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	05/09/2025

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

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 33 & 34) were treated with respect and dignity by ensuring residents body was covered while asleep in bed. This deficient practice resulted in Resident 33 and Resident 34 ' s unknown and/or unwanted exposure of the body and had the potential to lead to psychosocial (mental and emotional well-being) decline, resident ' s individuality, self-esteem, and self-worth. Findings: A review of Resident 33 ' s Admission Record [AR] indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (brain disorder that affects memory and thinking) and alcoholic cirrhosis (a disease that damages the liver) of the liver (organ in the body). A review of Resident 33 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the Patient ' s health status) signed by the attending physician on 2/11/2025, indicated Resident 33 could make needs known but cannot make medical decisions. A review of Resident 33 ' s Minimum Data Set (MDS, a assessment tool) dated 2/15/2025, indicated the Resident 33 ' s cognition (thought process) was impaired and was dependent on care. A review of Resident 34 ' s AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included cerebral vascular accident (CVA - blood flow interruption to the brain) and dominant side hemiplegia (severe weakness or paralysis (no movement) to one side of the body). A review of Resident 34 ' s HPE signed by the attending physician on 3/15/2025, indicated Resident 34 had the capacity to understand and make decisions. A review of Resident 34 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 2/28/2025, indicated the Resident 34 ' s cognition (thought process) was moderately impaired and was dependent on care. (continued on next page)

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

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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 - Few	During an observation of Resident 33 in Resident 33 ' s room on 5/6/2025 at 9:44AM, Resident 33 ' s brief (diaper) was visible, and gown was up, exposing Resident 33 ' s chest, arms and lower body. Resident 33 ' s blanket was placed on the left side of his body. During a concurrent observation and interview of Resident 33 in Resident 33 ' s room with the Director of Nursing (DON) on 05/06/25 at 9:48AM, DON stated that Resident 33 ' s lower body was exposed. DON stated this was a dignity issue since the resident was in a vulnerable state and did not have the capacity to ask for assistance. During an observation of Resident 34 in Resident 34 ' s room on 5/6/2025 at 10AM, Resident 34 ' s lower body was exposed and Resident 34 ' s brief was visible. Resident 34 ' s blanket was placed to the right side of his body. During a concurrent observation and interview of Resident 34 ' s room with Certified Nursing Assistant (CNA 1) on 05/06/25 at 9:48AM, CNA 1 stated that Resident 34 ' s lower body a was exposed. CNA 1 stated that Resident 34 ' s body should not be exposed, and it was a privacy issue. A review of the facility ' s P&P titled Promoting/Maintaining Resident Dignity revised 12/9/2024, indicated it is practice of this facility to protect and promote resident ' s rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident ' s quality of life by recognizing each resident ' s individuality. The policy indicated that it will maintain resident ' s privacy.

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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 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** 46779 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS, a resident tool) entries were accurate and reflect resident ' s status of one of three sampled residents (Resident 39) who was discharged home with home health services. The MDS was incorrectly coded as a transfer to a hospital which does not reflect the actual discharge disposition of the resident who was discharged home. This failure resulted in inaccurate documentation in the resident ' s medical record could impact continuity of care, facility reporting accuracy, and regulatory compliance. Incorrect discharge coding may also affect quality measures, reimbursement, and tracking of resident outcomes. Findings: During a review of Resident 39 ' s Admission Record (AD), the AD indicated the facility admitted Resident 39 on 3/21/2025 with diagnoses that included cellulites (a common and potentially serious skin infection) of right lower limb and depression (a common and serious mental illness that affects how you feel, think, and handle daily activities). During a review of Resident 39 ' s MDS dated [DATE], Section A indicated the resident had been discharged to an acute hospital. During a review of Resident 39's physician orders, dated 4/15/2025, indicated an order to discharge Resident 39 home on 4/16/2025 with home health services. During a review of Resident 39 ' s Progress Notes, dated 4/16/2025, indicated Resident discharge home and left the building in stable condition. During an interview on 5/7/2025 at 2:08 PM