STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555849	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Del Sol Care Center	11620 West Washington Blvd Los Angeles, CA 90066

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review, the facility failed to implement its policy titled Abuse Prevention Program reviewed 8/2024, for one of two sampled residents (Resident 1), when on 4/8/2025 at 11:55 AM Resident 1 accused Certified Nursing Assistant 1 (CNA1) of sexual abuse (non-consensual sexual contact/touching of any type or sexual harassment), CNA1 was not immediately removed from providing direct care (including incontinent care) to residents and continued to have access Resident 1. As a result of this deficiency, Resident 1 was not protected from the potential of further harm or retaliation from CNA1 after being identified as a perpetrator. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 11/21/2022 and readmitted on [DATE] with diagnoses that included functional quadriplegia (someone who has developed paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury but has regained some level of independence or functionality in daily activities), schizophrenia (a mental illness that is characterized by disturbances in thought) and muscle wasting (weakening, shrinking, and loss of muscle). A review of Resident 1's Quarterly Minimum Data Set (MDS- a resident assessment tool) dated 2/12/2025, indicated the resident had adequate hearing could usually make themselves understood and could usually understand others. The MDS indicated the resident had severe cognitive (ability to acquire and understand knowledge) impairment. The MDS indicated Resident 1 was always incontinent of urine and was dependent upon staff for toileting hygiene. A review of Resident 1's Change in Condition (COC - a written communication tool that helps provide important information) Evaluation Communication Form, dated 4/8/2025 at 11:55 AM, indicated Resident 1 accused a staff member (CNA1) of touching the resident's body inappropriately. The COC indicated staff interviewed the resident regarding the allegation and notified the primary physician and the resident's psychiatrist. A review of the facility's assignment sheet, dated 4/8/2025, indicated that on 4/8/2025 from7AM to 3 PM CNA 1 was on duty. The assignment sheet indicated CNA1 signed in at 7:03 AM and signed out at 4 PM. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's assignment sheet dated 4/9/2025, indicated that on 4/9/2025 from 7AM to 3 PM CNA 1 was on duty. The assignment sheet indicated CNA1 signed in at 7:05 AM. A review of the facility's Timecard Report for CNA 1 for 4/1/2025 thru 4/15/2025, indicated on 4/8/2025, CNA 1 signed in at 7:08 AM and signed out 3:40 PM (more than four hours after the abuse was alleged). The Timecard Report indicated on 4/9/2025 CNA1 signed in at 7:04 AM and signed out at 3:34 PM (the day after the abuse was alleged). A review Resident 1's care plan for the alleged accusation of being touched, initiated 4/9/2025, indicated the resident was at risk for emotional distress. The care plan indicated the goal was to minimize the resident's emotional distress. The interventions included to suspend CNA 1 until further notice, to protect the resident during abuse investigation and the Social Services Director would monitor resident for three days. A review of Resident 1's Social Services Note, dated 4/9/2025, indicated law enforcement spoke with Resident 1 regarding the abuse allegation. During a concurrent observation in Resident 1's room and interview on 4/10/2025 at 9:56 AM at Resident 1's bedside, Resident 1 was observed lying in bed. Resident 1 stated the week prior CNA1 touched the resident's private area inappropriately and made verbal sexually suggestive comments to Resident 1. Resident 1 stated she notified a nurse and staff interviewed the resident. Resident 1 stated a staff member (unidentified) stated CNA 1 would not work with the resident again. During an interview on 4/10/2025 at 11:10 AM, the Director of Rehabilitation (DOR) stated Certified Occupational Therapy Assistant 1 (COTA 1) notified the DOR about Resident 1's allegation of CNA 1 touching the resident in an unwelcome manner. The DOR then notified the Social Services Director (SSD) and Director of Nursing (DON). The DOR stated the SSD, and the DON then went to speak with the resident. The DOR confirmed by stating CNA 1 continued