STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
View Park Convalescent Center	3737 Don Felipe Drive Los Angeles, CA 90008

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 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. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure one out of three sampled residents (Resident 1) had a completed informed consent (a principle in medical ethics, medical law, and media studies, that a resident or resident representative must have sufficient information and understanding before making decisions about their medical care) for Ativan (an anti-anxiety medication) 1mg (milligram-unit of measurement) po (by mouth) prior to administering a one-time dose on 8/13/2025. This deficient practice infringed on the rights of Resident 1 to make an informed decision and had the potential for the resident to receive unwanted medication.Findings: A review of Resident 1's admission Record indicated the facility originally admitted the [AGE] year old female on 3/23/2024 and most recently readmitted the resident on 8/18/2025 with diagnoses including Diabetes Mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), cataracts, Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), Hyperlipidemia (high fat in the blood), alcohol use, Hypertension (high blood pressure), Angina (chest pain), Non-ST elevation (NSTEMI) myocardial infarction (heart attack), ischemic cardiomyopathy (weak heart muscle due to decreased blood flow), nonrheumatic mitral valve stenosis (narrowing of the heart valve), gastro-esophageal reflux disease (GERD- heartburn), tobacco use and history of traumatic fracture (broken bone). A review of Resident 1's minimum Data Set (MDS- a standardized resident assessment) dated 9/23/2025, indicated Resident 1's cognition (mental ability to make decisions for daily living) was not intact. The MDS indicated Resident 1required set up or clean up assistance (helper sets up or cleans up; resident completes activity) with toileting and Supervision or touch assistance (helper provides verbal cues and or touching/steadying and/or contact guard to complete activity) with ambulation (walking) and transferring (moving in between surfaces). A review of the physician order dated 8/13/2025 indicated Ativan 1mg; Give 1 dose by mouth STAT (immediately) for anxiety (condition causing a feeling or worry in response to stress with symptoms like rapid heart rates, sweating, restlessness and trouble concentrating). A review of Resident 1's Change of Condition (COC)/interact assessment form dated 8/13/2025 indicated Resident 1 was observed shivering and reported not feeling well. The form indicated Resident 1's blood pressure (BP) was 194mmHg (millimeters of mercury; unit of measurement)/102mmHg (normal range 120-140/60-90), heart rate (HR) 102 (normal range 60-100) and oxygen saturation (O2 sat) was 86% (normal range 90%-100%). The form indicated 911 was called and Resident 1 was taken to the hospital. A review of the Family Nurse Practitioner (FNP) note dated 8/19/2025 indicated Late Entry, A review of the medical record indicated a prior history of anxiety which at one point caused an acute refusal of both medication and the proposed transfer to the hospital. This required a single dose of Ativan to facilitate safe transport. Ativan was necessary for symptom management due to Resident 1's acute behavioral distress, which manifested as severe anxiety and refusal of essential medical intervention. This administration of this anxiolytic was a direct response to a behavioral disturbance that posed a direct threat to Resident 1's safety and continuity of care. The refusal of medication and transport represented an acute change in condition, and the use of a short acting benzodiazepine was clinically indicated to de-escalate the situation and ensure Resident 1's well-being and safe transport to a higher level of care. During an interview on 12/16/2025 at 1:57 pm with the Licensed Vocational Nurse (LVN). The LVN stated on 8/13/2025 Resident 1 was noted having a change in condition after a cigarette smoke break. The LVN stated Resident 1 was normally pleasant and cooperative with care. The LVN stated Resident 1 was pacing back and forth inside of the room, cursing and arguing with the roommates and continued to be very agitated and uncooperative, refusing transport to the hospital. The LVN then called Resident 1's family and they arrived shortly. The LVN stated the Nurse Practitioner (NP) happened to be rounding so the LVN asked the NP to come and assess Resident 1. The NP then ordered the Ativan to be given based on Resident 1's behavior. The LVN stated after about an hour; Resident 1 was more cooperative and calmer with the family at bedside noticing that Resident 1 went from agitated to calm; subsequently agreeing to be transferred to the hospital where Resident 1 was diagnosed with sepsis (a life-threatening blood infection) and pneumonia (an infection/inflammation in the lungs). The LVN stated Resident 1 was self-responsible (able to make own decisions) and did not recall if consent was obtained prior to giving the Ativan. During an interview on 12/16/2025 at 3:46pm with the director of nursing (DON). The DON stated consent had to be obtained prior to giving any antipsychotic medications. A review of the facility policy and procedure titled, Psychotropic