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	03/25/2024

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

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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** 43454 Based on observation, interview, and record review, the facility failed to provide care in a manner that promoted or enhanced resident's dignity and respect by failing to ensure staff was not standing over resident while eating for one of seven sampled residents (Resident 90). This deficient practice had the potential to cause psychosocial harm and can resident's right to be treated with dignity for Resident 90. Findings: A review of Resident 9's Admission Record indicated, the resident was originally admitted on [DATE] and was readmitted on [DATE], with diagnoses including unspecified severe protein-calorie malnutrition (the state of inadequate intake of food [as a source of protein, calories, and other essential nutrients] in the body), type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and recurrent depressive disorder (when a person has experienced depressive symptoms for most of the day, for more days than not over two years). A review of Resident 9's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 1/9/2024, indicated Resident 9 had a severely impaired cognition (ability to think and make decisions). The MDS indicated Resident 9 required moderate assistance on staff for eating. During a meal observation in Resident 9's room, on 3/25/2024 at 5:46 p.m., Resident 9 was observed being fed by Certified Nursing Assistant 3 (CNA 3). CNA 3 was standing over Resident 9 and the resident was extending his neck to look up at CNA 3. During an interview with CNA 3 on 3/25/2024 at 6:12 p.m., CNA 3 stated and confirmed CNA 3 was standing up while feeding Resident 9. CNA 3 stated, CNA 3 should have been sitting down while feeding Resident 9 because it might seem like CNA 3 was rushing the resident while being fed and, it is more comfortable for residents if they are sitting down while feeding them. A review of facility's policy and procedures (P&P), titled, Assistance with Meals, revised on 7/2017, indicated, residents who cannot feed themselves will be fed with attention to safety, comfort and dignity such as not standing over residents while assisting them with meals.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for resident needs and preferences for two of 16 sampled residents (Resident 30 and Resident 190) by: a. Failing to ensure Resident 30's preferences on preferences on daily activities. b. Failing to ensure Resident 190's bed and mattress was appropriate for Resident 190's height. This deficient practice had the potential to negatively impact the psychosocial well-being of the residents and may cause physical harm. Findings: A. A review of Resident 30's Admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), fibromyalgia (a condition that causes pain all over the body, sleep problems, fatigue, and often emotional and mental distress) and generalized anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of Resident 30's Minimum Data Set (MDS - a comprehensive standardized assessment and care screening tool) dated 1/12/2024, indicated Resident 30's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 30 required supervision from staffs for activities of daily living (ADLs - eating, oral hygiene, toileting hygiene, shower/bathe, and personal hygiene). The MDS also indicated, Resident 30's preferences on activities such as listening to music, group activities, keep up with the news while in the facility is very important. During an interview with Resident 30 on 3/23/2024 at 11:16 a.m., Resident 30 stated, they (residents) haven't been doing the scheduled activities in the Activity Room as much. Resident 30 stated, i think it's because of the short staffing of the nurses. Resident 30 further stated, Resident 30 loves playing Bingo with the group and she missed doing it as they haven't been doing it as much. During an interview with Activity Director (AD) on 3/24/2024 at 6:12 p.m., AD stated, the facility has been pulling out AD from activities to work as a Certified Nursing Assistant (CNA) when CNAs call-off. AD stated, there are few times when they (activities staff) can't follow the Activity Calendar because someone else is working in the activity department or there were no staffs to do the activities. AD further stated, AD tries to accommodate the residents but it's hard when she has work as a CNA. During an interview with Director of Nursing (DON) on 3/25/2024 at 10:47 p.m., DON stated, because of the staffs calling off, there were days when the facility has to reschedule AD to work as a CNA since AD has CNA certificate. DON stated, since activities are not being done, residents have not been able to do the activities as scheduled. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedures (P&P) titled, Job Description - Activity Director, reviewed on 2/22/2024, indicated, the primary function of the Activity Director is to develop and conduct an activity program for all residents which is designed to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent and to enable the resident to maintain the highest attainable social, physical and emotional functioning. A review of the facility's P&P titled, Activity Calendar, reviewed on 2/22/2024, indicated, it is the policy this facility to provide an ongoing program of activities designed to meet the physical, mental and psychosocial needs of each resident. It is the policy to inform residents of the date and time of group activity programs . Activity programs are provided seven days per week and coordinated with nursing and dietary services. B. A review of Resident 190's Admission Record indicated Resident 190 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of Resident 190's MDS, dated [DATE], indicated Resident 190 had an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate assistance from staff for ADL(roll left and right, sit to lying, lying to sitting on side of bed). The MDS also indicated, Resident 190's height was 78 inches (in - unit of measurement). During the initial tour of the facility on 3/23/2024 at 9:46 a.m., Resident 190 was observed lying laterally sideways on the bed, right arm was contracted, and both feet were hanging off the bottom of the bed. During an observation of Resident 190 on 3/23/2024 at 11:28 a.m., Resident 190 was observed lying lateral sideways on the bed, both feet were hanging off the bed. During a concurrent observation of Resident 190 and interview with Resident 190 on 3/24/2024 at 9:33 a.m., Resident 190 was observed lying lateral sideways in bed, both feet were hanging off the bottom of his bed. Resident 190 stated, Resident 190 was six feet tall. During an observation with Resident 190 on 3/25/2024 at 9:23 a.m., Resident 190 was observed lying lateral sideways on his bed, both feet were hanging off the bottom of his bed. During an interview with Registered Nurse 1 (RN 1) on 3/25/2024 at 10:17 a.m., RN 1 stated, Resident 190, is too tall for [Resident 190's] bed. RN 1 stated, if resident's bed and mattress are not appropriate for their height, it places them at risk of poor body positioning and contractions. During an interview with Maintenance Supervisor (MS) on 3/25/2024 at 10:25 a.m., MS stated, they (facility) can add extension on beds and mattress to accommodate residents who are tall. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P&P) titled, Resident Bed, reviewed on 2/22/2024 indicated, it is the policy of the facility to maintain essential equipment in a safe operating condition, in accordance to State and Federal regulations . the facility will conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. A review of the facility's P&P titled, Bed Safety, reviewed on 2/22/2024 indicated, to try to prevent deaths/injuries from the beds and related equipment, the facility shall promote the following approaches: inspection by maintenance staff of all beds . review the gaps within the bed system are within the dimensions established by the FDA (Food and Drug Administration) . Ensure that bed rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (example: avoid bowing, ensure proper distance from the headboard and footboard, etc).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to ensure eight of 16 sampled residents (Resident 1, 9, 21, 23, 24, 25, 189, and 190) had Advanced Directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) Acknowledgement forms (a signed acknowledgment indicating the resident and/or resident representative were provided with information regarding creating an Advanced Directive) documented in the residents' active medical record. This deficient practice had the potential for Resident 1, 9, 21, 23, 24, 25, 189, and 190 to be denied the right to request or refuse medical care and treatment. Findings: A review of Resident 1's Admission Record, indicated Resident 1 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), urinary tract infection (UTI-infection in the urinary system [kidneys, bladder, or urethra]) and epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]). A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 3/15/2024, indicated Resident 1 had moderate impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 9's Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition, DM, and recurrent depressive disorder (when a person has experienced depressive symptoms for most of the day, for more days than not over two years). A review of Resident 9's MDS dated [DATE], indicated Resident 9 had severely impaired cognition for daily decision-making and required maximum assistance from facility staff for ADLs. A review of Resident 21's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted to the facility on [DATE] with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and difficulty in walking. A review of Resident 21's MDS dated [DATE], indicated Resident 21 had moderately impaired cognition for daily decision-making and requiring supervision from facility staff for ADLs. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 23's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including encephalopathy, DM and dysphagia (difficulty swallowing food or liquid). A review of Resident 23's MDS dated [DATE], indicated Resident 23 had moderately impaired cognition for daily decision-making and requiring maximum assistance from staff for ADLs. A review of Resident 24's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), hypertension (HTN-elevated blood pressure) and COPD. A review of Resident 24's MDS dated [DATE], indicated Resident 24 had intact cognition for daily decision-making and requiring moderate assistance from staff for ADLs. A review of Resident 25's Admission Record indicated that Resident 25 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body) and DM. A review of Resident 25's MDS dated [DATE], indicated Resident 25 had severely impaired cognition for daily decision-making and required maximum assistance from staff for ADLs. A review of Resident 189's Admission Record indicated that Resident 189 was admitted to the facility on [DATE] with diagnoses including encephalopathy, UTI, and sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). A review of Resident 189's MDS dated [DATE], indicated Resident 189 had severely impaired cognition for daily decision-making and required maximum assistance from staff for ADLs. A review of Resident 190's Admission Record indicated that Resident 190 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia, hemiparesis, and cerebral infarction. A review of Resident 190's MDS dated [DATE], indicated Resident 190 had intact cognition for daily decision-making and required maximum assistance from staff for ADLs. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 3/24/2024 at 4:14 p.m., Resident 1, 9, 21, 23, 24, 25, 189, and 190's medical charts were reviewed, indicated missing Advance Directive Acknowledgement Forms (ADAF). RN 1 stated that ADAF were supposed to be completed by the facility staff upon admission and be kept in resident's chart. During a concurrent interview and record review with the Social Service Director (SSD) on 3/25/2024 at 4:41 p.m., the SSD provided Resident 1, 9, 21, 23, 24, 25, 189, and 190's ADAFs. The SSD stated that it was all completed and was kept in a binder inside her (SSD's) office. The SSD stated that she (SSD) failed to ensure all ADAFs were easily accessible by not keeping a copy in residents' medical chart. During an interview on 3/25/2024 at 7:45 p.m., the Director of Nursing (DON) stated that ADAF's had to be kept in residents' medical records for easy access when needed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedure (P&P), titled, Advance Directives, reviewed on 2/22/2024, P&P indicated that information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure protection of resident's medical record for one of three sampled resident (Resident 21). This deficient practice had the potential to violate Resident 21's right to privacy and confidentiality. Findings: A review of Resident 21's Admission Record indicated Resident 21 was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 2/10/2024, indicated Resident 21's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were moderately impaired and required moderate to supervision from staff for activities of daily livings (ADLs- sit to stand, toilet transfer and tub/shower transfer). During an observation of the facility on 3/23/2024 at 3:47 p.m., medication cart laptop screen was open and unattended in the hallway, showing Resident 21's information. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 3/23/2024 at 3:49 p.m., LVN 1 stated, she stepped away from the medication cart because she was talking to a colleague and forgot to close the laptop. LVN 1 stated, she should have closed the laptop so that the screen were not visible for others to see and it violates resident's privacy. During an interview with Registered Nurse 2 (RN 2) on 3/23/2024 at 4:11 p.m., RN 2 stated, staffs should not leave the laptop screen unattended because others may see resident's information and it is against HIPPA (Health Insurance Portability and Accountability Act) law. A review of the facility's policy and procedures (P&P) titled, Confidentiality of Information and Personal Privacy, reviewed on 2/22/2024 indicated, our facility will protect and safeguard resident confidentiality and personal privacy . access to resident personal and medical records will be limited to authorized staff and business associates. A review of the facility's P&P titled, Resident Rights, reviewed on 2/22/2024 indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . access personal and medical records pertaining to him or herself, privacy and confidentiality.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview, and record review, the facility failed to ensure that four of 16 sampled residents (Residents 9, 21, 25 and 189) were free from physical restraint (any action or procedure that prevents freedom of a person's body movement) by failing to ensure: 1. Resident 25 was free of unnecessary physical restraint when Resident 25 was found with bilateral full side rails while in bed. 2. That resident was free from physical restraint by failing to ensure the consent was completed and the physician's order for bed siderails were in place for Residents 9, 21 and 189. These deficient practices had the potential to result in entrapment (state of being caught in) and possible injury to Resident 9, 21, 25 and 189. Findings: A review of Resident 25's Admission Record, indicated that Resident 25 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). A review of Resident 25's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 3/8/2024, indicated Resident 25 has severe impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 25's Physician Order dated 3/8/2024, indicated an order for a padded side rails up times two while in bed to prevent skin bruising when in contact with rails. No other orders indicating a less restrictive measures. A review of Resident 25's Side Rails Care Plan dated 3/8/2024, indicated bilateral side rails for as indicated for safety with interventions to assess need for side rails usage and notify physician for reason for use of side rails and obtain order. During an observation on 3/23/2024 at 9:46 a.m., Resident 25 was observed calm and quietly laying in bed with bilateral full side rails up. During a concurrent interview and record review with the Registered Nurse 1 (RN 1) on 3/24/2024 at 4:36 p. m., Resident 25's medical chart (progress notes, care plan, side rail assessments and physician orders) was reviewed. Resident 25's medical chart indicated missing less restrictive measures were provided prior to ordering bilateral full side rails up. RN 1 stated that before ordering bilateral full side rails up, the facility should have exhausted all other less restrictive measures and if those things were still not working, then they can order the full side rails up as the last resort. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedures (P&P), titled, Side Rails, reviewed on 2/22/2024, P&P indicated, Side rails will only be used on residents whose movement should be restricted due to safety, but only after the facility has attempted to use less restrictive alternatives. P&P also indicated that facility will do a restraint assessment with approval of the interdisciplinary team and document less restrictive measures attempted. A review of facility's P&P, titled, Bed Safety, reviewed on 2/22/2024, P&P indicated, if side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the attending physician and input from the resident and/or legal representative. 43454 2a. A review of Resident 9's Admission Record indicated Resident 9 was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition (the state of inadequate intake of food [as a source of protein, calories, and other essential nutrients] in the body), type 2 DM, and recurrent depressive disorder (when a person has experienced depressive symptoms for most of the day, for more days than not over two years). A review of Resident 9's MDS dated [DATE], indicated that Resident 9 had a severely impaired cognition (ability to think and make decisions) and required maximal assistance from staff for mobility such as rolling left to right, sit to lying, sit to stand, and toilet transfer. A review of Resident 9's Side Rail Assessment form effective dated 1/5/2024, entered by Registered Nurse 2 (RN 2) indicated, the assessment has determined the use of side rail for non-restrictive device, with benefits of side rails use for mobility aid, reminder to wait for assistance and to increase sense of security and safety. The Bed Side Rail Permission form indicated the resident was not notified of the use of the bed side rails. During an observation of Resident 9 on 3/23/2024 at 9:28 a.m., observed Resident 9 lying on a bed with a bilateral upper side rail up. Resident 9 observed unable to move or get up on his own and unable to move the siderails down on his own. A review of Resident 9's Physician Order Report as of 3/23/2024, indicated there was no physician order for the use of bilateral bed side rails or any other type of siderails. A review of Resident 9's Care Plan as of 3/23/2024 indicated, there was no comprehensive care plan for the use of bilateral bed side rails. A review of Resident 9's informed consent, indicated, no informed consent for the use of bilateral side rails was given and signed by resident or resident's representative. During an interview with Registered Nurse 1 (RN 1), RN 1 stated, the utilized bed side rails for Resident 9 for mobility. RN 1 stated and confirmed, there was no physician's order in placed and no informed consent for the use of bilateral bed siderails. RN 1 stated, a consent and a physician's order should be in placed because the use of side rails places residents at risk of restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. A review of Resident 21's Admission Record indicated Resident 21 was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of Resident 21's MDS dated [DATE], indicated that Resident 21 had a moderately impaired cognition and required moderate to supervision from staff for mobility such as sit to stand, toilet transfer and tub/shower transfer. A review of Resident 21's Side Rail Assessment form, effective date 1/23/2024 indicated, the assessment has determined the use of side rail for non-restrictive device, with benefits of side rails use for mobility aid, minimize risk for falling or sliding out of bed, reminder to wait for assistance, to increase sense of security and safety and space awareness. A review of Resident 21's Physician Order Report as of 3/23/2024, indicated there was no physician order for the use of bilateral full side rails or any other type of siderails. A review of Resident 21's Care Plan as 3/23/2024 indicated, there was no comprehensive care plan for the use of bilateral full side rails. During an observation of Resident 21 on 3/23/2024 at 9:41 a.m., observed Resident 21 lying on a bed with a bilateral upper side rail up. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 3/23/2024 at 4:09 p.m., LVN 1 stated, they utilized the bed side rails for Resident 21 due for mobility. LVN 1 reviewed Resident 21's medical chart and confirmed, there was no physician's order for the use of bilateral bed siderails and no informed consent as well. LVN 1 stated, there should be a physician's order in place and a consent for the use of the bilateral side rails. 2c. A review of Resident 189's Admission Record indicated the resident was admitted on [DATE] and with diagnoses including toxic encephalopathy, sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), and muscle wasting and atrophy. A review of Resident 189's MDS dated [DATE], indicated that Resident 189 had a moderately impaired cognition and required maximal assistance from staff for mobility such as sit to lying, sit to stand and toilet transfer. A review of Resident 189's Side Rail Assessment form effective date 3/12/2024, entered on 3/23/2024 by RN 2, the assessment has determined the use of side rail for non-restrictive device, with benefits of side rails use for mobility aid, reminder to wait for assistance and to increase sense of security and safety. A review of Resident 189's Physician Order Report as of 3/23/2024, indicated there was no physician order for the use of bilateral full side rails or any other type of siderails. (continued on next page)