to work after Resident 1 made the abuse allegation. During an interview on 4/10/2025 at 11:40 AM, COTA 1 stated on 4/9/25, COTA1 was attempting to give Resident 1 therapy when Resident 1 reported not wanting CNA1 changing the resident's incontinence brief. COTA 1 stated Resident 1 did not like the way CNA1 touched the resident. COTA 1 stated after Resident 1 made the abuse allegation, CNA1 was moved from Resident 1's side of the facility and started working on the opposite side of the facility. During an interview on 4/10/2025 at 1:08 PM, Licensed Vocational Nurse 1 (LVN 1) stated on 4/8/2025 upon returning from lunch around 11:30 AM, LVN 1 was notified of Resident 1's abuse allegation toward CNA 1 and at that time LVN 1 wrote a COC regarding Resident 1's abuse allegation. LVN 1 stated Resident 1 reported CNA 1 touched the resident inappropriately. During a concurrent review of the facility assignment sheet dated 4/8/2025, LVN 1 stated per the assignment sheet, CNA 1 signed out of work at 4 PM. LVN 1 stated generally after being accused of abuse, staff were to be suspended immediately, because the facility had to take the word of the resident to protect them from further harm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/10/2025 at 2:03 PM, CNA1 stated the last time CNA1 worked with Resident 1 was a week ago. CNA1 stated they first heard of Resident 1's abuse allegation on 4/9/2025. CNA1 confirmed by stating that CNA1 worked the full shift on 4/8/2025 (the day of the abuse allegation) and came into work the next day as well (4/9/2025). CNA 1 stated the facility suspended CNA1 from work on 4/9/2025 at 12:30 PM. During a concurrent interview and record review on 4/10/2025 at 2:18 PM with Registered Nurse Supervisor 1 (RN 1), RN 1 reported Resident 1's abuse allegations to the mandated entities. RN 1 stated on 4/9/2025 around 12 noon RN 1 and the DSD suspended CNA1. RN 1 stated employees accused of abuse had to be suspended immediately to protect the residents from harm or retaliation. During a phone interview on 4/10/2025 at 3:39 PM, the DSD stated, with RN 1 the DSD suspended CNA 1 on 4/9/2025. The DSD stated staff are to be suspended right away and remain on suspension while the abuse investigation is underway. During an interview on 4/10/2025 at 4:02 PM, the Director of Nursing (DON) stated staff accused of abuse had to be suspended immediately to protect the resident's safety. A review of a facility P7P titled Abuse Prevention with a review date of 8/2024, indicated Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy indicated As part of the resident abuse prevention, the administration will . 8. Protect residents during abuse investigations. A review of the facility's P&P titled, Abuse Investigation and Reporting, reviewed 8/2024, indicated the administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation and the administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to investigate and report allegations sexual abuse (non-consensual sexual contact/touching of any type or sexual harassment), for one out of two sampled residents (Resident 1) to the Department of Public Health, Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and to the local law enforcement in accordance with the facility's policy and procedures (P&P) titled Abuse Investigation and Reporting reviewed 8/2024. By failing to report a sexual abuse allegation to the State Survey Agency (SSA) within 2 hours after the allegation occurred on 4/9/2025. This deficient practice had the potential to delay of an onsite inspection by the California Department of Public Health and law enforcement to ensure Resident 1's circumstance were investigated. This deficient practice also had the potential to place Resident 1 at further risk for abuse. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 11/21/2022 and readmitted on [DATE] with diagnoses that included functional quadriplegia (someone who has developed paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury but has regained some level of independence or functionality in daily activities), schizophrenia (a mental illness that is characterized by disturbances in thought) and muscle wasting (weakening, shrinking, and loss of muscle). A review of Resident 1's Quarterly Minimum Data Set (MDS- a resident assessment tool) dated 2/12/2025, indicated the resident had adequate hearing could usually make themselves understood and could usually understand others. The MDS indicated the resident had severe cognitive (ability to acquire and understand knowledge) impairment. The MDS indicated Resident 1 was always incontinent of urine and was dependent upon staff for toileting hygiene. A review of A review of Resident 1's Change in Condition (COC - a written communication tool that helps provide important information) Evaluation Communication Form, dated 4/8/2025 at 11:55 AM, indicated Resident 1 accused a staff member (CNA1) of touching the resident's body inappropriately. The COC indicated staff interviewed the resident regarding the allegation and notified the primary physician and the resident's psychiatrist. A review Resident 1's care plan for the alleged accusation of being touched, initiated 4/9/2025, indicated the resident was at risk for emotional distress. The care plan indicated the goal was to minimize the resident's emotional distress. The interventions included to suspend CNA 1 until further notice, to protect the resident during abuse investigation and the Social Services Director would monitor resident for three days. A review of Resident 1's Social Services Note, dated 4/9/2025, indicated law enforcement spoke with Resident 1 regarding the abuse allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 1's room and interview on 4/10/2025 at 9:56 AM at Resident 1's bedside, Resident 1 was observed lying in bed. Resident 1 stated the week prior CNA1 touched the resident's private area inappropriately and made verbal sexually suggestive comments to Resident 1. Resident 1 stated she notified a nurse and staff interviewed the resident. Resident 1 stated a staff member (unidentified) stated CNA 1 would not work with the resident again. During an interview on 4/10/2025 at 11:10 AM, the Director of Rehabilitation (DOR) stated Certified Occupational Therapy Assistant 1 (COTA 1) notified the DOR about Resident 1's allegation of CNA 1 touching the resident in an unwelcome manner. The DOR then notified the Social Services Director (SSD) and the Director of Nursing (DON). The DOR stated the SSD, and the DON then went to speak with the resident. The DOR stated staff had to report allegations of abuse immediately. During an interview on 4/10/2025 at 11:40 AM, COTA 1 stated they were attempting to give therapy to Resident 1 when Resident 1 reported they did not want CNA 1 changing the resident's incontinence brief and Resident 1 stated they did not like the way CNA 1 touched them. During a concurrent review of the facility's Abuse Investigation and Reporting policy and procedure, COTA 1 stated the policy indicated abuse allegations are reported within 2 hours. During an interview on 4/10/2025 at 1:08 PM, Licensed Vocational Nurse 1 (LVN 1) stated on 4/8/2025 upon returning from lunch around 11:30 AM, LVN 1 was notified of Resident 1's abuse allegation toward CNA 1 and at that time LVN 1 wrote a COC regarding Resident 1's abuse allegation. LVN 1 stated Resident 1 reported CNA 1 touched the resident inappropriately. During a concurrent interview and record review on 4/10/2025 at 2:18 PM with Registered Nurse Supervisor 1 (RN 1), the facility fax confirmations of reporting were reviewed. RN 1 stated COTA 1 informed the DON on 4/8/2025 around lunch time of Resident 1's abuse allegation. RN 1 stated RN 1 reported the abuse to the mandated entities. RN 1 confirmed by stating RN1 notified the ombudsman and L&C (licensing and Certification/State Agency) by phone message and fax after 7 PM on 4/8/2025 and reported the resident's allegation of sexual abuse to law enforcement the next day on 4/9/2025. RN 1 confirmed by stating RN 1 did not report the abuse allegation within 2 hours. RN 1 stated abuse allegations had to be reported within 2 hours to L&C, the ombudsman, and law enforcement to prevent a delay in the investigation. During an interview on 4/10/2025 at 4:02 PM, the Director of Nursing (DON) stated the DON was informed of the abuse allegation on 4/8/2025 around 3:30 PM. The DON stated sexual abuse allegations had to be reported within 2 hours. The DON further stated staff alerted the DON late and the facility did not report Resident 1's abuse allegation within 2 hours. A review of the facility's (P&P) titled, Abuse Investigation and Reporting, reviewed 8/2024, indicated any alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property closed parentheses will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.