with the MDS Coordinator (MDSC), the MDSC stated Resident 39 was discharged home with home health service on 4/16/2025. The MDSC stated it was a mistake to document in the MDS that Resident 39 was transferred to an Acute hospital on the MDS. The MDSC stated she did not notice the discrepancy until the surveyor indicated today. The MDSC stated she did not accurately document Resident 39 ' s discharge status on the MDS to ensure consistent plan of care for the resident. During an interview on 5/9/2025 at 10:33 AM with the Director of Nursing (DON), the DON stated Resident 39 ' s discharge status was not accurately documented, and it would affect the continuation of care for the resident negatively and result in the incorrect tracking for the resident ' s outcome. During a review of the Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, the Manual indicated that facilities must ensure MDS discharge assessments accurately reflect the resident ' s discharge location and care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44372 Based on observation, interview, and record review, the facility failed to develop and/or implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the resident ' s needs for 4 of 4 sampled residents (Residents 192, 20, 5 & 21) by failing to: 1. For Resident 192 had no care plan to address interventions and goals while receiving Lovenox (a medication or an anticoagulant or blood thinner that makes blood less likely to clot and can cause bleeding). 2. For Resident 20 the plan of care was not implement care Plan interventions who had a diagnosis of impaired immunity related to viral infection to monitor and document sign and symptom of delirium as indicated in care plan. 3. For Resident 5, there were no care plans indicating the specific activities needed since Resident 5 had impaired vision. 4. For Resident 21, there was not care plan indicting Resident 21 ' s specific needs for nutrition based on Resident 1 ' s therapeutic diet ordered. These deficient practices had the potential to delay care and services that were specific to each residents needs to produce desired outcomes. Findings: 1. During a review of Resident 192's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur (fracture(a break in a bone) that occurs in the area between the greater and lesser trochanters of the femur (upper thigh bone), where the fracture is displaced, meaning the broken bone fragments are out of alignment), Anemia (condition where the blood has a reduced ability to carry oxygen, can be caused by several factors), and hyperlipidemia (a condition of high cholesterol level). During a review of Resident 192's History and Physical (H&P) dated 4/29/2025, the H&P indicated Resident 192 has the capacity to understand and make decisions. During a review of Resident 192's Minimum Data Set (MDS, an assessment tool) dated 5/05/2025, indicated the resident ' s cognition (the mental process of knowing, including awareness, perception, reasoning, and judgment) was severely impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 192's physician orders dated 5/1/2025 to 5/31/2025, the physician orders indicated Lovenox (an anticoagulant that helps prevent the formation of blood clots) Injection Solution Prefilled [NAME] 40 milligrams per 0.4 milliliters (mg/mL, a unit of measurement) inject 40 mg subcutaneously (under the skin) one time a day for deep vein thrombosis (DVT, condition where a blood clot forms in a deep vein, most commonly in the legs or arms) prophylaxis (PPX) started on 4/20/25 until 5/19/2025 . During a review of Resident 192's Medication Administration Record (MAR) from 5/1/2025 to 5/31/2025 indicated Resident 192 received Lovenox Injection Solution Prefilled [NAME] 40 MG/0.4 ml inject 40 mg subcutaneously one time for DVT PPX one time a day at 9:00 AM on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, and 5/5/2025, the route of administration was not recorded only the site was reordered. During a concurrent interview and record review on 5/09/2025 at 1:35 PM with the DON, Resident 192 ' s Medication Administration Record (MAR) dated 5/1/2025 to 5/31/2025 was reviewed. The DON stated Resident 192 received Lovenox Injection Solution Prefilled [NAME] 40 MG/0.4 ml inject 40 mg subcutaneously for DVT PPX at 9:00 AM on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, and 5/5/2025. The DON stated Lovenox was an anticoagulant and could cause major bleeding which was serious. The DON stated a care plan was necessary for anticoagulants, so nurses know what to monitor, what interventions to implement in cases of emergencies, such as bleeding. During the same interview DON reviewed Resident ' s 192 care plans and stated there was no care plan for Resident 192 taking Lovenox. The DON stated the care plan provided guidelines, and the intervention were necessary to provide quality of care to meet the residents ' needs and desired outcome 2. During a review of Resident 20's AR, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including immunodeficiency (inability of the body to produce an adequate immune response because of an insufficiency or absence of