

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Vista Del Sol Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Certified Nurse's Aide (CNA) 3 reported the alleged violation of abuse to the facility Administrator (Admin) within 2 hours of receiving report of abuse allegation for one of three sampled residents (Resident 1) according to facility policy and procedures titled, Reporting of Alleged Violations with a review date of 01/2025. This deficient practice of failing to report the alleged violation of abuse had the potential to result in delayed investigation by California Department of Public Health (CDPH) of the abuse in the facility and failure to protect Resident 1 from further abuse. Findings: During a review of Resident 1's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 1 was admitted to the facility on [DATE] with the following diagnoses: unilateral primary osteoarthritis, right knee, generalized muscle weakness (lack of physical or muscle strength), major depressive disorder, recurrent (a mood disorder that causes a persistent feeling of sadness and loss of interest), spondylosis without myelopathy (age-related wear and tear in the spine, specifically the cervical [neck] or lumbar [lower back] areas, without any nerve compression or spinal cord damage), and type 2 diabetes mellitus without complications (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's history and physical (H&P - a physician's complete patient examination) dated 11/05/2025 indicated, Resident 1 had the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/05/2025, indicated, Resident 1 had intact cognition (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). During a review of Resident 1's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) dated 11/11/2025, indicated, Resident 1 had an alleged accusation of sexual abuse by a CNA. The CP goal indicated Resident 1 will establish a sense of safety and trust within the facility. The CP interventions included assigning resident to another CNA, re-enforce training of professional boundaries and abuse prevention, assess Resident 1 for possible injuries, closely monitor Resident 1's whereabouts through visual check. During a review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) sign-in sheet dated 11/11/2025 indicated, CNA 3 signed in and received Allegation of abuse must be reported immediately to abuse coordinator education. During an interview on 11/13/2025 at 1 PM with Resident 1, Resident 1 stated CNA 2 told Resident 1, Oh, you have a nice boob (breast) while CNA 2 was assisting Resident 1 with the shower. Resident 1 also stated that after CNA 2 made Resident 1's bed, CNA 2 kissed Resident 1 on the right cheek then left Resident 1's room. Resident 1 stated feeling shocked, [CNA 2] is not suppose to say anything about any part of my body. Resident 1 stated reporting the alleged abuse to CNA 3 on 11/10/2025 right away. During an interview on 11/13/2025 at 3:14 PM, CNA 3 stated Resident 1 approached CNA 3 with the an allegation that CNA 2 told Resident 1 this new CNA [2] told me I have nice breast. CNA 3 stated Resident 1 did not say anything else. CNA 3 stated, I was charting when [Resident 1] approached me. CNA 3 was asked what CNA 3 did with the information about an allegation of abuse, CNA 3 stated, I just finished my charting. Then later I came home, that was my fault. I should have told someone. That was my mistake. I should have reported this. CNA 3 was asked what CNA 3 should have done after Resident 1 reported to CNA 3 an allegation of abuse, CNA 3 responded I have to report it right way to the Administrator to solve the problem. CNA 3 stated the allegation of abuse was reported to [CNA 3's] supervisor the next day, 11/11/2025 when CNA 3 came back to work. During a review of the facility policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Reporting of Alleged Violations with a reviewed of 01/2025 indicated, Employees must immediately report any suspected abuse or incidents of abuse to the Administrator and/or Director of Nursing Service.</p>		