p.m., with the RD, the RD stated the facility did not have a system in place to determine the nutritional values for the menus provided to facility residents. The RD stated every meal served had unique nutrient content, with varying levels of protein, calories, fats, and other key nutrients. The RD stated kitchen staff were to notify her if a resident was refusing the provided meal, and she was responsible for determining if the alternative or substitute being offered was of similar or equal nutritive value. The RD stated there was no system in place to allow her to do that. The RD stated the alternatives provided to residents included peanut butter sandwiches, grilled cheese sandwiches, or a chef's salad. The RD stated she could not state the nutritional content of those items, or if their nutritional content was sufficient to replace the planned menu items. The RD stated all residents had daily nutritional needs and stated that she was responsible to ensure those needs were met. The RD stated an inability to identify the nutritional content of the planned menu, and the alternatives, created the potential for residents to sustain malnourishment and loss of muscle mass. During an interview on 2/14/2025 at 9:24 a.m., with the Director of Nursing (DON), the DON stated all meals provided in the facility should be sufficient in meeting the residents' nutritional needs. The DON stated that if nutritional needs were not met, it placed residents at for undesired weight loss. During a review of facility's Policy and Procedure (P&P) titled Menu Planning, dated 2020, the P&P indicated menus are planned to meet nutritional needs of residents in accordance with national guidelines During a review of the facility's P&P titled Daily Food Menu Alternative, dated 2020, the P&P indicated residents were to be provided a suitable, nourishing alternate meal after the planned, served meal has been refused. 47286

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45009 Based on interview and record review, the facility failed to employ a dietary supervisor (DS) that met the qualifications of having an associate's degree or higher in food service management or in hospitality, was a certified dietary manager, certified food service manager or had national certification for food service management and safety. This deficient practice had the potential to affect 146 residents residing in the facility by potentially not receiving the nutritional assistance and guidance they needed to attain their highest practicable well-being. Findings: During a review of the Dietary Supervisor's (DS) Food Card certificate, dated 12/5/2023, the certificate indicated the DS was recognized for successfully completing the food Handler basic course. During a review of the DS's school transcript, dated Spring 2025, the transcript indicated the DS was enrolled in Introduction of food service work and Food production management. During an interview on 2/11/2025 at 8:30 a.m. with Dietary [NAME] (DC) 1, DC 1 stated the DS began working as the facility's dietary supervisor in December 2024. DC 1 stated the DS used to work as a cook for the facility. During an interview on 2/12/2025 at 1:27 p.m. with the Registered Dietician (RD), the RD stated the facility did not have a DS but the facility had a job posting. The RD stated she was physically at the facility on Tuesdays only and on the other days no one was in charge of the kitchen because there was no DS. During an interview on 2/13/2025 at 2:08 p.m. with DS, the DS stated she was in school taking classes to become the DS. The DS stated she had been working as the facility's DS while she was in school. The DS stated she over saw the kitchen activities. During an interview on 2/14/2025 at 11:00 a.m. with the Director of Nursing (DON), the DON stated the DS was interim under the RD's supervision. The DON stated she did not know what education was required to be qualified for the DS position. The DON stated the DS was not qualified to work as a DS because she was still in school. The DON stated the RD was not at the facility everyday and when the RD was not at the facility the DS was in charge of the kitchen and residents' dietary needs. During a review of the facility's job description titled Director of Food Services, undated, the job description indicated the DS must be a graduate of an accredited course in diuretic training approved by the American Dietetic Association (academy committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy). The job description indicated the DS must have training in cost control, food management and diet therapy. The job description indicated the DS must be registered as a food service director in this state.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45009 Based on observation, interview and record review, the facility did not ensure dietary staff followed the dietary menus for 146 residents out of 146 sampled residents by failing to: 1. Ensure dietary staff provided a breakfast sandwich with sausage. 