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	03/25/2024

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

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 189's Care Plan as 3/23/2024 indicated, there was no comprehensive care plan for the use of bilateral full side rails. During an observation of Resident 189 on 3/23/2024 at 9:19 a.m., observed Resident 189 lying on a bed with a bilateral full bed siderails up. Resident 189 was observed unable to get up on her own and unable to move the bed siderails down on her own. During a concurrent interview and record review with LVN 2 on 3/23/2024 at 11:08 a.m., LVN 2 stated, they utilized the bed side rails for Resident 189 for mobility. LVN 2 reviewed Resident 189's medical chart and confirmed, there was no physician's order for the use of bilateral bed siderails and no informed consent as well. LVN 2 stated, there should be a physician's order in place and a consent for the use of the bilateral side rails as the side rails are a form of restrain if there is no consent and physician's order in placed. A review of the facility's P & P titled, Side Rails, reviewed on 2/22/2024, the P&P indicated, the side rails will be used to restrict the resident's movement for safety and a non-restrictive method used on a resident who uses the rails to assist in their movement (as an enabler). The same P&P also indicated, have physician get an informed consent from the surrogate decision-maker or resident, and the patient or responsible party will be explained risks and benefits of using side rails, care plan side rail use. A review of the facility's P&P titled, Bed Safety, reviewed on 2/22/2024, the P&P indicated, if side rails are used there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative . the staff shall obtain consent for the use of side rails from the resident or the resident's legal representative . side rails may be used if assessment and consultation will the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified.