antibodies, immune cells, or both), chronic obstructive pulmonary disease(is a progressive lung disease that makes it hard to breathe. It's characterized by airflow obstruction, often caused by damage to the airways or air sacs in the lungs), and depression (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities previously enjoyed). During a review of Resident 20's H&P dated 3/28/2025, indicated Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's MDS, dated [DATE], indicated the resident ' s cognition is moderately impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/09/2025 at 1:50 PM with DON, Resident 20 ' s care plan-initiated date 3/28/2025 was reviewed. DON stated the care plan indicated Resident 20 had impaired immunity related to viral (illness caused by a virus) infection, . The DON stated Resident 20 had a diagnosis of Human immunodeficiency virus (HIV, a virus that attacks the body's immune system). The DON stated the care plan intervention included to monitor, record and report to the medical doctor (MD) signs and symptoms of delirium (a sudden change in mental state causing confusion, disorientation, and difficulty concentrating, often with fluctuating alertness) such as changes in behavior, altered mental status. The care plan indicated that Resident 20 would not display any complication related to immune deficiency and Resident 20 would remain free from infection. The DON stated there was no monitoring for Resident 20 ' s delirium. DON stated it was crucial to monitor delirium to prevent any complications related to immune deficiency. The DON stated Resident 20 ' s care plan did not indicate how often staff should monitor and document the interventions. 44429 3. During a review of Resident 5 ' s AR, the AR indicated Resident 5 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (high blood sugar levels) and glaucoma (loss of vision or blindness). During a review of Resident 5 ' s H&P, dated 3/24/2025, the HP indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5 ' s MDS the MDS indicated the Resident 5 ' s cognition (thought process) was severely impaired. During a review of Resident 5 ' s active care plans did not indicate any care plans for Resident 5 ' s specific activity needs. During a concurrent interview and record review on 5/7/2025 at 3:45PM with the DON, Residents 5 ' s Care Plans were reviewed. DON stated Resident 5 did not have activities care plan specific to Resident 5's activities needs. DON stated there was no coordination with the activity director to develop specific activity care regarding Resident 5 needs relating to her glaucoma (a chronic eye disease that damages the optic nerve, potentially leading to vision loss and blindness if left untreated) and/or inability to see. DON stated by not developing a specific care plan for activities for Resident 5 there was a potential for Resident 5 to feel isolated and could lead to behavioral issues such as depression (a mental illness that negatively affects how you feel, think, act, and perceive the world). 4. During a review of Resident 21 ' s AR indicated Resident 21 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (high blood sugar levels) and chronic kidney disease (CKD - damage to the kidneys (organ in the body)). During a review of Resident 21 ' s HP, dated 4/28/2025, the HP indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21 ' s MDS dated [DATE], the MDS indicated the Resident 21 ' s cognition was moderately impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21 ' s active Care plans, the care plans did not indicate the specific Nutrional needs for Resident 21. During an interview on 5/9/2025 at 9:12AM with the Dietary Supervisor (DS), the DS stated that Resident 21 was on a 2 gram (unit of measurement) sodium (salt) diet because of her diabetes (chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels) and chronic kidney disease (CKD a condition where the kidneys are damaged and cannot properly filter blood, leading to waste buildup) diagnosis. DS stated that the nurses were aware of checking for food brought from home for Resident 21 since she was on a specific diet for her kidneys and diabetes. During a concurrent interview and record review on 5/9/2025 at 3:45PM with the DON, Residents 21 ' s Care Plans were reviewed. DON stated Resident 21 did not have a care plan addressing her nutritional needs related to her diabetes and CKD. DON stated that food brought to Resident 21 room without being checked by the nursing staff had the potential for nutritional intake noncompliance. DON stated by not developing a specific care plan for Resident 21 ' s nutritional needs and interventions to screen food brought into the facility from had the potential for Resident 21 ' s blood sugar to be elevated from foods that are noncompliant with her specific diet. A review of the facility ' s policy and procedure titled Comprehensive Care Plans, revised on December 2024 indicated: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s policy and procedure titled High Risk Medications - Anticoagulants, revised in December 2024 indicated: This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety. Definitions: Anticoagulant refers to a class of medications that are used to prevent clot extension and formation. They do not dissolve clots. Examples include warfarin, heparin, Lovenox, Xarelto, Pradaxa, and Eliquis. Adverse consequence is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. Indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines. The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants included bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool), fall in hematocrit or blood pressure, Thromboembolism. The &P indicated the resident's plan of care shall include interventions to minimize risk of adverse consequences with examples include (depending on the medication), Limit venipunctures and injections, as possible. Be aware of the need to apply pressure following these procedures, Use soft toothbrush and electric razors. Limit intake of foods high in vitamin, broccoli, cabbage, collard greens, spinach, kale, turnip greens, and brussel sprouts, Avoid cranberry juice and cranberry products. Caution resident/family about alcohol use while taking anticoagulants. educate resident/family on risks of bleeding, dietary modifications, and symptoms to report to nurse/physician, and avoid (strenuous) activities that may lead to injury. 51233

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372 Based on interview and record review the facility failed to ensure adequate monitoring of potential side effects for Lovenox (an anticoagulant or an injectable medication that thins blood or prevents development of blood clots) is documented for one of 3 sampled residents (Resident 192). This deficient practice had the potential for Resident 192 to develop adverse effect (undesired effect) and the staff not to notice sign and symptoms of bleeding and cause severe bruising and bleeding that is undetected and lead severe blood loss and eventually death. Findings: During a review of Resident 192's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur fracture (a break in a bone) that occurs in the area between the greater and lesser trochanters of the femur (upper thigh bone) where the fracture is displaced, meaning the broken bone fragments are out of alignment), anemia (condition where the blood has a reduced ability to carry oxygen, can be caused by several factors) and hyperlipidemia (a condition of high cholesterol level). During a review of Resident 192's History and Physical (H&P) dated 4/29/2025, indicated Resident 192 has the capacity to understand and make decisions. During a review of Resident 192's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 5/5/2025, indicated the resident ' s cognition was severely impaired. During a review of Resident 192's physician orders dated from 5/1/2025 to 5/31/2025 indicated to administer Lovenox injection solution prefilled syringe 40 mg/0.4 ml inject 40 mg subcutaneously (injected under the skin) one time a day for DVT (deep vein thrombosis- a blood clot inside the large vein) PPX (prophylaxis or prevention) start date 4/30/2025 until 5/19/2025. During a review of Resident 192's Medication Administration Record (MAR) from 5/1/2025 to 5/31/2025 indicated, Resident 192 received Lovenox injection solution prefilled syringe 40 mg/0.4 ml inject 40 mg subcutaneously for DVT PPX one time a day at 9AM on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, and 5/5/2025. During an interview and record review on 5/9/2025 at 1:40 PM with DON, Resident 192 ' s Medication Administration Record (MAR) dated 5/1/2025 to 5/31/2025 was reviewed. DON stated Resident 192 received Lovenox injection for DVT PPX at 9AM on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, and 5/5/2025. DON stated Lovenox was an anticoagulant and can cause major and serious bleeding. DON stated staff should monitor and document the side effect of Lovenox injection in Electric Medical Records (EMAR) which included bleeding. During the same interview the DON reviewed Resident ' s 192 EMAR dated 5/1/2025 to 5/31/2025 and stated there was no record to indicate that Resident 192 was monitored for bleeding. DON stated regular monitoring of the residents allows staff to identify early signs and symptoms of bleeding and report to MD. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled High Risk Medications - Anticoagulants, revised on 12/2024 indicated: This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addressed the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety. Adverse consequence is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. Indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines. The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include:bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool), fall in hematocrit or blood pressure, thromboembolism. The resident's plan of care shall include interventions to minimize risk of adverse consequences. Examples include (depending on the medication) and educate resident/family on risks of bleeding, dietary modifications, and symptoms to report to nurse/physician. Avoid (strenuous) activities that may lead to injury.