2. Ensure the Dietary Supervisor (DS) checked the food before it was provided to residents. These deficient practices had the potential to impact resident's nutritional status and placed all residents at risk for unintentional weight loss. Findings: During an observation on 2/13/2025 at 7:11 a.m. in the kitchen, breakfast sandwich without meat was served to the residents. The breakfast sandwich contained only scrambled eggs. During an interview on 2/13/2025 at 7:20 a.m. with the DS, the DS stated they were serving a vegetarian (diet with no meat) breakfast sandwich. The DS stated the breakfast sandwich did not come with meat and that made it a vegetarian sandwich. During a concurrent observation and interview on 2/13/2025 at 7:39 a.m. with Dietary [NAME] (DC) 2, DC 2 stated she was serving residents a sandwich with scrambled eggs for breakfast. DC 2 stated the breakfast sandwich was supposed to have sausage, but she did not have any sausage in the kitchen. DC 2 stated per the menu all residents were supposed to receive sausage on their sandwich. DC 2 stated she notified the DS about not having sausage and she was serving the sandwiches without sausage. DC 2 stated this had happened before when the kitchen did not have any sausage for the resident meals. DC 2 stated it was important to serve residents a meal that provided nutritional value. During a concurrent interview and record review on 2/13/2025 at 8:36 a.m. with the DS, the menu dated 2/13/2025 was reviewed. The [NAME] Spreadsheet indicated residents had to receive a breakfast sandwich with sausage meat. The DS stated cooks must follow the menu when cooking for residents. The DS stated she did not know the breakfast sandwich had to have meat. The DS stated she was supposed to check on the food that was served to the residents, but she did not. The DS stated when she observed food being plated, she did not notice anything wrong with the food. The DS stated she did not notice the breakfast sandwiches did not have sausage. The DS stated it was important to provide all residents with the correct nutrition to prevent weight loss. During a review of facility's Recipe titled Mc muffin Sandwich (breakfast sandwich), dated 2024, the recipe indicated breakfast sandwich needed 1 teaspoon of margarine, 1 fried egg, 1/2 ounce slice of cheddar cheese and 1 sausage patty. During a review of facility's Policy and Procedure (P&P) titled Menu Planning dated 2020, the P&P indicated menus are planned to meet nutritional needs of residents in accordance with national guidelines. (continued on next page)

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	02/14/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's Job Description titled Cook, undated, the job description indicated cooks' primary purpose was to prepare food in accordance with current applicable federal, state and local standards, guidelines and regulations. The job description indicated cooks must review menus prior to preparation of food and During a review of facility's Job Description titled Director of Food Services, undated, the job description indicated the DS would monitor food services to assure all residents' food services needs were met.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure residents' food preferences were respected, alternates were provided, and food allergy was noted on the diet card (a document that listed a resident's dietary needs, including allergies, preferences, and restrictions) for three of 29 sampled residents (Resident 97, Resident 51, and Resident 81) when: 1. Resident 97 was not provided with an alternative lunch substitute on 2/11/2025, and Resident 97's preference for two quesadillas for lunch and dinner was not documented timely in the medical record. 2. Resident 51's preference for a snack of fresh fruit, was documented timely in the medical record from admission. 3. Resident 81's preference of not having beans was not honored on 2/13/2025 during lunch. 4. Resident 81's shrimp allergy was not documented on the diet card on 2/13/2025. These deficient practices had the potential to result in Resident 97 and 81's decreased meal intake, and at risk for weight loss and malnutrition. This deficient practice also had the potential to result in Resident 51 not being able to receive their preferred choice of a healthier snack, and lead to a delay in their desired weight loss. This deficient practice had the potential to result in Resident 81's shrimp allergic reaction (body's immune system overreacted to proteins found in shrimp) resulting in possible itching, swelling, hives, or difficulty breathing. Findings: During an observation on 2/11/2025 at 12:17 p.m., in the dining room, Resident 97 was observed telling Licensed Vocational Nurse (LVN) 3 she did not want the tofu, and Resident 97 was observed asking LVN 3 for a cheese quesadilla. LVN 3 was observed going to the kitchen. 1. During a review of Resident 97's Admission Record, the Admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's admitting diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and high blood pressure. During a review of Resident 97's Minimum Data Set (MDS, a resident assessment tool), dated 12/26/2024, the MDS indicated Resident 97 did not have cognitive impairments (problems with thinking, learning, or memory). The MDS indicated Resident 97 could eat independently and was independent with mobility while both in and out of bed. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/2025 at 10:17 a.m., with Resident 97, Resident 97 stated she did not like the meals she was currently receiving, and stated she preferred to have a cheese quesadilla for lunch and dinner. Resident 97 stated staff only offered substitutes of either a peanut butter sandwich, grilled cheese sandwich, or salad. Resident 97 stated she did not like those options, and stated she requested a cheese quesadilla instead. Resident 97 stated facility staff told her a quesadilla was not an option. During a concurrent observation and interview on 2/11/2025 at 12:15 p.m., with Resident 97 in the dining room, Resident 97's lunch tray was observed. Resident 97's lunch tray had a plate with tofu, sauteed vegetables, and a scoop of white rice. Resident 97 stated she did not want to eat the tofu, stating it did not look appetizing. Resident 97 stated she preferred to have a quesadilla instead. During an observation on 2/11/2025 at 12:19 p.m., in the dining room, LVN 3 was observed telling Resident 97 that the kitchen could not provide a quesadilla, and LVN 3 asked Resident 97 if she wanted a peanut butter sandwich, grilled cheese sandwich, or another salad instead. Resident 97 declined these options, and LVN 3 was observed taking Resident 97's plate, and LVN 3 told Resident 97 she would bring her something different from the tofu. During an observation on 2/11/2025 at 12:21 p.m., in the dining room, LVN 3 was observed placing a new plate onto Resident 97's lunch tray. The new plate had sauteed vegetable and a scoop of rice. There was no quesadilla on the plate as requested by Resident 97. During an interview on 2/11/2025 at 12:23 p.m., with LVN 3, LVN 3 stated the only other alternatives available to the residents were a peanut butter sandwich, a grilled cheese sandwich, or a salad. LVN 3 stated she requested for a quesadilla from the Director of Staff Development (DSD), but it was not available. During an interview on 2/11/2025 at 12:24 p.m., with the DSD, the DSD stated she was assisting to pass out trays, but she did not know if quesadillas were available to residents as a substitute. The DSD directed the surveyor to speak with the Dietary Supervisor (DS). During an interview on 2/11/2025 at 12:25 p.m., with the DS, the DS stated the kitchen had the ingredients needed to make a cheese quesadilla. The DS stated the option to have a cheese quesadilla was not included on the substitute request list, but residents could request one. The DS stated this substitution request would need to be submitted before the lunch trays were served. During an interview on 2/11/2025 at 12:36 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA staff were responsible for completing and submitting the substitute request form to the kitchen if a resident requested something different from what was being served. CNA 1 stated the option for a quesadilla was not provided to residents. During a concurrent observation and interview on 2/12/2025 at 12:18 p.m., in the dining room, Resident 97's lunch tray was observed. Resident 97 had a sandwich with two un-melted slices of cheese, and an assortment of raw vegetables, on a plate. Resident 97 had a side of soup and a bowl of fruit in syrup. Resident 97 stated she requested a quesadilla and did not receive one. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/12/2025 at 2:10 p.m., with the Registered Dietician (RD), Resident 97's lunch tray, and replacement tray provided by LVN 3, was observed. The RD stated it was not appropriate to remove the tofu and not provide an alternative item. The RD stated she was supposed to be notified whenever kitchen staff were making substitutions to a resident's tray to ensure that the substitute provided was of similar or equal nutritional value. The RD stated LVN 3's actions was not appropriate, and placed Resident 97 at risk of not having her nutrient needs met by the meal. The RD stated this placed Resident 97 at risk for malnourishment and loss of muscle mass. The RD also stated if the kitchen had the ingredients necessary to make an item requested by the resident, it should be prepared and provided to the resident. The RD stated that providing residents with meals of their choice was their right and promoted the resident's autonomy. During a review of Resident 97's diet order on 2/12/2024 at 4:11 p.m., dated 11/14/2024, the diet order did not reflect Resident 97's preference to have cheese quesadillas for lunch and dinner. During an interview on 2/13/2024 at 10:04 a.m., with Resident 97, Resident 97 stated she spoke with staff on 2/12/2025 about her preference to have two quesadillas for lunch and dinner. During a review of Resident 97's diet order on 2/13/2025 at 10:15 a.m., the diet order did not reflect Resident 97's preference to have cheese quesadillas for lunch and dinner. During a concurrent interview and record review on 2/13/2025 at 2:50 p.m., with the RD, Resident 97's diet order was reviewed. The RD stated resident food preferences would be indicated in the resident's diet order, and stated Resident 97's diet order did not reflect the preference for cheese quesadillas. The RD stated she spoke with Resident 97 on 2/12/2025 about her preference cheese quesadillas for lunch and dinner. The RD stated she would change the order after the interview. During a concurrent interview and record review, on 2/14/2025 at 9:24 a.m., with the Director of Nursing (DON), Resident 97's diet order was reviewed. The DON stated Resident 97's diet order was revised on 2/13/2025 at 3:57 p.m. to reflect the preference to have cheese quesadillas for lunch and dinner. The DON stated a resident's dietary preferences were to be reviewed and updated in the electronic medical record (EMR) as needed and stated that if the dietary staff were aware on 2/12/2025 of Resident 97's request for cheese quesadillas for lunch and dinner, the diet order should have been updated on 2/12/2025. The DON stated prompt update of the EMR to reflect those preferences would ensure the kitchen staff could prepare a meal to accommodate the preference. The DON stated that when preferences were not accommodated or respected, and a resident was not eating, it could lead to weight loss and malnutrition. The DON also stated that the trays provided should meet the resident's nutritional needs and stated kitchen staff should be communicating with the RD if substitutes were requested. During a review of the facility document titled Alternative Menu Request - Only One Alternative, undated, the facility document indicated the alternative options available to the facility residents. The document indicated the option of a salad, peanut butter sandwich, or grilled cheese sandwich. The document did not provide nursing staff the option to indicate any other food items the resident might request, including a quesadilla. (continued on next page)