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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 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** 43454 Based on interview and record review, the facility failed to implement its policy regarding reporting of an unusual occurrence and injury of unknown source and to submit a conclusion report of investigation within five days or in accordance with state or federal law for one of one sampled resident (Resident 26). This resulted in a delay of an onsite inspection by the Department to ensure the safety of the residents and had the potential to place residents at further risk for injuries. Cross Reference F610 Findings: A review of Resident 26's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including unspecified type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), unspecified sequelae cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), and memory deficit following cerebral infarction and unspecified dementia (loss of cognitive functioning-thinking, remembering, and reasoning). A review of Resident 26's Minimum Data Set (MDS - a comprehensive standardized assessment used as a care-planning tool), dated 12/27/2023, indicated the resident's cognition (ability to think, understand and reason) was moderately impaired. The MDS indicated Resident 26 required maximal assistance from staff with mobility such as changing position from sit to lying, lying to sitting, sit to stand and toilet transfer. A review of Resident 26's Order Summary Report dated 3/3/2024, indicated a physician ordered a x-ray (a form of electromagnetic radiation, similar to visible light) stat (immediately) to the skull and both knees due to s/p (status post - after) fall. A review of Resident 26's Progress Notes dated 3/3/2024 at 12:52 p.m., indicated, Resident 26 was found on the stomach position, unwitnessed fall, the bed was in lower position . upon investigation, noticed a small abrasion on right eye and small abrasion on right knee, Medical Doctor (MD) informed and ordered a stat x-ray on the head and both knees. During an observation of Resident and interview with Resident 26 on 3/23/2024 at 5:55 p.m., Resident 26 was observed with light purple, brown discoloration under the right eye. Resident 26 stated, Resident 26 could not remember what caused the discoloration under the right eye. (continued on next page)

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	555849	A. Building B. Wing	03/25/2024

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 2 (RN 2) on 3/25/2024 at 3:58 p.m., RN 2 stated, Resident 26 was found on the floor by one of the staff on 3/3/2024 and found a discoloration on the right eye. RN 2 stated, staff asked Resident 26 what happened and how Resident 26 ended up on the floor, but Resident 26 could not remember. RN 2 stated the injury to Resident 26's right eye, was unknown and that there was no witness how Resident 26 ended up on the floor. RN 2 stated, it should have been investigated further to make sure resident does not have further injury and they should have investigated why resident was found on the floor. RN 2 further stated, the facility should have investigated other cause as it can be a case of an abuse. RN 2 stated the incident was not reported to the Ombudsman, Police, and State department. A review of the facility's policy and procedures (P&P) titled, Unusual Occurrence Reporting reviewed on 2/22/2024 indicated, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors . Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations . A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency within 48 hours. A review of the facility's P&P titled, Abuse Investigation and Reporting, reviewed on 2/22/2024, indicated, All reports of residents abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management . All alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately within two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury . The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to implement its policy regarding reporting of an unusual occurrence and injury of unknown source within 24 hours in accordance with state or federal law for one of one sampled resident (Resident 26). This resulted in a delay of an onsite inspection by the State Agency to ensure the safety of the residents and had the potential to place residents at further risk for injuries. Cross Reference F609 Findings: A review of Resident 26's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including unspecified type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), unspecified sequelae cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), and memory deficit following cerebral infarction and unspecified dementia (loss of cognitive functioning-thinking, remembering, and reasoning). A review of Resident 26's Minimum Data Set (MDS - a comprehensive standardized assessment used as a care-planning tool), dated 12/27/2023, indicated, the resident's cognition (ability to think, understand and reason) was moderately impaired. The MDS indicated Resident 26 required maximal assistance from staff with mobility such as changing position from sit to lying, lying to sitting, sit to stand and toilet transfer. A review of Resident 26's Order Summary Report dated 3/3/2024, indicated a physician ordered a x-ray (a form of electromagnetic radiation, similar to visible light) stat (immediately) to the skull and both knees due to s/p (status post - after) fall. A review of Resident 26's Progress Notes dated 3/3/2024 at 12:52 p.m., indicated, Resident 26, was found on the stomach position, unwitnessed fall, the bed was in lower position . upon investigation, noticed a small abrasion on right eye and small abrasion on right knee, Medical Doctor (MD) informed and ordered a stat x-ray on the head and both knees. During an observation of Resident 26 on 3/23/2024 at 5:55 p.m., Resident 26 was observed with light purple, brown discoloration under her right eye. Resident 26 stated, she doesn't remember why she had that (discoloration) under her right eye. (continued on next page)

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	555849	A. Building B. Wing	03/25/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 2 (RN 2) on 3/25/2024 at 3:58 p.m., RN 2 stated, Resident 26 was found on the floor by one of the staff on 3/3/2024, and Resident 26 had discoloration on the right eye. RN 2 stated, staff asked Resident 26 what happened and how Resident 26 ended up on the floor, in which Resident 26 stated, she doesn't remember. RN 2 stated the injury was unknown as staff did not witness how Resident 26 ended up on the floor. RN 2 stated, it should have been investigated further to make sure resident does not have further injury and they (facility) should have investigated why resident was found on the floor. RN 2 further stated, the facility should have investigated other cause as it can be a case of an abuse. RN 2 stated, this incident (Resident 26 found on the floor) was not reported to the Ombudsman, Police, and State department. A review of facility's policy and procedures (P&P) titled, Unusual Occurrence Reporting reviewed on 2/22/2024 indicated, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors . Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations . A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency within 48 hours. A review of the facility's P&P titled, Abuse Investigation and Reporting, reviewed on 2/22/2024 indicated, All reports of residents abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management . All alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately within two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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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** 43261 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan that meet the care/services based on the resident's individual assessed needs for six of 16 sampled residents (Resident 9, 13, 21, 31, 37, and 189) by failing to: 1. Develop a comprehensive care plan when resident had a change of condition for Residents 31 and 13. 2. Develop a comprehensive care plan for the use of bed side rails for Residents 9, 21, and 189. 3. Develop and implement comfort measure (treatments used to ease pain and distress when life-prolonging options are not available) care plan for Resident 37. These deficient practices had the potential to result negative impact on the health and safety, and the quality of care and services provided to Residents 9, 13, 21, 31, 37, and 189. Cross Reference F604 Findings: 3. A review of Resident 37's Admission Record, indicated Resident 37 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow), hyperlipidemia (abnormally high levels of fats in the blood) and dysphagia (difficulty swallowing food or liquid). A review of Resident 37's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 12/29/2023, indicated Resident 37 had moderate impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 37's Order Summary Report, dated 1/17/2024, indicated an order for Comfort Measure (treatments used to ease pain and distress when life-prolonging options are not available) every shift. During a concurrent interview and record review with Registered Nurse 2 (RN2), on 3/25/2024 at 11:42 a.m., Resident 37's care plans were reviewed. Resident 37's comfort measure care plan was missing. RN2 stated that a comfort measure care plan was supposed to be initiated on 1/17/2024 to be able to provide the proper care for Resident 37. A review of facility's policy and procedures (P&P), titled, Care Plans, Comprehensive Person-Centered, reviewed on 2/22/2024, indicated, that a comprehensive, person-centered care plan that includes measure objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. (continued on next page)

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	03/25/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43454 2A. A review of Resident 9's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition (the state of inadequate intake of food [as a source of protein, calories, and other essential nutrients] in the body), type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and recurrent depressive disorder (when a person has experienced depressive symptoms for most of the day, for more days than not over two years). A review of Resident 9's MDS dated [DATE], indicated Resident 9 had severely impaired cognition (ability to think and make decisions) and required maximal assistance from staff for mobility such as rolling left to right, sit to lying, sit to stand, and toilet transfer. A review of Resident 9's Side Rail Assessment form effective dated 1/5/2024, entered by Registered Nurse 2 (RN 2) indicated, the assessment has determined the use of side rail for non-restrictive device, with benefits of side rails use for mobility aid, reminder to wait for assistance and to increase sense of security and safety. The Bed Side Rail Permission form indicated the resident was not notified of the use of the bed side rails. During an observation of Resident 9 on 3/23/2024 at 9:28 a.m., observed Resident 9 lying on a bed with a bilateral upper side rail up. Resident 9 observed unable to move or get up on his own and unable to move the siderails down on his own. A review of Resident 9's Physician Order Report as of 3/23/2024, indicated there was no physician order for the use of bilateral bed side rails or any other type of siderails for Resident 9. A review of Resident 9's Care Plan as of 3/23/2024 indicated, there was no comprehensive care plan for the use of bilateral bed side rails for Resident 9. A review of Resident 9's informed consent, indicated, no informed consent for the use of bilateral side rails was given and signed by resident or resident's representative for Resident 9. During an interview with Registered Nurse 1 (RN 1) on 3/23/24 at 3:59 p.m., RN 1 stated, staff utilize bed side rails for Resident 9 for mobility. RN 1 stated and confirmed, LVN 1 reviewed Resident 9's medical chart and confirmed, there was no comprehensive care plan developed for Resident 9's use of bed side rails. 2B. A review of Resident 21's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of Resident 21's MDS dated [DATE], indicated Resident 21 had moderately impaired cognition and required moderate to supervision from staff for mobility such as sit to stand, toilet transfer and tub/shower transfer. (continued on next page)