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372 Based on observation and interview, the facility staff failed to ensure one of three sampled residents (Resident 192), who was on a anticoagulants (blood thinners which makes blood flow through veins and arteries more easily, which means blood is less likely to clot), was free of any significant medication errors. This deficient practice had the potential to result in an increased or delayed effectiveness of the medication due to the incorrect route of the medication administered, and could potentially lead to further health complications. Findings: During a review of Resident 192's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur (fracture(a break in a bone) that occurs in the area between the greater and lesser trochanters of the femur (upper thigh bone), where the fracture is displaced, meaning the broken bone fragments are out of alignment), Anemia (condition where the blood has a reduced ability to carry oxygen, can be caused by several factors), and hyperlipidemia (a condition of high cholesterol level). During a review of Resident 192's History and Physical (H&P) dated 4/29/2025, the H7P indicated Resident 192 has the capacity to understand and make decisions. During a review of Resident 192's Minimum Data Set (MDS, a assessment tool) dated 5/05/2025, the MDS indicated the resident ' s cognition is severely impaired. During a review of Resident 192's physician orders dated from 5/1/2025 to 5/31/2025, the physician orders indicated a start date of 4/30/2025 for Lovenox (an anticoagulant medication) Injection Solution Prefilled [NAME] 40 milligrams per 0.4 milliliter (mg/mL, a unit of measurement) inject 40 mg subcutaneously (under the skin) one time a day for Deep Vein Thrombosis (DVT, a condition where a blood clot forms in a deep vein, most commonly in the leg, but it can also occur in other veins), Prophylaxis (PPX) action taken to prevent disease, especially by specified means or against a specified disease until 5/19/2025 . During a review of Resident 192's Medication Administration Record (MAR) from 5/1/2025 to 5/31/2025 indicated Resident 192 received Lovenox Injection Solution Prefilled [NAME] 40 mg/0.4 ml inject 40 mg subcutaneously one time for DVT PPX one time a day at 9:00 AM on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, and 5/5/2025, the route of administration was not recorded only the site was reordered. During an observation on 5/7/2025 at 9:47 AM with licensed vocational nurse (LVN) 1 in the hallway, LVN 1 was observed next to Medication Cart 1 and obtained Resident 192 ' s Lovenox prior to entering Resident 192 ' s room. LVN1 was observed reviewing the Lovenox syringe to Resident 192 ' s MAR. (continued on next page)

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	555030	A. Building B. Wing	05/09/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/7/2025 at 9:48 AM with LVN 1 in Resident 192 ' s Room, LVN 1 cleaned Resident 192 right upper arm with an alcohol swab, held the skin taut (tight), and held the syringe needle 90 degree. LVN 1 stated the medication route of administration for the Lovenox was to be administered into the muscle. LVN 1 then verified the medication administration route, and then stated the medication should be administered subcutaneous (under the skin). LVN 1 stated she did not check the MAR prior to administrating Lovenox and she would have administered the medication via the wrong route During an interview on 5/7/2025 at 9:59 AM with LVN 1 in presence of Director of Nursing (DON), LVN 1stated she was about to administer Lovenox Intramuscular for Resident 192, and would have been an error, since Lovenox should be administered subcutaneous. During an interview on 5/7/2025 at 10:02 AM with DON, DON stated based on the medical doctors (MD) orders. Lovenox should be administered subcutaneously, and that Lovenox was a high alert medication (that pose a heightened risk of significant patient harm when used in error and can cause severe side effects). DON stated if Lovenox was administered into muscle, it could lead to complication such as increase bleeding, pain, discomfort in muscle, and would also alter the medication absorption. DON stated LVN 1 should check the MAR prior to administering any medication to residents. A review of the facility ' s policy and procedure titled Medication Administration, revised on December 2024 indicated: Medications are administered by licensed nurses, or other staff who are Legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication, name, form, dose, route, and time. If other than PO route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.). Correct any discrepancies and report to nurse manager. A review of the facility ' s policy and procedure titled High Risk Medications - Anticoagulants, revised on December 2024 indicated: This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety. Definitions: Anticoagulant refers to a class of medications that are used to prevent clot extension and formation. They do not dissolve clots. Examples include warfarin, heparin, Lovenox, Xarelto, Pradaxa, and Eliquis. Anticoagulants shall be prescribed by a physician or other authorized practitioner with clear indications for use. Examples include prevention and treatment of deep vein thrombosis, pulmonary embolism, atrial fibrillation with embolization, stroke or management of myocardial infarction.