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	056417	A. Building B. Wing	02/14/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled Daily Food Menu Alternative - Food Substitutions for Residents who Refuse the Meal, dated 1/2024, the P&P indicated residents were to be provided a suitable nourishing alternate meal after the planned, served meal was refused. The P&P indicated residents were to be offered food according to their stated preferences and indicated updating of the resident's preferences was to be done as the residents' needs changed. 2. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted on [DATE]. Resident 51's admitting diagnoses included obesity (the state or condition of being very fat or overweight). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 did not have cognitive impairments. The MDS indicated Resident 51 reported it was very important to have snacks available between meals while in the facility and indicated Resident 51 could eat independently. The MDS indicated Resident 51 was independent with all mobility while in and out of bed. During an interview on 2/11/2025 at 10:55 a.m., with Resident 51, Resident 51 stated she received oatmeal cream cookies as a snack between meals but preferred to have a healthier option. Resident 51 stated she preferred to have fresh fruit. Resident 51 stated she did not recall anyone talking to her about her food preferences about what she would like to eat. During an interview on 2/12/2025 at 2:10 p.m., with the RD, the RD stated inquiries about food preferences, diet changes, and or requests were not routinely documented in the resident's progress notes, dietary profiles, or nutritional assessments by nursing staff. The RD stated she and the DS were responsible for conducting reviews of residents' food preferences, and stated the facility did not currently have an official DS, therefore the task of assessing food preferences was currently her responsibility. The RD stated she was onsite at the facility one day a week. The RD stated there was no system in place for her to assure that she spoke with and assessed all residents who had questions or concerns related to their food preferences or diet. During an interview on 2/13/2025 at 2:42 p.m., with the RD, the RD stated she was unaware of Resident 51's stated preference to have fresh fruit as a snack between meals. During a review of Resident 51's physician orders, progress notes, dietary profile, and nutritional assessments, on 2/14/2025 at 8:26 a.m., there were no records indicating Resident 51's preference for fresh fruit as a snack. During an interview on 2/14/2025 at 9:24 a.m., with the DON, Resident 51's physician orders, progress notes, dietary profile, and nutritional assessments since admission, were reviewed. The DON stated that based on the documentation, there was no way for staff to know of Resident 51's preference for fresh fruit as a snack between meals. The DON stated fresh fruit was a nutritious option and was available in the kitchen. The DON stated it was Resident 51's right to be offered and provided with their preferred snack choice. During a review of the facility P&P titled Daily Food Menu Alternative - Food Substitutions for Residents who Refuse the Meal, dated 1/2024, the P&P indicated residents were to be offered food according to their stated preferences and indicated updating of the resident's preferences was to be done as the residents' needs changed. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 81's Admission Record, the Admission Record indicated Resident 81 was originally admitted on [DATE] and readmitted on [DATE]. Resident 81's admitting diagnoses included schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior). The Admission Record indicated Resident 81 was allergic to shrimp and had a public guardian (responsible for the care of individuals who were no longer able to make decisions or care for themselves). During a review of Resident 81's MDS, dated [DATE], the MDS section F indicated Resident 81 reported it was very important to have snacks available between meals while in the facility. During a review of Resident 81's MDS, dated [DATE], the MDS section C indicated Resident 81 did not have cognitive impairments, and the MDS section GG indicated Resident 81 could eat independently. The MDS section GG indicated Resident 81 was independent with all mobility while in and out of bed. During a review of Resident 81's physician orders report, dated from 2/1/2025 -2/14/2025, the report indicated Resident 81did not want beans and needed protein replacement for beans with all meals. During an observation and interview on 2/13/2025 at 12:42 p.m. with Resident 81, in facility's dining room, black beans were observed on Resident 81's lunch plate. Resident 81's preference of not wanting beans was not on the diet card. Resident 81 used fork to push away the black beans on his lunch plate and stated he did not like beans. During an observation and interview on 2/13/2025 at 12:42 p.m. with Resident 