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	03/25/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 21's Side Rail Assessment form, effective date 1/23/2024 indicated, the assessment has determined the use of side rail for non-restrictive device, with benefits of side rails use for mobility aid, minimize risk for falling or sliding out of bed, reminder to wait for assistance, to increase sense of security and safety and space awareness. A review of Resident 21's Physician Order Report as of 3/23/2024, indicated there was no physician order for the use of bilateral full side rails or any other type of siderails for Resident 21. A review of Resident 21's Care Plan as 3/23/2024 indicated, there was no comprehensive care plan for the use of bilateral full side rails for Resident 21. During an observation of Resident 21 on 3/23/2024 at 9:41 a.m., observed Resident 21 lying on a bed with a bilateral upper side rail up. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 3/23/2024 at 4:09 p.m., LVN 1 stated, staff utilize the bed side rails for Resident 21 due for mobility. LVN 1 reviewed Resident 21's medical chart and confirmed, there was no comprehensive care plan developed for Resident 21's use of bed side rails. 2C. A review of Resident 189's Admission Record indicated the resident was admitted on [DATE] and with diagnoses including toxic encephalopathy, sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), and muscle wasting and atrophy. A review of Resident 189's MDS dated [DATE], indicated Resident 189 had moderately impaired cognition and required maximal assistance from staff for mobility such as sit to lying, sit to stand and toilet transfer. A review of Resident 189's Side Rail Assessment form effective date 3/12/2024, entered by RN 2 on 3/23/2024, the assessment has determined the use of side rail for non-restrictive device, with benefits of side rails use for mobility aid, reminder to wait for assistance and to increase sense of security and safety. A review of Resident 189's Physician Order Report as of 3/23/2024, indicated there was no physician order for the use of bilateral full side rails or any other type of siderails for Resident 189. A review of Resident 189's Care Plan as 3/23/2024 indicated, there was no comprehensive care plan for the use of bilateral full side rails for Resident 189. During an observation of Resident 189 on 3/23/2024 at 9:19 a.m., observed Resident 189 lying on a bed with a bilateral full bed siderails up. Resident 189 was observed unable to get up on her own and unable to move the bed siderails down on her own. During a concurrent interview and record review with Licensed Vocational Nurse 2 (LVN 2) on 3/23/2024 at 11:08 a.m., LVN 2 stated, staff utilized the bed side rails for Resident 189 for mobility. LVN 2 reviewed Resident 189's medical chart and confirmed, there was no care plan for the use of bed side rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 procedures (P&P) titled, Side Rails, reviewed on 2/22/2024, indicated, the side rails will be used to restrict the resident's movement for safety and a non-restrictive method used on a resident who uses the rails to assist in their movement (as an enabler). The same P&P also indicated, have physician get an informed consent from the surrogate decision-maker or resident, and the patient or responsible party will be explained risks and benefits of using side rails, care plan side rail use. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, reviewed on 2/22/2024, indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident. D. A review of Resident 31's Admission Record indicated the resident was admitted on [DATE] with diagnoses including asthma (respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing), muscle wasting and atrophy, and chronic atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart). A review of Resident 31's MDS dated [DATE], indicated Resident 31 had moderately impaired cognition and required maximal assistance from staff for ADLs (toileting hygiene, shower/bathe self, upper and lower body dressing). A review of Resident 31's Progress Notes indicated the following: i. On 3/17/2024: Resident 31 started to cough after dinner. ii. On 3/18/2024 at 2:00 a.m., Resident 31 was on monitoring for productive cough and congestion. iii. On 3/18/2024 at 11:24 p.m., Chest x-ray (a type of radiation used to create a picture of the inside of the body) results faxed to MD (medical doctor), very small left effusion (an abnormal collection of fluid in hollow spaces or between tissues of the body) with very mild left lower lung airspace disease, possibly atelectasis (the collapse of a lung or part of a lung, also known as a lobe), though concerning for pneumonia (PNA - lung infection that inflames air sacs with fluid or pus) iv. On 3/19/2024 at 2:14 p.m., Resident 31 had wheezing sounds noted during shift. v. On 3/19/2024 at 2:19 p.m., X-ray result was sent to MD and MD ordered Augmenting (treat infections) 875 milligram (mg) two times a day for 10 days. vi. On 3/20/2024 at 12:50 p.m., Resident 31 was noted with increasing chest congestion and was on monitoring for cough congestion and antibiotic for respiratory infection pneumonia. Medical Doctor (MD) was notified with new order to transfer resident to General Acute Care Hospital 1 (GACH 1). During an interview with Registered Nurse 2 (RN 2) on 3/25/2024 at 5:03 p.m., RN 2 stated Resident 31 had a change of condition on 3/17/2024 due to cough and congestion and with x-ray result of PNA. RN 2 stated, she did not initiate a care plan after Resident 31 had a change of condition. RN 2 further stated, she should have initiated a care plan after Resident 2 developed symptoms of PNA so that they can follow-up if the interventions are effective. (continued on next page)