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46779 Based on observation, interview, and record review the facility failed to properly store and discard expired medication, and store Lorazepam safely for two of three sampled residents (Resident 31 and 36) controlled drugs (medications that can create mental and physical addiction or dependency) in a separately locked compartment in the medication storage room in accordance with the facility ' s policy and procedure (P&P), titled Medication Storage by failing to : 1. Properly store and discard a box of expired Microdot glucose gel (a medication used to treat low blood sugar) in the medication storage room. 2. store Resident 31 and 36 ' s Lorazepam (a controlled medication that can create mental and physical addiction or dependency used to treat anxiety [fear of the unknown]) in separately locked from other non-controlled medications (not addictive or habit forming) in the refrigerator inside the medication storage room. These deficient practices had potential to result in nursing staff administering expired medication with reduced potency and ineffective blood glucose management, which may lead to adverse reactions (undesired effects) from the medication and harm to the residents. These deficient practices also had the potential for medication theft or diversion (when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed). Findings: 1. During a concurrent observation and interview on 5/9/2025 at 9:30 AM with Licensed Vocational Nurse (LVN) 1, a box of Microdot glucose gel, dated 4/2025, was inside the top cabinet in the medication room. LVN 1 stated the box of Microdot glucose gel was expired and they did not notice this expired medication in the medication storage room until the surveyor pointed out. LVN 1 stated the expired medication should be discarded right away to prevent administration of expired medication to the residents. During an interview on 5/9/2025 at 10:38 AM with the Director of Nursing (DON), the DON stated she was supposed to check and remove the expired medications weekly in the medication storages in the facility, but she missed to remove the expired Microdot glucose gel at the end of 4/2025. The DON stated it was important to check and remove the expired medications to prevent nursing staff from administering expired medications to the residents which could lead to medication errors, ineffective management of the illness, and harm to the residents. 2. a. During a review of Resident 31 ' s Admission Record (AR), the AR indicated the facility originally admitted Resident 31 on 9/23/2024 and readmitted him on 11/22/2024 with diagnoses that included sepsis (a life-threatening medical emergency caused by the body's overwhelming response to an infection) and cellulitis (a common and potentially serious skin infection) of both legs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 31 ' s Minimum Data Set (MDS, a federally mandated standardized assessment and care planning tool), dated 3/18/2025, indicated Resident 31 had severely impaired memory and cognition (ability to think and reason). The MDS indicated Resident 31 required substantial/maximal assistance with oral hygiene, and was dependent with eating, toileting hygiene and personal hygiene. b. During a review Resident 36 ' s AR, the AR indicated the facility originally admitted Resident 36 on 3/21/2025 and readmitted her on 4/15/2025 with diagnosis that included sepsis and hypotension (low blood pressure). During a review of Resident 36 ' s MDS, dated [DATE], indicated Resident 36 had severely impaired memory and cognition. The MDS indicated Resident 36 was dependent with oral hygiene, toileting hygiene and personal hygiene. During a concurrent observation and interview on 5/9/2025 at 9:35 AM with LVN 1, in the locked medication storage room, two vials of Lorazepam oral (mouth) solution labeled with Resident 31 ' s name and one vial of Lorazepam labeled with Resident 36 ' s name was stored with other noncontrolled medications in a single-locked medication refrigerator. LVN 1 stated Lorazepam was a controlled medication and should be double locked. LVN 1 stated even though Resident 31 and 36 ' s Lorazepam was stored with other noncontrolled medications, it was double locked with the lock to the medication storage room and the lock to the medication refrigerator. During an interview on 5/9/2025 at 10:39 AM with the DON, the DON stated it was important to store the controlled medication and double locked in a separate space and not share the same access with the noncontrolled medication, so they could track down and manage the controlled medications and prevent medication diversion. During a review of the facility ' s P&P titled, Medication Storage, dated 12/9/2024, the P&P indicated the facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer ' s recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The P&P also indicated Scheduled II (a class of medication at high risk for both physical and psychological dependence) controlled medications are to be stored within a separately locked permanently affixed compartments when other medications are stored in the same area, such as in refrigerator.