81, in facility's dining room, shrimp allergy was not on Resident 81's diet card. Resident 81 stated he was allergic to shrimp, and the diet card used to have the shrimp allergy on but not anymore. During a review of facility's menu, dated 2/13/2025, the menu indicated black beans was served for lunch. During an interview on 2/13/2025 at 3:19 p.m. with the RD, the RD stated the diet card should have resident's food allergy because it was important to not give food that resident was allergic to. The RD stated resident might receive the food that they were allergy to and have allergic reaction if there was no allergy information on the diet card. The RD stated the DS needed to check resident's diet card every day. The RD stated it was not acceptable to have the diet card without the allergy information if resident had food allergy. During a concurrent picture review and interview on 2/13/2025 at 3:19 p.m. with the DS, Resident 81's diet card picture, dated 2/13/2025 at 1:51 p.m., was reviewed. The picture indicated the diet card did not have Resident 81's preference of not wanting beans. The DS stated Resident 81's diet card did not indicate shrimp allergy. The DS stated resident's food allergy needed to be on the diet card because facility did not want to serve the food resident were allergic to. The DS stated resident might have allergic reaction, such as itchy throat, hives, and closed throat which was life threatening. The DS stated she was responsible to check the diet card against resident's diet list and allergy. The DS stated it was possible to wash off resident's allergy information which was written on the diet cards when sanitizing. The DS stated staff should not put beans on the plate because they need to follow the diet order. The DS stated resident might decrease oral intake and potentially result in weight lost when preference was not respected. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled Food Allergies, dated 12/2024, the P&P indicated Steps are taken to prevent resident exposure to the allergen(s)(a substance that can cause an allergic reaction) and Severe food allergies are noted on the face of the chart and communicated in writing directly to the dietitian and the director of food and nutrition services. During a review of the facility P&P titled Tray Card System Policy, dated 12/2024, the P&P indicated Each meal tray at breakfast, lunch and dinner will have a tray card which designates the resident's name, diet, food dislikes, food allergies, and portion (serving) size. 49900

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled Nourishment Policy for two of two residents (Resident 56 and Resident 81) by failing to: a. Provide Resident 56 snacks when requested. b. Provide Resident 81 snacks. This deficient practice violated Resident 56 and 81's rights to eat as they wanted to. Findings: 1. During a review of Resident 56's Admission Record (Face Sheet), the Face Sheet indicated Resident 56 was initially 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), alcohol dependence (a chronic disease where the individual craves drinks with alcohol and unable to control their drinking), and nicotine dependence (a compulsive need for nicotine, the additive chemical in tobacco products). During a review of Resident 56's Minimum Data Set ([MDS], a resident assessment tool), dated 11/13/2024, the MDS indicated Resident 56's cognition (process of thinking) was intact. The MDS indicated Resident 56 was independent with eating, toileting, bathing, and dressing. During a review of Resident 56's Orders, dated 2/1/2025 through 2/28/2025, the Orders indicated Resident 56 was on a regular diet (a meal plan that allows the individual to eat a variety of foods without restrictions). During an interview on 2/11/2025 at 8:03 a.m., with Resident 56, Resident 56 stated when he asked the nurses for a snack, they would not give him a snack. During an interview on 2/13/2025 at 10:15 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated the scheduled snack times were 10 a.m., 2 p.m., and 8 p.m. CNA 2 stated all the residents received a snack at 2 p.m., but only specific residents on the Nourishments list would receive specific snacks at 10 a.m. and 8 p.m. CNA 2 stated when a resident requests additional snacks, the licensed nurse would have to consult with the Registered Dietician (RD) whether or not the resident could receive additional snacks. During an interview on 2/13/2025 at 10:19 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated if a resident requested for additional snacks, the resident would have to be weighed and the RD would be consulted to see if the resident was allowed an additional snack. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review at 2/13/2025 at 2:59 p.m., with the RD, the facility's Nourishment and Time, dated 2/13/2025, was reviewed. The RD stated residents were allowed up to three snacks per day. The RD stated every resident received a snack at 2 p.m., however, only specific residents were allowed a snack at 10 a.m. and 8 p.m. based on her clinical assessment if the resident required additional calories. The RD stated Resident 56 was not on the Nourishment list to receive snacks at 10 a.m. and 8 p.m. The RD stated if a resident requested additional snacks, the licensed nurse would inform her, and the additional snacks would not be provided to the resident until she (RD) assessed the resident at the facility. 