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	03/25/2024

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

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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	A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, reviewed on 2/22/2024, indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident. 45524 C. A review of Resident 13's admission record indicated Resident 13 was initially admitted the facility on 6/23/2023 and was readmitted on [DATE], with diagnoses including, pneumonia, asthma (chronic disease in which the bronchial [passages in the lungs] that extend from the trachea [windpipe] and airways in the lungs that become narrowed and swollen, making it difficult to breathe), and secondary hypertension (high blood pressure that's caused by another medical condition). A review of Resident 13's MDS dated [DATE], indicated Resident 13 had some moderate cognitive impairment (fair communication skills but cannot typically communicate on complex levels) and required substantial to maximum assistance for ADL (bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). A review of Resident 13's history and physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 1/25/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 13's COC dated 3/20/2024 at 9:22 p.m., indicated Resident 13 was observed with a nonproductive cough. The COC did not indicate a complete respiratory assessment was performed. During an observation and interview with Resident 13 on 3/23/2024 at 10:30 am, Resident 13 was observed sitting in a wheelchair outside Resident 13's room in the hallway, coughing continuously during the interview. Resident 13 stated Resident 13 felt tired, was unable to sleep because Resident 13 was constantly coughing during the night. Resident 13 stated Resident 13 felt as if Resident 13 was bothering the other residents in the facility. Resident 13 stated Resident 13, felt their stares whenever I coughed. Resident 13's eyes appeared watery, red, sunken in, and the resident constantly was repositioning herself in bed. Resident 13 stated Resident 13 had been coughing for a couple days and that the cough was non-productive: no sputum. Resident 13 stated the nurses were aware and were giving Resident 13 something for the cough (Ipratropium-Albuterol inhalation solution via inhaler every 4 hour- a medication used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema) but the medication was not working. During an interview Licensed Vocational Nurse 1 (LVN 1) on 3/23/2024 at 4:30 pm, LVN 1 stated Resident 13 developed a cough approximately two days after receiving a COVID vaccination on 3/18/2024. LVN 1 stated the cough was a reaction to the COVID vaccination. LVN 1 confirmed and stated coughing was not one of the symptoms listed as an adverse (negative) effect according to the Centers for Disease Control and Prevention (CDC- national public health agency whose main goal is the protection of public health and safety through the control and prevention of disease, injury, and disability). LVN 1 stated that when a resident has a COC, a COC document needs to be completed, a care plan developed, and a physician and family notified about the COC. LVN 1 admitted that there was no care plan developed for Resident 13's cough. LVN 1 stated that having a care plan helps all the staff working with the resident know what type of care to provide the resident. (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 of Resident 13's chart with Director of Nursing (DON) on 3/24/2024 at 10:15 a.m., DON confirmed and stated there was no documented evidence that there was care plan in place for the cough for Resident 13. DON stated a care plan directs what interventions to carryout for a resident and helps show if those interventions are working or not. A review of the facility's policy and procedures (P&P) titled, Side Rails, reviewed on 2/22/2024, indicated, the side rails will be used to restrict the resident's movement for safety and a non-restrictive method used on a resident who uses the rails to assist in their movement (as an enabler). The same P&P also indicated, have physician get an informed consent from the surrogate decision-maker or resident, and the patient or responsible party will be explained risks and benefits of using side rails, care plan side rail use. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, reviewed on 2/22/2024, indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident. The same P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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** 43261 Based on observation, interview, and record review, the facility failed to provide preventive care consistent with professional standards of practice to two of two sampled residents (Residents 9 and 21), who was at risk for development of pressure injuries, by failing to: 1. Ensure low air loss mattress (LALM-a mattress designed to prevent and treat pressure wounds) was functioning and was not turned off when Resident 9 was in bed. 2. Ensure the appropriate setting of the LALM was properly set up according to physician's order (MD order) for Resident 21. These deficient practices can place Residents 9 and 21 at risk of poor wound healing of the current pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) and possibly development of a new pressure injury. Findings: 1. A review of Resident 9's Admission Record indicated Resident 9 was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition, type 2 diabetes mellitus (DM-a ongoing condition that affects the way the body processes blood sugar [glucose]), and recurrent depressive disorder (when a person has experienced depressive symptoms for most of the day, for more days than not over two years). A review of Resident 9's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 1/9/2024, indicated that Resident 9 had a severely impaired cognition (ability to think and make decisions) and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).MDS also indicated Resident 9 was admitted with a stage four (4) pressure ulcer. A review of Resident 9's Order Summary Report (OSR) dated 3/23/2024, OSR indicated an order for a LALM for treatment and management of pressure ulcer. During a concurrent observation and interview with Registered Nurse 2 (RN 2) on 3/25/2024 at 8:23 p.m., Resident 9 was heard screaming for help. Resident 9 stated, Being uncomfortable. and Resident 9 was observed sunken from the bed. LALM machine was observed turned off. RN 2 stated that LALM machine should be turned on at all times since Resident 9 has multiple wounds and high risk for pressure injury. A review of facility's policy and procedures (P&P), titled, Low Air-Loss Mattress/Bed, P&P indicated that LALM will be used to maintain skin integrity and to promote healing of existing pressure ulcers. 43454 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 21's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of the MDS, dated [DATE], indicated Resident 21's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were moderately impaired and required moderate to supervision from staff for ADLs. The same MDS also indicated that Resident 21 has a pressure ulcers/injury and is using a pressure reducing device for bed. A review of Resident 21's Physician Order, dated 3/23/2023 indicated, as of 12/4/2023, low air loss therapy bed for treatment and management of pressure ulcer, settings depending on the patient weight every shift for wound management. A review of Resident 21's care plan for at risk or potential for skin breakdown, initiated on 11/1/2023, indicated a goal of resident will minimize skin impairment. During a concurrent interview and observation of Resident 21 on 3/23/2024 at 9:41 a.m., observed Resident 21 lying on a low air loss mattress at two (2) setting which indicated 105 pounds (lbs.). Resident 21 stated, his mattress feels rough. During a concurrent interview with Licensed Vocational Nurse 1 (LVN 1) and record review of Resident 21's medical chart on 3/23/2024 at 4:09 p.m., LVN 1 stated, Resident 21 has a physician's order for LAL mattress depending on the weight. LVN 1 further stated, Resident 21 most current weight (wt.) was 137 lbs. which was measured on 3/1/2024. During a follow-up interview with LVN 1 and observation of Resident 21 on 2/23/2024 at 4:21 p.m., LVN 1 observed Resident 21's LAL mattress setting and stated, Resident 21's LAL mattress was not in the correct setting as Resident 21 weighs 137 lbs. LVN 1 further stated, this puts resident at risk of delay of wound healing and further pressure ulcer. A review of the facility's P&P titled, Low Air-Loss Mattress/Bed, reviewed on 2/22/2024 indicated, a specialty bed will be obtained upon provider order.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure resident receives appropriate treatment and services to increase, prevent, or maintain the range of motion (ROM- the extent of movement of a joint) mobility for one of three sampled resident (Resident 190). This deficient practice had the potential to place Resident 190 at risk for further ROM decline and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: A review of Resident 190's Admission Record indicated Resident 190 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side and muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). A review of Resident 190's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 3/14/2024, indicated Resident 190 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate assistance from staff for activities of daily living (ADL-roll left and right, sit to lying, lying to sitting on side of bed). MDS also indicated that Resident 1 was not on a restorative nursing program (a person-centered nursing care designed to improve or maintain the functional ability of residents). A review of Resident 190's Care Plan for ADL self-care deficit revised on 1/12/2023 and cerebral infarction, revised on 2/1/2023, indicated an intervention to turn and reposition every two hours and as needed and keep body in good alignment. During an initial tour of the facility on 3/23/2024 at 9:46 a.m., Resident 190 was observed lying laterally sideways on the bed, right arm was contracted, and both feet were hanging off the bottom of the bed. During a concurrent observation and interview with Resident 190 on 3/23/2024 at 11:28 a.m., Resident 190 stated, he is unable to use his left side and his left arm is contracted. Resident 190 stated, he does not remember if he gets exercises on his arm, and no one has repositioned him since this morning. Resident 190 was observed lying lateral sideways on the bed, both feet were still hanging off the bed. During an observation with Resident 190 on 3/23/2024 at 3:29 p.m., Resident 190 was observed with eyes closed, lying lateral sideways on the bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with Resident 190 on 3/24/2024 at 9:33 a.m., Resident 190 was again observed lying lateral sideways on his bed, both feet were hanging off the bottom of his bed. During a concurrent interview with Licensed Vocational Nurse 3 (LVN 3) and observation of Resident 190 on 3/24/2024 at 5:48 p.m., Resident 190 was observed lying lateral sideways. LVN 3 stated, they reposition resident every 2 hours and Resident 190 tends to refuse care and repositioning. LVN 3 stated, Resident 190's refusal was not documented when asked for the turning and reposition logbook. During an observation with Resident 190 on 3/25/2024 at 9:23 a.m., Resident 190 was observed lying lateral sideways on his bed, both feet were hanging off the bottom of his bed. During an interview with Registered Nurse 1 (RN 1) on 3/25/2024 at 10:17 a.m., RN 1 stated, residents who are dependent on mobility and bed bounds are to be repositioned every two hours. RN 1 stated, Resident 190 tend to refuse to be repositioned. RN 1 stated, they do not document the refusal on the turning and reposition logbook, but it should have been documented. RN 1 stated, if residents are not repositioned frequently, it puts them at risk of further pressure ulcer. A review of the facility's policy and procedures (P&P) titled, Repositioning, reviewed on 2/22/2024 indicated, repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief . repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. The same P&P also indicated, residents who are in bed should be on at least every two hour repositioning schedule.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview, and record review, the facility failed to provide an environment that is free from accident hazards in preventing avoidable accidents to one of five sampled residents (Resident 3) by failing to ensure Resident 3's medications were not left unattended at bedside during medication pass. This deficient practice had the potential to result in an unsafe medication administration to Resident 3. Findings: A review of Resident 3's Admission Record, indicated that Resident 1 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow) and schizophrenia (mental disorder in which people interpret reality abnormally). A review of Resident 3's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 1/30/2024, indicated Resident 3 had moderate impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 3's Order Summary Report (OSR), indicated the following medications were ordered for Resident 3: Allopurinol (medication to treat gout [severe pain, swelling and redness in joints]) 300 milligram (mg) one (1) tablet by mouth daily, ordered on 7/30/2023 Amiodarone (medication to treat heart rhythm problems) 200 mg 1 tablet by mouth daily, ordered on 7/29/2023 Eliquis (medication to prevent blood clots) 5 mg 1 tablet by mouth twice a day, ordered on 1/26/2024 Empagliflozin (medication to treat DM) 25 mg 1 tablet by mouth daily, ordered on 7/29/2023 Ferrous Sulfate (supplement) 325 mg 1 tablet by mouth twice a day, ordered on 11/3/2023 Folic Acid (supplement) 1 mg 1 tablet by mouth daily, ordered on 7/29/2023 Levothyroxine (medication to treat hypothyroidism [condition in which gland does not produce enough thyroid hormone]) 100 microgram (mcg) 1 tablet by mouth daily, ordered on 2/1/2024 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Magnesium Oxide (supplement) 400 mg 1 tablet by mouth twice a day, ordered on 7/29/2023 Metoprolol Tartrate (medication to treat high blood pressure) 50 mg 1 tablet by mouth twice a day, ordered on 7/30/2023 Midodrine hydrochloride (blood pressure support) 10 mg 1 tablet by mouth three times a day, ordered on 7/30/2023 Multi-vitamins (supplement) 1 tablet by mouth daily, ordered on 8/26/2023 Rosuvastatin Calcium (medication to treat high cholesterol) 20 mg 1 tablet by mouth daily, ordered on 7/29/2023 Seroquel 25 (anti-psychotic medication) mg 1 tablet by mouth twice a day, ordered on 10/25/2023 During a concurrent observation in Residenty 3's room and interview with the Licensed Vocational Nurse 2 (LVN 2) on 3/23/2023 at 10:12 a.m., observed Resident 3's morning medications were left unattended at bedside table. LVN 2 was assisting Resident 3's roommate with curtain closed. LVN 2 stated that she (LVN 2) was not supposed to leave all the morning medications unattended at bedside for safety. During an interview with Registered Nurse 2 (RN 2) on 3/25/2024 at 5:24 p.m., RN 2 stated that during medication pass, resident's medications should not be left unattended due to safety issues. A review of facility's policy and procedures (P&P), titled, Administering Medications, reviewed on 2/22/2024, indicated, medications shall be administered in a safe, timely manner, and as prescribed. A review of facility's P&P, titled, Safety and Supervision of Residents, reviewed on 2/22/2024, indicated, the facility will strives to make the environment as free from accident hazards as possible. P&P also indicated that resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents, (Resident 9), who was at risk for dehydration (lack of drinking sufficient fluids to meet the body's need) and malnutrition (food ingested [eaten]) does not provide enough nutrients or the right balance for optimal health), was offered sufficient food and did not experience unplanned severe weight (wt) loss (a body weight loss of greater than five [5] percent [% - unit of measure] in one month). The facility failed to: 1. Identify interventions related to Resident 9's poor food intake since admission to prevent progressive wt loss. 2. Monitor and document Resident 9's high protein nutrition (HPN - supplement nutritional drink with high protein) intake to determine Resident 9's intake met his nutritional needs. 3. Develop intervention including frequent foods and snacks when Resident 9 yelled or asked for food. 4. Ensure Registered Dietitian 1 (RD 1) promptly evaluated Resident 9 after the resident was identified with severe wt loss of 12 pounds (lbs - unit of measurement) on 2/2/2024. 5. Implement facility's policy and procedures (P&P) on Fortified Food (the process of adding nutrients to foods that are not naturally present or are insufficient in the original food) Program to provide appropriate and equivalent food substitute for Resident 9 who had intolerance to dairy products. 6. Implement the facility's P&P on Weight Variance Assessment and Interventions when Resident 9 was identified with 12 lbs wt loss on 2/2/2024. 7. Implement Resident 9's care plan interventions related to alteration in nutrition, severe protein-calorie malnutrition, and wt loss. These deficient practices resulted in: 1. Resident 9 experienced 12 lbs severe wt loss in one month from 1/5/2024 to 2/2/2024 (equivalent to 7.8% of Resident 9's body weight). 2. Resident 9 was agitated, complained of being hungry, and kept requesting for more food on multiple occasions. 3. Resident 9 not been assessed and re-evaluated by a Registered Dietician (RD for 20 days after Resident 9 experience 12 lbs wt loss in one month. These deficient practices had the potential for further decline and complications related to Resident 9's: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	1. Severe protein-calorie malnutrition (the state of inadequate intake of food [as a source of protein, calories, and other essential nutrients] in the body). 2. Stage four (4) pressure ulcer (severe tissue damage caused by injury to skin and underlying tissue resulting from prolonged pressure on the skin; a stage four is the largest and deepest of all pressure ulcer stages). Findings: A review of Resident 9's Admission Record indicated the facility originally admitted Resident 9 on 12/18/2020 with a readmitted d 1/4/2024. Resident 9's diagnoses included unspecified severe protein-calorie malnutrition, type 2 diabetes mellitus (long-term condition in which the body has trouble controlling blood sugar and using it for energy), and recurrent depressive disorder (when a person has experienced depressive symptoms [feelings of sadness and/or a loss of interest in activities you once enjoyed] for most of the day, for more days than not over two years). A review of Resident 9's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 1/9/2024, indicated Resident 9 had a severely impaired cognition (ability to comprehend, think, solve problem, process information, and make decisions). The MDS indicated Resident 9 required moderate staff assistance with eating and weighed 154 pounds (lbs). The MDS indicated Resident 9 was on a mechanically altered diet (foods are mechanically altered by whipping, blending, grinding, chopping, or mashing so that they are easy to chew and swallow) and therapeutic diet (meal plan that control and promote the intake of certain foods or nutrients). The MDS also indicated Resident 9 was admitted with a Stage4 pressure ulcer. A review of Resident 9's Physician Order, dated 1/12/2024, indicated: - Puree (foods that have a soft, pudding like consistency), controlled carbohydrate diet (CCHO - same number of carbohydrates every day to help people manage blood sugar levels), fortified (food with extra nutrients added to increase the calories and protein) diet with thin liquids (watery liquids) - Four ounces (oz.) HPN three times daily for poor oral intake (low food /liquids ingestion). A review of Resident 9's Care Plan, revised on 1/6/2024 for Resident 9's risk for dehydration and weight loss fluctuation, had a goal for Resident 9 not having significant weight changes of 5 lbs or more monthly. The interventions included monitoring Resident 9's skin turgor for tenting (very slow to return to normal, or the skin tents up during a check; this can indicate severe dehydration that needs quick treatment), monitoring for dry mouth, muscle cramps, and changes in mental status. A review of Resident 9's Care Plan revised on 1/7/2024 for Resident 9's severe protein-calorie malnutrition, had a goal for Resident 9 to gain one to two lbs per month in the next three months. The care plan interventions included monitoring Resident 9's weight loss and report to the physician and the RD promptly (if any wt loss). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 9's Nutritional Care Assessment (NCA) form, documented by RD 1 on 1/12/2024, indicated Resident 9 weighed 154 lbs and was 66 inches tall. Resident 9's usual weight range was 186-193 lbs, the ideal body weight (IBW) range was128-156 lbs, with a desirable BW range of 149-159 lbs. RD 1 assessed Resident 9's daily caloric needs range 25-30 calorie per kilogram of weight cal/kg) equivalent to 1750-2100 calories per day. Resident 9's daily protein needs range from 1.4-1.5 grams (gm -unit of measurement)/kg equivalent to 98-105 gm ER [NAME]. The NCA form indicated Resident 9's Body Mass Index (BMI - a tool used to estimate the amount of body fat; a BMI less than 18.5 falls is considered underweight) was 24.85. The NCA form indicated the goal was to maintain Resident 9's current body wt. A review of Resident 9's Weekly Weights Record indicated: 1/5/2024: 154 lbs. Admission wt. 1/12/2024: 151 lbs. Three (3) lbs wt loss in seven (7) days. 1/19/2024: 148 lbs. Six (6) lbs wt loss in 14 days. 1/26/2024: 145 lbs. Nine (9) lbs wt loss in 21 days. 2/2/2024: 142 lbs. 12 lbs wt loss in 28 days and in four weeks (one month). 2/7/2024: 144 lbs. 2 lbs weight gain. A review of Resident 9's meal consumption percentage indicated the following: 1/9/2024 - Breakfast (B) 50%; Lunch (L) 50%; Dinner (D): 60% 1/10/2024 - no meal % recorded. 1/11/2024 - B 75%; L 50%, D 40% 1/12/2024 - B 50%; L 35%, D 30% 1/13/2024 - B 25%; L 40%, D 30% 1/14/2024 - B 25%, L 25%, D 50% 1/15/2024 - B 75%; L no record, D 50% The percentage of the HPN consumed was not recorded. (continued on next page)