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44429 Based on observation and interviews, the facility failed to ensure the kitchen was in safe and sanitary condition by failing to: 1. Ensure the kitchen sink area did not have white residue (a small amount of something that remains after the main part has gone or been taken or used) on the drainage pipes and on the floor. 2. Ensure the kitchen floor did not contain white paint remnants (a small remaining quantity of something) 3. Ensure the kitchen drywall was not exposed. These deficient practices had the potential for foods to be contaminated and placed residents at risk for foodborne illnesses. Findings: During the initial kitchen tour on 5/6/2025 at 8:50AM, in the presence of the Dietary Supervisor (DS), white residue was observed underneath the sink by the drainage pipe. Also observed were white paint remnants (on the floor of the kitchen due to a tile that fell off the wall and onto the floor. During a concurrent observation and interview on 5/6/2025 at 9:00AM with the DS, DS stated that underneath the food preparation table on the floor was a white and brown color residue with paint remnants on the floor, due to a tile from the wall that fell off. The DS stated there was a small area with dry wall that was exposed. DS stated that the residue, paint chips and exposed dry wall had the potential to contaminate the food which would lead to residents getting sick from food contamination. During a concurrent observation and interview in the kitchen on 5/6/2025 at 9:05AM with the Maintenance Supervisor (MS), MS stated that underneath the kitchen sink and, on the floor, there was white residue and paint remnants on the floor. During a concurrent observation and interview 5/6/2025 at 9:10AM in the kitchen, with the MS, MS stated the area in the kitchen that had exposed dry wall should be repaired since the because residue and the paint remnants could contaminate the food that was being prepared for the residents at the facility. MS stated the residents could get sick from the contamination. During a review of the facility's Policy and Procedure (P&P) titled, Food Safety and Food Storage, revised on 12/19/2022, the P&P indicated food will be stored, prepared, distributed and served in accordance with professional standard for food service safety. The P&P indicated contamination was the unintended presence of potentially harmful substances included, but not limited to microorganisms, chemicals or physical objects. The P&P indicated foodborne illness was caused by indigestion of contaminated food or beverages. The P&P indicated all equipment used in the handling of [NAME] shall be cleaned and sanitized and handled in a manner to prevent contamination.

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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** 46779 Based on interview and record review, the facility failed to explain an Arbitration Agreement (a provide agreement that allows individual parties to resolve disputes rather than in a lawsuit) to two of three sampled residents (Residents 18 and 29) correctly and thoroughly in a manner that the residents and/or their responsible parties could understand. Residents 18 and 29 reported the facility staff did not explain in a manner that they understand what an Arbitration Agreement and Arbitration Agreement to allow them to make an informed decisions and choices about important the aspects of their health, safety, and welfare. This failure resulted in Residents 18 and 29 ' volitation of resident ' s rights and not make an informed decision about their care to ensure they receive care according to their rights and preferences. Findings: 1.During a review of Resident 18 ' s Admission Record (AR), the AR indicated the facility admitted Resident 18 on 4/1/2025 with diagnoses that included diabetes mellitus (a chronic condition that affects how the body uses blood sugar) and anxiety (a feeling of uneasiness or worry, often about a future event or situation). During a review of Resident 18 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/8/2025, the MDS indicated Resident 18 had moderately impairment memory and cognition (ability to think and reason). During a concurrent interview and record review on 5/8/2025 at 3:15 PM with Resident 18, an Arbitration Agreement for Resident 18 dated 5/8/2025, was reviewed. Resident 18 stated a staff (Director of Admission) asked her to sign a form (Arbitration Agreement) today while she was in the physical therapy (PT, a combination of exercises, stretches and movements that will increase the strength, flexibility and mobility) room during PT session. Resident 18 stated the staff did not explain what the form was about and just told to just sign the form. Resident 18 stated she did not have time to read the form because she was doing her exercise. Resident 18 stated she signed and dated the form today without knowing what she was signing for and the staff told her she would receive a copy of it for her to read later. Resident 18 stated she would have an issue if she had to give up her constitutional right to present her dispute in the court and she needed to discuss arbitration with her family members before signing it. Resident 18 stated the staff did not tell her she had 30 days to rescind the agreement. 