49900 2. During a review of Resident 81's Face Sheet, the Face Sheet indicated Resident 81 was originally admitted on [DATE] and readmitted on [DATE]. Resident 81's admitting diagnoses included schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior). The Face Sheet indicated Resident 81 had a public guardian (responsible for the care of individuals who were no longer able to make decisions or care for themselves). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 reported it was very important to have snacks available between meals while in the facility. During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 did not have cognitive impairments. The MDS indicated Resident 81 could eat independently, and was independent with all mobility while in and out of bed. During a review of Resident 81's physician orders report, dated from 2/1/2025 -2/14/2025, the report indicated Resident 81 was on a low fat diet (an eating plan that limited fat to 30 percent (%) or less of your daily calories). During an interview on 2/11/2025 at 10:21 a.m. with Resident 81, in Resident 81's room, Resident 81 stated he was not provided snacks when he asked staff. Resident 81 stated the nurse (unidentified) told him that staff could not provide snacks if it was not on paper. Resident 81 stated he felt inadequate and not as important as other residents. During an interview on 2/13/2025 at 4:17 p.m., with the Director of Nursing (DON), the DON stated residents should be provided additional snacks when requested. The DON stated if a resident was hungry and wanted a snack, outside of the normal snack and mealtimes, the resident should be provided a snack, and the licensed nurse should inform the RD so the RD could assess the resident's needs and preferences. The DON stated snacks should not be withheld from the resident while they wait for the RD to assess them. The DON stated if a resident was hungry, it was the responsibility of the facility to feed them. The DON stated withholding additional snacks from a resident put the resident at risk of hunger and weight loss. During a review of the facility's policy and procedure (P&P) titled, Nourishment Policy, dated 12/2024, the P&P indicated, Snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled snack times. The P&P indicated facility shall provide nourishments up to three times per day.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review the facility failed to ensure safe and sanitary food storage practices in the kitchen that affected 146 residents out of 146 sampled residents when: 1. The walk -in refrigerator contained lettuce with no in date (the date when the food was placed in the refrigerator), no use by date (date the food item must be consumed by) and cheese with no use by date. 2. The dry storage room did not have a thermometer to monitor room temperature. 3. The walk-in refrigerator had three bags of expired spinach. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illnesses in all residents who received food from the kitchen. Findings: During the initial kitchen tour observation on [DATE] at 8:31 a.m., the walk-in refrigerator was observed with a bag of cheese without a use by date, bags of spinach that were expired and lettuce that was not labeled and undated. During the initial kitchen tour observation on [DATE] at 8:44 a.m., in the dry storage room, the storage room did not have a thermometer. During an interview on [DATE] at 8:51 a.m. with Dietary cook (DC) 1, in the dry storage room, DC 1 stated there must be a thermometer in the dry storage room, but she could not find it. DC 1 stated when the dietary staff added new food items into storage room, they misplaced it. DC 1 stated it was important to have a thermometer in the dry storage room to monitor temperatures daily and without a thermometer there was no way of knowing if temperature was within the required temperature range. During an interview on [DATE] at 8:59 a.m. with DC 1, DC 1 stated the spinach bags were expired and should not be in the refrigerator. DC 1 stated the cheese should have a use by date and the lettuce should be labeled with the correct dates. DC 1 stated all food items placed in the refrigerator should have an in date and a use by date to inform all staff if food item was still good to be used. DC 1 stated it was important to date all food items to inform staff if food item was safe to consume. During an interview on [DATE] at 7:49 a.m. with the Dietary Supervisor (DS), the DS stated all food that goes into a refrigerator must be dated with an in date and a use by date to prevent residents from getting sick. The DS stated if food items were not labeled, they could potentially serve old food to residents. (continued on next page)

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	056417	A. Building B. Wing	02/14/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's Policy and Procedure (P&P) titled Dry Storage Areas, dated ,d+[DATE], the P&P indicated storeroom temperature should be 50 degrees to 70 degrees Fahrenheit ([F], scale for temperature). The P&P indicated a thermometer must be present in the storeroom and storeroom must be monitored on a regular basis. During a review of facility's P&P titled Dietary Refrigerated Storage, dated ,d+[DATE], the P&P indicated food items should be arranged so that older items will be used first, by dating food items would facilitate this practice. The P&P indicated all food items are to be stored in the refrigerator for the correct amount of time. The P&P indicated all leftover food would be covered, labeled and dated.