STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555030	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Vista Post-Acute	4681 Eagle Rock Blvd. Los Angeles, CA 90041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481 Based on observation, interview, and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 1) who filed a grievance was provided with written grievance decision that included all the required information, in accordance with the facility ' s policy and procedure titled Resident and Family Grievances. This deficient practice violated in Resident 1 ' s right to receive a proper grievance report. Findings: A review of Resident 1 ' s Admission Record (AR), the AR indicated Resident 1 was initially admitted on [DATE] with diagnoses including Hepatic Encephalopathy (brain dysfunction due to liver dysfunction) and Cirrhosis of Liver (a condition in which a liver is scarred and permanently damaged). A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/9/25 indicated Resident 1's cognition was moderately impaired (short-term memory is more affected, significant difficulty with memory, reasoning). The MDS also indicated that Resident 1 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) on sit-to-lying, sit-to stand, chair/bed-to-chair transfer, toilet transfer, and walk-10-feet. During a review of the Concerns/Grievance Reporting Form dated 2/8/25 indicated: Resident 1 was disturbed by roommate. The grievance form indicated under Follow up Action that Room Change was done to separate the residents. The grievance form further indicated under Comment and indicated Resident and family are satisfied, no concern. The form did not indicate that either Resident 1 or the resident ' s family (Family 1) signed the grievance form and indicated verbal consent under Resident/Complainant portion of the form with no date. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/7/25 at 10:25 am with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Nursing Progress note dated 2/8/25 indicated LVN 1 heard an episode of Resident 2 (Resident 1 ' s roommate) cursing and yelling towards Resident 1 around 9 am as LVN 1 was by the room entrance passing medications. LVN 1 stated Resident 2 was yelling in another language (other than the dominant language at the facility), a certified nurse assistant (CNA) translated He said I ' m God and I see demons. LVN 1 stated Resident 2 was having delusions. LVN 1 stated Resident 1 told him Resident 2 said something that insulted his family member that ' s why Resident 1 got very mad. LVN 1 stated LVN 1 and 3 other CNAs deescalated the situation and immediately reported to the Director of Nursing (DON) and Administrator (ADM). During an interview on 3/7/25 at 11:29 am with the Social Service Director (SSD), the SSD stated she was informed about the episode by the DON that day, and spoke to Resident 1 and 2 respectively, 30 minutes apart, SSD stated room change was already done at the moment. The SSD stated she filled out the grievance form, but did not have documentations in Resident 1 or 2 ' s progress note. The SSD stated she did not have the grievance investigation report provided to the family, due to a previous issue that Resident 1 ' s family had with the SSD. The SSD stated she chose to have the DON and/or the ADM to take over communication with Resident 1 ' s family, because the SSD did not want to be involved with Resident 1 ' s family. During an interview on 3/7/25 at 12:20 pm with the DON, the DON stated the facility ' s policy indicated a written summary report would be prepared by the SSD, but the DON or the ADM would be the person to write the summary. The DON stated they did not write a written summary report about this grievance, but provided nursing progress note to the family. During a review of the facility ' s policy and procedure (P&P) titled Resident and Family Grievances revised on on 12/16/24, the policy indicated Social Service Designee has been designated as the Grievance Official. In accordance with the resident ' s right to obtain a written decision regarding his or her grievance, the Grievance Official may issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: -The date the grievance was received. -The steps taken to investigate the grievance. -A summary of the pertinent findings or conclusions regarding the resident ' s concern(s). -A statement as to whether the grievance was confirmed or not confirmed. -Any corrective action taken or to be taken by the facility as a result of the grievance. -The date the written decisions was issued.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48481 Based on observation, interview, and record review, the facility failed to provide the necessary care and interventions to prevent pressure injury ([PI]-damage to an area of the skin caused by constant pressure on the area for a long time) for one (1) of three (2) sampled residents (Resident 1) by failing to turn, reposition and off-offload (release pressure) from an area of the body every two hours while in bed, keep clean and dry after a bowel movement or wetness from urine due to incontinence (unwanted passage of urine or stool that you can't control). These deficient practices resulted in Resident 1 developing a facility-acquired Stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound) PI on the intergluteal cleft (crease located between the two buttocks) area on 2/16/25. Resident 1 was discharged to home with home health services on 2/19/25. Home health services licensed nurse skin assessment on admission indicated Resident 1 was observed with a Stage 2 pressure injury on the intergluteal cleft described as with skin irritation, redness, and infection were present. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included Hepatic Encephalopathy (brain dysfunction due to liver dysfunction), Cirrhosis of Liver (a condition in which a liver is scarred and permanently damaged), and Morbid Obesity (severe overweight) Due to Excess Calories. During a review of Resident 1's Minimum Data Sheet (MDS- a Federal mandated resident assessment tool) dated 1/9/25, the AR indicated Resident 1 was assessed with moderate cognitive impairment (short-term memory is more affected, significant difficulty with memory, reasoning, problem-solving, and daily tasks, including confusion, trouble following conversations, and challenges managing complex situations). Resident 1's MDS also indicated that Resident 1 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs, but provide less than half the effort) on rolling left to right, sit-to-lying, lying-to-sit, sit-to-standing, and chair/bed-to-chair transfer. During a record review and concurrent interview with the Treatment Nurse (TN) on 3/5/25 at 10:15 am of Resident 1's clinical records were reviewed, the records indicated the following: - Resident 1's Braden Score Assessment (a tool to evaluate a patient's risk for developing pressure injuries) dated 10/30/24, with latest update dated 11/20/24, indicated Resident 1 was at high risk for developing PI due to skin often moist, completely immobile, stays majority of hours each shift in bed or chair, does not make even slight changes in body or extremity position, and requires moderate to maximum assistance in moving. - Resident 1's Skin Check dated 10/30/24 indicated Resident 1 was admitted with MASD (moisture associated skin damage-caused from prolonged exposure to moisture) on 10/30/24 in perineal area extending to the perianal area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 1's Care Plan, dated 10/30/24 (no revised date) indicated the resident has MASD on perineal extending to the perianal area. The interventions indicated to cleanse with normal saline solution, pat dry, apply zinc oxide cream to the affected area then leave open to air. The interventions further included to keep skin clean and dry, use lotion on dry scaly skin. Medication/treatment as ordered by PCP (primary care physician). - Resident 1's Care Plan, dated 10/30/24 indicated the resident was at risks for developing pressure ulcer or potential for pressure ulcer development related to immobility, thin and fragile skin, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (low blood level). The interventions included to educate the causes of skin breakdown, good nutrition and frequent repositioning. - Resident 1's Nursing Progress Note dated 2/15/25 timed 10:05, the record indicated Skin Issue#001: Location: Perineum extending to perianal, issue type MASD/IAD, wound was present on admission. - The SBAR (Situation, Background, Assessment, and Recommendation- a structured method of communication that helps teams share information about a patient's condition) dated 2/18/2025, authored by Treatment Nurse (TN) 2 indicated Resident 1 was noted with a new MASD with excoriation located in the intergluteal cleft, measuring 1.0 cm x 0.8 cm x 0.1 cm. The nursing summary indicated that initial treatment was rendered per facility protocol, physician notified with new orders. During a review of Resident 1's Treatment Administration Record (TAR) dated 2/1/25 to 2/28/25, the TAR indicated wound treatments as follows: Pressure Ulcer Stage 2 (site: Left gluteal fold) was started on 2/16/25 and stopped on 2/18/25. Everyday shift cleanse with NSS (normal saline solution), pat dry, pack lightly with collagen powder then cover with dd (dry dressing). Excoriation r/t (related to) MASD, Incontinence, site: left inner buttock, started 2/18/25. Cleanse with soap and water. Apply Triad cream as needed. During a review of Resident 1's Nursing Progress Notes dated 2/19/25 indicated Late Entry Skin Alteration Care Conference. Brief description of wound status: Resident 1 has MASD with excoriations on perineal extending to perianal area. MASD site appeared stable, with no s/s of infection noted, no further skin breakdown noted, no c/o pain or discomfort noted. Wound care provided as tolerated, healing is stable but slow d/t resident underlying condition and status. Resident was offered LALM for preventing of further skin breakdown but Resident 1 refused. RP (responsible party) made aware and honored resident ' s right. Current treatment plan is effective. During a review of Resident 1's physician order dated 2/19/25, the order indicated May Discharge Home on 02/19/2025 with Home Health. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Home Health Record after Resident 1 was discharged to home by the facility, titled Physician's Certification for Hospice Benefits, dated 2/19/25, the record indicated during the assessment, a Stage 2 wound was noted in the intergluteal cleft of Resident 1. The record further indicated that skin irritation, redness, and infection were present. To manage these conditions, Calmoseptine Topical Ointment was applied to the perineal area at every diaper change to manage redness, Triple Antibiotic Ointment was applied in small amounts to the affected area 2 to 3 times a day for infection management, and Vitamin A & D Ointment was applied as needed for irritation. During an interview on 3/5/25 at 10:15 am, TN 1 stated Resident 1 was high risk for skin integrity impairment. TN 1 stated Resident 1 was admitted to the facility with MASD to the perineal area due to incontinence and impaired mobility. TN 1 stated Resident 1 called frequently, during his shift he checked and made sure Resident 1 was kept clean and dry when he helped answer call lights, since Resident 1 needs help with brief change or reposition. During a record review and concurrent interview on 3/7/25 at 1:49 pm with TN 2, Nursing Progress Note dated 2/16/25 indicated that Resident 1 was observed with Stage 2 PI on the gluteal fold. TN 2 stated she assessed Resident 1's skin and reclassified from Stage 2 PI to MASD on 2/18/25 (as indicated in SBAR note) because the skin appeared pink, the impairment was scattered, it ' s open but not shaped as pressure injury. TN2 stated she could not measure the wound due to appearance, the surrounding skin was wet and a little pale, and that was from moisture. TN 2 stated she did not consider it as a pressure injury, so TN 2 did not conduct a Braden Score Assessment. During an interview on 3/7/25 at 4 pm with the DON, the DON stated Resident 1 had a stable MASD site although healing is slow due to underlying condition and status, very limited mobility but he had therapy. The DON stated the resident was also offered low air loss mattress at beginning when identified Resident 1's skin damage on 2/16/25 but he refused. DON stated she documented that as Late Entry on 2/19/25 while the Skin Alteration Meeting was held on 2/18/25. During a review of the facility's policy and procedure (P&P) titled Pressure Injury Prevention and Management, revised on 9/16/24, the P&P indicated the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The P&P indicated Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.