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	555849	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 9's Situation - Background - Assessment - Recommendation (SBAR - a written or verbal communication tool used by the healthcare team to provide essential and concise information, usually during crucial situations), dated 2/7/2024, documented by Licensed Vocational Nurse 2 (LVN 2), indicated, Resident 9 had weight loss of 12 lbs in one month (five days after Resident 9 was weighed and the weight was 142 lbs). The Nurse Practitioner (working for the attending physician) was notified and gave no new orders. The SBAR did not indicate if the RD was notified of Resident 9's 12 lbs wt loss in one month for further recommendation as per the Care Plan. A review of Resident 9's Care Plan, initiated on 1/6/2024 for Resident 9's risk for dehydration and weight loss fluctuation, indicated it was revised on 2/7/2024, to include Resident 9's 12-lbs weight loss in one month. A review of Resident 9's Care Plan revised on 1/7/2024 for Resident 9's severe protein-calorie malnutrition indicated it was revised on 2/7/2024 to include in the interventions to report Resident 9's wt loss to the physician and the RD. A review of Resident 9's Dietary Progress Notes, dated 2/22/2024, indicated Resident 9's wt of 142 lbs was down to 12 lbs in one month (a 7.8% wt loss), the current diet of pureed fortified CCHO, 4 oz HPN three times a day provided 600 calories and 8 gm of protein). RD 1's recommendations included to: - Discontinue (DC-stop) four oz HPN (no dairy) - Give Boost glucose control (a nutritional drink, no dairy, specially formulated for people with diabetes) one can twice daily - 474 millimeter (ml)/380 calories/32 gm protein (supplement) - Change diet to puree CCHO (discontinue the fortified diet due to no dairy for beverage). On 3/23/2024 at 5:20 p.m., during an interview, Licensed Vocational Nurse 2 (LVN 2) stated Resident 9 had 12 lbs wt loss and that LVN 2 had initiated the SBAR dated 2/7/2024. LVN 2 stated not remembering if RD 1 was notified of Resident 9's severe wt loss. On 3/23/2024 at 5:58 p.m., during an interview with RD 1 and concurrent review of Resident 9's Dietary Progress Notes dated 2/22/2024 were reviewed. RD 1 stated Resident 9 had a severe wt loss in a month after admission. RD 1 stated she recommended to discontinue the fortified diet due to Resident 9's digestive (the process of breaking down food into substances the body can use for energy, tissue growth, and repair) issues with dairy products. RD 1 stated, with fortified diet, [Resident 9] is receiving additional 600 calories per day. RD 1 further stated Resident 9 was given Boost Glucose Control twice daily as a substitute which had/contained 380 Cal per day. RD 1 stated the facility did not notify RD of Resident 9's wt loss on 2/2/2024. RD 1 did not provide documented evidence the Interdisciplinary Team (IDT - a group from different healthcare who work together to help residents to receive the care they need) met to address Resident 9's wt loss of more than 5% in one month. A review of Resident 9's Physician Orders, dated 2/22/2024, indicated to give Resident 9 CCHO diet pureed texture, thin liquid consistency, which was changed from Puree CCHO fortified diet, thin liquid, and Boost Glucose twice a day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview with LVN 3 on 3/24/2024 at 8:45 p.m., Resident 9 was observed yelling from Resident 9's room. LVN 3 stated Resident 9, yells at night because he is hungry and would always ask for more food on a daily basis. LVN 3 walked into the kitchen after Resident 9 asked for more food, but LVN 3 did not provide food to Resident 9. During a concurrent observation in Resident 9's room and interview with Resident 9 on 3/25/2024 at 9:27 a.m., Resident 9 stated, I have not been eating good. I want water, Resident 9 was observed with loose and sagging skin. During an interview with Certified Nursing Assistant 2 (CNA 2) on 3/25/2024 at 11:20 a.m., CNA 2 stated Resident 9 needed assistance with eating and yelled from his room and would always ask for more water and food. CNA 2 stated would yell for food. On 3/25/2024 at 11:47 a.m., during an interview, RD 1 stated, she recommended to discontinue Resident 9's fortified diet and HPN on 2/22/2024. RD 1 stated Resident 9 was receiving 600 Cal per day while on fortified diet and was now receiving 380 Cal per day while on CCHO puree diet and Boost Glucose Control twice a day. When asked the reasons the calories were decreased from 600 Cal to 380 Cal on 2/22/2024 after Resident 9 had a wt loss of 7.8% in one month, RD 1 stated, because [Resident 9] had digestive issues with milk. When asked if milk could be substituted with other non-dairy products when residents were on fortified diet, RD 1 stated, Yes, milk can be substituted with butter or mayonnaise. RD 1 further stated not been aware Resident 9 yelled for more food because Resident 9 was hungry. RD stated, when a resident receives less calories, it can cause them to be hungry and agitated. On 3/25/2024 at 1:07 p.m., Resident 9 was observed in bed assisted by CNA 2 and ate 80 % of his lunch tray. During an interview on 3/25/2024 at 1:11 p.m., the Dietary Supervisor (DS) stated the kitchen provided Resident 9 with mocha mix (non-dairy drink) as a substitute of milk because Resident 9 could not have dairy products. DS stated, Resident 9 was not on any fortified food other than mocha mix. Resident 9 was given the Boost supplement as ordered. On 3/25/2024 at 6:11 p.m., Resident 9 observed in bed assisted with eating and ate 70% of his dinner. During a concurrent observation and interview with Registered Nurse 2 (RN 2) and Resident 9 on 3/25/2024 at 8:12 p.m., Resident 9 was in bed yelling. Resident 9 said, I want ice cream, please. RN 2 stated Resident 9 already ate dinner and that Resident 9 frequently exhibited agitation saying he was hungry. A review of the facility's P&P titled, Weight Variance Assessment and Intervention reviewed by the facility on 2/22/2024, indicated, it is the policy of this facility to identify significant weight variance, assess and intervene using good nursing practice and then utilizing an interdisciplinary weight variance committee. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's P&P titled, Fortified Food Program, reviewed by the facility on 2/22/2024, indicated, food preferences are obtained and foods high in calories and protein will be provided to help maintain or gain weight. Milk/dairy intolerant residents there are different options and will need to be individualized per likes and dislikes of specific products . follow the lactose free and the fortified pattern on the menu extension sheets which may be further individualized using the fortified foods program sheet: a minimum of two (2) items need to be served per meal. A review of the facility's P&P titled, Fortified Diets, reviewed by the facility on 2/22/2024, indicated, a fortified diet is available for those residents who are deemed at nutritional risk and in need of increased calories and protein by the registered dietitian or interdisciplinary team. Examples of foods that may be fortified: hot cereal, milk, cream soup, mashed potatoes, pudding, ice cream . If a resident chooses not to eat the items typically served on a fortified diet or is unable to tolerate foods, alternative options to increase calories will be implemented. A review of the facility's P&P titled, Job Description - Consultant Dietitian, reviewed by the facility on 2/22/2024, indicated, primary function to evaluate and monitor food services systems and nutritional status of residents . evaluates and monitors food service systems, making recommendations for a conformance level that will provide nutritionally adequate, acceptable quality food.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45524 Based on observation, interview, and record review, the facility failed to provide respiratory treatment and care for one of 16 sampled residents (Resident 13), who had chronic obstructive pulmonary disease (COPD, group of diseases that cause airflow blockage and breathing-related problems) and history of pneumonia (a serious infection of one or both lungs in which the air sacs fill with pus and other liquid). The facility failed to: 1. Closely monitor Resident 13's respiratory condition, including response to treatment after being identified to have a change of condition (COC, a sudden clinically important deviation from a patient's baseline) when Resident 13 develop a cough on 3/20/2024. 2. Perform a complete respiratory assessment (breathing rate, pattern and effort, skin color, chest configuration, and symmetry of expansion of the chest with each breath) as per policies and procedures (P&P) on Residents COC, Pneumonia, Bronchitis [inflammation of the lining of bronchial tubes, which carry air to and from the lungs], and Lower Respiratory Infections -Clinical Protocol, and Resident Examination and Assessment. 3. Monitor and notify the attending physician (Physician 1) about Resident 13's worsening cough. 4. Notify Physician 1, on 3/21/2024, of Resident 13's chest X-ray results and recommendation to repeat X-rays if symptoms persisted or worsened. These deficient practices resulted in: 1. A four-day delay for Resident 13 to receive respiratory care consistent with Resident 13's respiratory symptoms. 2. Resident 13 having inability to sleep, fatigue (extreme sense of tiredness and lack of energy that can interfere with a person's usual daily activities), poor appetite, and loss of ability to taste food/fluids. 3. Transferring Resident 13 to General Acute Care Hospital 1 (GACH 1) on 3/24/2024, because of fever, coughing, and difficulty breathing. At GACH 1, Resident 13 was diagnosed with pneumonia and required intravenous (IV- delivered into a vein) antibiotics (medications used to treat infection). These deficient practices had the potential for further decline and complications related to increased risk for sepsis (a life-threatening infection in the blood that travels throughout the entire body), respiratory failure, organ failure, and death. Findings: (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 13's Admission Record indicated the facility initially admitted Resident 13 on 6/23/2023, and the most recent readmission was dated on 1/6/2024. Resident 13's diagnoses included pneumonia, asthma (chronic [ongoing] disease in which the bronchial [passages in the lungs] that extend from the trachea [windpipe] and airways in the lungs that become narrowed and swollen, making it difficult to breathe), and hypertension (high blood pressure). A review of Resident 13's Physician Order, dated 1/6/2024, indicated to administer Ipratropium-Albuterol Inhalation Solution (combination medication used to help control the symptoms of lung diseases and treat air flow blockage) ipratropium 0.5 milligrams (mg) - albuterol 3 mg (2.5 mg base) in three milliliters (ml) solution, vial inhaler, every four hours as needed for SOB (shortness of breath). A review of Resident 13's Minimum Data Set (MDS - standardized assessment and care screening tool) dated 1/10/2024, indicated Resident 13 had moderate impaired cognition (ability to comprehend, think, solve problem, process information, and make decisions). The MDS indicated, Resident 13 required substantial to maximum assistance for activities of daily living (ADLs such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). A review of Resident 13's History and Physical exam (H&P) completed by Physician 1 on 1/25/2024, indicated that Resident 13 had the capacity to understand and make decisions. A review of Resident 13's COC, dated 3/20/2024 and timed at 9:22 p.m., indicated Resident 13 had nonproductive cough (a cough that is dry and does not produce sputum [mixture of saliva and mucus coughed up]). The COC did not include Resident 13's respiratory assessment. A review of Resident 13's chest X-rays results, dated 3/21/2024, indicated no acute focal consolidation (fluid or other material that consolidates inside the lung) or effusion (buildup of fluid between the chest cavity and the tissue lining the lungs). The x-ray indicated, if Resident 13's symptoms persisted or worsened, then the recommendation was to repeat frontal (front) and lateral (side) chest X-rays. A review of Resident 13's COC, dated 3/23/2024 and timed at 5:37 pm, indicated Resident 13 had productive cough and redness on the eyes, the respiration was even and unlabored (easy/relaxed), there was no shortness of breath, and Resident 13 did not get good sleep in the past two nights (3/21/2024 and 3/22/2024). The COC indicated the Director of Nursing (DON), assessed Resident 13 and the lung sounds were clear and no wheezing (high-pitched whistling sound made while breathing) was noted. The COC indicated Resident 13 did not have fever (high body temperature) or change in level of consciousness. The COC indicated Physician 1 was notified about Resident 13's COC on 3/23/2024 at around 5:15 pm and ordered Robitussin Peak Cold DM (Dextromethorphan-Guaifenesin - a combination medication used to relieve coughs) oral (by mouth) syrup 100 -10 milligrams (mg- unit of measurement) per 5 milliliters (ml- unit of measurement), every four hours as needed for 30 days. A review of Resident 13's nursing Progress Note, dated 3/24/2024 at 6:25 pm, indicated that on 3/24/2024 at 5 pm, Family Member 1 (FM 1) called concerned about Resident 13's difficulty of breathing. The Progress Note indicated Resident 13's oxygen saturation (02 sat - amount of oxygen in the blood) was 94 percent (% - normal range is 95-100%) while Resident 13 was on oxygen at two liters per minute (2 L/min) via nasal cannula (NS- a flexible tube used to deliver oxygen through the nose). The Progress Note indicated Physician 1 was notified regarding Resident 13 having difficulty of breathing with new orders. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 13's Physician Order dated 3/24/2024, indicated to administer oxygen inhalation at 2L/min via nasal cannula as needed for shortness of breath/comfort. A review of Resident 13's Physician Progress Note dated 3/24/2024, no time specified, indicated Resident 13's 02 sat was 90%, had cough and rhonchi (coarse, loud sounds caused by constricted larger airways) upon chest assessment. A review of Resident 13's nursing Progress Note, dated 3/24/2024 indicated that at 6:40 pm Resident 13 developed a fever of 100.7 degrees Fahrenheit (F- normal body temperature range is between 97 F and 99 F), Physician 1 was notified and ordered transferring Resident 13 to GACH 1. A review of Resident 13's Transfer to Hospital Summary form, dated 3/24/2024 at 10:40 pm, indicated Resident 13 was transferred to GACH 1 due to fever, coughing, and difficulty breathing. A review of Resident 13's GACH Emergency Department note dated 3/24/2024, untimed, indicated, Resident 13 presented with cough and SOB. GACH Emergency Department note indicated, Resident 13, reported that over the past week, [Resident 13] was having increased congested sounding cough, but unable to bring up any sputum. GACH Emergency Department note indicated, [Resident 13] reported to facility staff associated shortness of breath, with increased wheezing sensation requiring oxygen. GACH ED diagnosed Resident 13 with pneumonia. A review of Resident 13's GACH 1 chest X-ray report dated 3/25/2024 and timed at 12:32 am, indicated, subtle patchy infiltrates (areas filled with fluid, may be a manifestation of aspiration [breathing in food particles in airway]) in the right lower lung zone. A review of Resident 13's GACH 1 Infectious Disease Specialist Progress Note, dated 3/28/2024, indicated Resident 13 was treated for pneumonia with IV Zosyn (a combination of two antibiotics namely piperacillin and tazobactam) 3.375 grams (gm, unit of measurement). The Progress Note indicated to discontinue Zosyn and continue Levaquin (levofloxacin - antibiotic) 500 mg for three more days. On 3/24/2024 at 10:15 a.m., during a concurrent interview with the Director of Nursing (DON) and a review of Resident 13's clinical record, the DON could not find documented evidence that a care plan was developed on 3/20/2024, when Resident 13 was identify to be coughing. On 3/23/2024 at 10:30 am, during an observation, Resident 13 was sitting in a wheelchair outside room, in the hallway and was not receiving oxygen therapy. Upon interview, Resident 13 was observed coughing continuously. Resident 13 stated feeling tired, was unable to sleep because of constantly coughing during the night and was bothering others with the cough. Resident 13 stated feeling that other residents were staring when coughing. Resident 13's eyes appeared watery, red, and sunken. Resident 13 stated having nonproductive cough for a couple days and felt fatigued from not being able to sleep. Resident 13 stated receiving medication (Ipratropium- Albuterol) inhalation (via inhaler, a device that gets medicine directly into a person's lungs. The medicine is a mist or spray that the person breathes in), but the medication was not working. A review of Resident 13's Care Plan developed on 3/23/2024 for Resident 13's having a productive cough, included in the interventions: -Monitoring for any shortness of breath and notify Physician 1. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Administering medication as ordered, Robitussin Peak Gold DM oral syrup every four hours for 30 days. -Monitoring vital signs (measurement of the body's most basic functions such as heartbeat and breathing rates, and body temperature) every shift for the next three days and notify Physician 1 if any significant or any abnormalities. On 3/23/24 at 4:10 pm, a concurrent observation in Resident 13's room and interview with Resident 13 in the presence of the Director of Nursing (DON) was conducted. Resident 13 was in bed and appeared tired. Resident 13's eyes were watery, red, and sunken in. Resident 13 reported coughing for a few days and unable to cough up any sputum. Resident 13 stated feeling fatigued from not sleeping well at night due to constantly coughing. Resident 13 stated having no appetite and unable to taste food since the cough started which the nurses were aware. Resident 13 stated the nurses were giving some type of liquid medication, which did not work at all. The DON auscultated (examine by listening to the sounds of the heart, lungs, arteries, and belly using a stethoscope (a medical instrument used for listening to sounds in the body) Resident 13's lungs and stated Resident 13's lungs were clear (no abnormal sounds). The DON stated the respiratory assessment must be performed when a resident displays any respiratory concerns including coughing. The DON stated Resident 13 should have had a respiratory assessment as soon as Resident 13 started coughing on 3/20/2024, to identify problems and prevent worsening of Resident 13's condition. On 3/23/2024 at 4:30 pm, during an interview Licensed Vocational Nurse 1 (LVN 1) stated that on 3/18/2024, Resident 13 received COVID-19 vaccine and developed a cough approximately two days after. LVN 1 stated Resident 13's cough was a reaction to the vaccine. On 3/23/2024 at 4:43 p.m., during a concurrent interview with the DON and a review of Resident 13's clinical record, the DON stated there was no documentation Physician 1 was notified of the chest X-rays report and the recommendation from the radiologist (a medical doctors that specialize in diagnosing and treating injuries and diseases using medical imaging [radiology] procedures such as X-rays) to repeat the X-rays if cough persisted or worsened. The DON admitted that not notifying Physician 1 led to a delay in Resident 13's care. On 3/23/2024 at 5 pm, during a telephone interview, Physician 1 (who was also the facility's medical director), stated the nurses did not inform him of Resident 13's worsening cough and the recommendations to repeat chest x-ray the if symptoms (cough) persisted or worsened was not implemented. Physician 1 stated not being informed Resident 13 had the eyes red and sunken. MD 1 stated, it was normal part of aging to feel fatigued, be unable to sleep, and have some type of discomfort such as aches. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A review of facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status revised 2/22/2024, indicated, Our facility shall promptly notify the resident, his or her Attending Physician, Attending Licensed Healthcare Practitioner acting within the scope of his or her professional /licensure, representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments., resident rights, etc.). Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and relevant and pertinent information for the provider, including (for example) information prompted by the SBAR [Situation - Background - Assessment - Recommendation, a written or verbal communication tool used by the healthcare team to provide essential and concise information, usually during crucial situations). The P&P also indicated, policy interpretation and implementation included, the nurse will notify the resident's Attending Physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. A review of a facility P&P titled, Pneumonia, Bronchitis, and Lower Respiratory Infections -Clinical Protocol revised, 2/22/2024, indicated, as part of assessment and recognition: I. As part of the initial assessment, the physician will help identify residents who have recently had pneumonia or bronchitis and who are at risk for getting respiratory infections (for example, those with COPD or a history of respiratory failure). 2. The staff will identify residents with symptoms that suggest possible bronchitis or pneumonia (for example, dyspnea (at rest and/or on exertion), tachypnea, increased sputum production, chest pain, chronic cough, or hemoptysis [blood in the mucus]). 3. The staff and physician will identify individual risk, such as significant oral or dental disease, presence of a feeding tube, or clinically significant swallowing abnormalities. The P&P also included: Clinical signs suggesting more severe cases may tachypnea (respiratory rate in the upper 20's [breaths per minute]) with labored [difficult] respirations, unstable vital signs, and a substantial and persistent decline in pulse oximetry results of greater than 3% from baseline. A review of a facility P&P titled, Resident Examination and Assessment, with a revision date of 2/2014, indicated, The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. Under respiratory physical exam, it listed: a. Lung sounds (upper and lower lobes) for wheezing, rales (small clicking, bubbling, or rattling sounds in the lungs), rhonchi, or crackles (bubbling or popping sounds). b. Irregular or labored respirations. c. Cough (productive or nonproductive); and d. Consistency and color of sputum.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to ensure staff had the appropriate competencies to provide nursing and related services to assure safety of the residents by failing to: 1. Maintain and update basic life support/Cardiopulmonary Resuscitation (BLS/CPR) certification for two of seven sampled facility staff (Licensed Vocational Nurse 2 [LVN 2] and Certified Nursing Assistant 5 [CNA 5]). 2. Ensure Licensed Vocational Nurse 5 (LVN 5) had the specific competencies and skills sets necessary to perform safe medication administration for Resident 15. This deficient practice had the potential to place resident at risk of not getting proper immediate care in a life-threatening situation. Findings: 1. During a concurrent record review and interview with the Infection Preventionist Nurse/Director of Staff Development (IPN/DSD), on [DATE] at 12:53 p.m., LVN 2 and CNA 5 staff files were reviewed. Staff files indicated not up to date BLS/CPR for LVN 2 and CNA 5. IPN/DSD stated IPN/DSD was supposed to make sure that BLS/CPR are up to date for all the staff. A review of facility's policy and procedures (P&P), titled, Emergency Procedure-CPR, reviewed on [DATE], indicated, Facility personnel have completed training on the initiation of CPR and BLS for victims of sudden cardiac arrest. Staff will obtain and/or maintain American Red Cross or American Heart Association certification in BLS/CPR including non-licensed personnel. A review of facility's job description (JD), titled, DSD, reviewed on [DATE], indicated under responsibilities, that, DSD will: Maintain an acceptable standard of nursing practice and professional decorum. Plan and conduct meaningful in-service education programs according to regulatory requirements for nursing personnel. Maintain department records in a complete and orderly manner. 45524 2. A review of Resident 15's admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including Benign Prostatic Hyperplasia (BPH- a condition in men in which the prostate gland is enlarged and not cancerous), secondary hypertension (when the pressure in your blood vessels is too high [,d+[DATE] mmHg or higher] and is caused by another medical condition), and hyperlipidemia (also known as dyslipidemia or high cholesterol, means you have too many lipids (fats) in your blood). (continued on next page)