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure one of three sampled residents' (Resident 21) conservator (a person who has been appointed by the court to make decisions for another person who is deemed incompetent) understood the Arbitration Agreement (an agreement between the facility and the resident where they would resolve any disputes through a neutral person rather than going to court) in a language Conservator 1 understood. This deficient practice resulted in Conservator 1 not understanding what entering a binding Arbitration Agreement meant. Findings: During a review of Resident 21's Admission Record (Face Sheet), the Face Sheet indicated Resident 21 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), alcohol dependence (a chronic disease where the individual craves drinks with alcohol and unable to control their drinking), and nicotine dependence (a compulsive need for nicotine, the additive chemical in tobacco products). The Face Sheet indicated Conservator 1 was Resident 21's private conservator and responsible party. During a review of Resident 21's Minimum Data Set ([MDS], a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 21's cognition (process of thinking) was intact. The MDS indicated Resident 21 was independent with eating, toileting, bathing, and dressing. During a review of Resident 21's Resident-Facility Arbitration Agreement, dated 7/15/2024, the Resident-Facility Arbitration Agreement indicated Conservator 1 signed and entered the binding agreement on behalf of Resident 21. The Resident-Facility Arbitration Agreement was in English. During an interview on 2/12/2025 at 4:48 p.m., with Conservator 1, Conservator 1 stated her primary language was Spanish and paperwork from the facility was given to her in English. Conservator 1 stated she spoke very little English and was unable to explain what arbitration was. During an interview on 2/13/2025 at 8:30 a.m., with the Admissions Coordinator (AC), the AC stated the facility only offered the Resident-Facility Arbitration Agreement in English. The AC stated if a resident or their conservator's primary language of Spanish, a translator would explain the Resident-Facility Arbitration Agreement to them in Spanish. The AC stated the facility should have the Resident-Facility Arbitration Agreement in different languages to ensure the resident and their conservator could read and understand the contract before deciding to enter the binding Arbitration Agreement. The AC stated although the contract was translated in Spanish to Conservator 1, if Conservator 1 wanted to refer back to the contract, which was in English, Conservator 1 would not be able to have a full understanding of the Arbitration Agreement.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 47679 Based on interview and record review, the facility failed to include the selection of a venue that was convenient to both parties in the Arbitration Agreement (an agreement between the facility and the resident where they would resolve any disputes through a neutral person rather than going to court). This deficient practice had the potential to cause bias in venue selection process for residents who enter into a binding arbitration agreement and want to resolve a dispute. Findings: During a concurrent interview and record review on 2/13/1015 at 12:57 p.m., with the Administrator (ADM), the facility's Resident-Facility Arbitration Agreement, undated, was reviewed. The ADM stated the facility had updated the Resident-Facility Arbitration Agreement to indicate a section for the selection of a venue that was convenient to both parties, however, the Resident-Facility Arbitration Agreement currently utilized was not the updated version. The ADM stated the facility's administration was responsible for providing the updated Resident-Facility Arbitration Agreement to the Admissions Coordinator (AC), who would review the contract with the resident and their conservator (a person who has been appointed by the court to make decisions for another person who is deemed incompetent). The ADM stated the residents and their conservators who signed on their behalf were given the wrong version of the Resident-Facility Arbitration Agreement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49900 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled Water Temperature Policy For Facility Laundry and Preventative Maintenance Policy by failing to: 1. Monitor the washer water temperature on 2/14/2025. 2. Clean the dyer lint trap (a mesh filter located inside a dryer that caught lint and fabric fibers from clothes during the drying cycle) on 2/14/2025. This deficient practice had the potential to increase the risk of infection which could increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death) among 146 residents residing in the facility. Findings: 1. During a concurrent observation and interview on 2/14/2025 at 9:21 a.m. with the Maintenance Supervisor (MS), in the facility's laundry room, there were no monitors on the washer indicating the water temperature. The MS stated the water temperature needed to be between 125-165 degrees Fahrenheit (F, a measurement of temperature). The MS stated the facility was unable to read the water temperature of the washers because the monitor was broken for the past few days. The MS stated staff checked the water temperature by feeling how hot the outside of the washer viewing glasses was, and the chlorine (a disinfectant that killed germs in water) in the washing solution also disinfected the linen. The MS stated they ordered the new monitors for the washer and waiting for the delivery. The MS stated staff were not certain if the linen was getting cleaned or disinfected properly when they did not know the water temperature. 