2. During a review of Resident 29 ' s AR, the AR indicated the facility admitted Resident 29 on 8/14/2025 with diagnoses that included diabetes mellitus (a chronic condition that affects how the body uses blood sugar) and anxiety (a feeling of uneasiness or worry, often about a future event or situation). During a review of Resident 29 ' s MDS, dated [DATE], the MDS indicated Resident 29 had moderately impairment memory and cognition. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 3:20 PM with Resident 29, an Arbitration Agreement for Resident 29 dated 9/13/2024, was reviewed. Resident 29 stated two staffs came and asked him to sign an Arbitration Agreement, but he did not know what the form was about. Resident 29 stated the staff did not explain what the form was about and told him It is not something bad. Resident 29 stated he signed with his initial on the form, but he did not write the date, 9/13/2024, on the form. Resident 29 stated someone else wrote the date on the form for him and he did not know who. Resident 29 stated he did not know he had the right to not sign this form. Resident 29 stated the staff did not tell him he had 30 days to rescind this agreement. During a concurrent interview and record review on 5/8/2025 at 4:00 PM with the Director of Admission (DA), Resident 18 ' s Arbitration Agreement, dated 5/8/2025, and Resident 29 ' s Arbitration Agreement dated 9/13/2025, were reviewed. The DA stated she was responsible for providing the arbitration agreement forms and explaining the Arbitration Agreement to the residents and responsible parties when the residents were admitted to the facility. The DA stated she asked Resident 18 and 29 to sign the Arbitration Agreement forms today because these two residents ' electronic arbitration agreement forms were blank due to technical issues. The DA stated these two residents signed the arbitration agreement when they were admitted to the facility, so she asked them to resign the agreement today. The DA stated Resident 18 signed and dated today ' s date,5/8/2025, but she signed as the facility representative and back dated it to 4/7/2025. The DA stated she should date the agreement as today ' s date, 5/8/2025. The DA stated she back dated Resident 29 ' s agreement to 9/13/2025. The DA stated she should date Resident 29's agreement as today ' s date, 5/8/2025, since there was no record of arbitration which was signed on 9/13/2025. The DA stated she did not explain what Arbitration Agreement to the residents is in which they would give up their constitutional right to present their case in the court in front of the jury. The DA stated she did not know if the residents had the right to rescind the agreement. During an interview on 5/9/2025 at 9:20 AM with the Receptionist, the Receptionist stated she assisted the DA to translate for Resident 29 when the DA asked Resident 29 to sign the Arbitration Agreement. The Receptionist stated she explained the Arbitration Agreement to Resident 29 that the resident would get a lawyer, and the facility would get a lawyer, then, they would go to the court to resolve a dispute. The Receptionist stated the residents would have 60 days to rescind the signed arbitration agreement. During a concurrent interview and record review on 5/9/2025 at 10:37 AM with the Director of Nursing, Resident 18 ' s Arbitration Agreement, dated 5/8/2025, and 29 ' s Arbitration Agreement, dated 9/13/2025, were reviewed. The DON stated there were no records of Resident 18 and Resident 29 signed the Arbitration Agreement when they were admitted into the facility. The DON stated the DA should not back date the agreements for these two residents. The DON stated the arbitration meant the residents would give up their constitutional right to present their disputes in the court in front of the jury, instead, the residents and the facility would resolve the dispute through the arbitration. The DON stated the residents would have 30 days to rescind the agreement after signing it. The DON stated the staff did not understand what Arbitration Agreement was and did not provide the correct and thorough explanation about arbitration agreement to the residents, as a result, the facility violated the residents ' rights. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedures titled, Binding Arbitration Agreements, dated 12/9/2024, indicated When explaining the arbitration agreement, the facility shall: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, this facility. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledges that he or she understands the agreement and The agreement must: Explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.