2. During a concurrent observation and interview on 2/14/2025 at 9:40 a.m. with the MS, in the facility's laundry room, the dryer lint trap had lint. The MS stated staff were supposed to remove the dryer lint twice a shift, starting with the morning shift at 5:30 a.m. During a concurrent interview and record review on 2/14/2025 at 9:42 a.m. with the MS, in the facility's laundry room, the dryer lint removal log, dated 2/2025, was reviewed. The log indicated no documentation on the dryer lint removal on 2/14/2025 at 7 a.m. nor at 9 a.m. The log further indicated staff were to remove lint from the lint trap after every 3rd load or 2 hours of operation per manufacturer requirements. The MS stated staff were supposed to clean the dryer lint trap at 9 a.m. but it was not done. The MS stated the risk was fire, and the dryer temperature would drop and affect the linen sanitizing process. The MS stated if the linen was not dry enough, staff would double dry the linen to make sure they were dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/14/2025 at 9:59 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated the dryer might not kill all the bacteria and viruses in the linen if the dryer lint trap was not clean. The IPN stated staff were unsure if the linen were cleaned properly nor if the bacteria was killed when the washer water temperature was not monitored. The IPN stated the linen might not be clean and cause infection among residents. The IPN stated residents might experience signs and symptoms of sickness and cold with cough. During a review of the facility's Policy and Procedure (P&P) titled, Water Temperature Policy For Facility Laundry, dated on 12/2014, the P&P indicated Water temperatures shall be at least maintained at a minimum reading of 160 F for a minimum of 25 minutes for hot water washing. The temperature will be monitored at the beginning, middle and end of shift. During a review of the facility's P&P titled, Preventative Maintenance Policy, dated on 12/2014, the P&P indicated The dryer lint trap or filter will be cleaned after every two dryer loads. Careful records should be kept making sure all cleanings have been recorded noting the time of each cleaning. During a review of the facility's P&P titled, Standard Infection Precaution, dated on 12/2014, the P&P indicated Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 45009 Based on observation, interview, and record review, the facility failed to accommodate residents in the dining room during mealtimes by not ensuring: 1. The dining room offered enough space for all residents to sit down at the same time for mealtime. 2. Residents were sent to not their rooms to wait until a seat became available. 3. Residents were asked to form a line to wait for a seat to become available. This deficient practice had the potential to affect Resident's self-esteem and self-worth. Findings: During an observation on 2/11/2025 at 12:10 p.m., in the dining room, the dining room was observed having 40 chairs. During an observation on 2/11/2025 at 12:22 p.m., in the dining room, residents were observed forming a line at the entrance of the dining room. Residents were in line waiting for a seat to become available. During an observation on 2/12/2025 at 12:07 p.m., in the dining room, an identified resident walked into the dining room, looked around the room for a place to sit and remained standing in the middle of the dining room because he could not find an empty seat. Certified Nursing Assistant (CNA) 3 asked the resident to go stand by the door until there was an available seat for the resident to use. During an observation on 2/13/2025 at 1216 p.m., in the dining room, an unidentified resident was observed entering the dining room but could not find an available seat. CNA 3 told the resident to go to back to their room and he (CNA 3) would call the resident when there was an available chair. The resident stood standing in the middle of the dining room looking around at all seated residents. CNA 3 told resident again to go back to her room and the resident left the dining room. During an interview on 2/13/2025 at 12:18 p.m. with CNA 3, in the dining room, CNA 3 stated the dining room did not have enough space for all residents to sit down and eat together. CNA 3 stated residents must wait until there was an available chair for them. CNA 3 stated residents must wait against the wall while the other residents seated were eating. CNA 3 stated the dining room did not have enough chairs for all the residents and that was the reason why residents had to wait to eat. (continued on next page)

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/14/2025 at 10:35 a.m. with the Director of Nursing (DON), the DON stated the north side of the facility housed 50 residents and the dining room had 40 chairs to accommodate residents during mealtimes. The DON stated staff sent residents back to their rooms to wait for a seat because the facility's dining room could not accommodate all residents. The DON stated it was an acceptable practice to send residents back to their rooms or have them wait in line because they could not accommodate all the residents. The DON stated this practice would make residents feel bad because they were sent away and had to wait to eat. During a review of the facility's Policy and Procedure (P&P) titled Dining Room Service dated 12/2024, the P&P indicated meals would be distributed promptly to maintain adequate temperature and appearance. The P&P indicated all individuals should be encouraged to sit in a dining room chair.