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	555849	A. Building B. Wing	03/25/2024

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 15's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], indicated, Resident 15 had mildly impaired cognition (people have more memory or thinking problems than other people their age) cognition (ability to make decisions of daily living) and was dependent for activities of daily living (ADL-- bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a concurrent medication administration observation by Licensed Vocational Nurse 4 (LVN 4) and interview with LVN 4 on [DATE], at 9:28 a.m., LVN 4 was observed crushing the following medications together: 1. Apixaban 2.5mg (anticoagulant used to reduce the risk of stroke and blood clots) 2. Proscar (medication to treat enlarged prostate gland) 5mg daily 3. Metoprolol (used alone or in combination with other medications to treat high blood pressure) 25mg. 4. Aspirin (used to treat mild to moderate pain, inflammation, or arthritis. It also lowers your risk of heart attack) 81 mg. 5. Loratadine (used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and other allergies) 10 mg. LVN 4 placed all five medications in a clear plastic pouch and crushed the medications using a pill crusher (a metal tool used to crush pills at the same time). LVN 4 stated that medications must be crushed separately and one at a time because one may be unaware which medications a resident has taken or not taken. LVN 4 stated Proscar should not have been crushed per manufacture's guidelines because it was teratogenic (relating to or causing developmental malformations). LVN 4 confirmed that it would be impossible to explain which medications were being administered after being crushed together. During a concurrent observation and interview with Director of Nursing (DON) on [DATE], at 9:30 a.m., DON confirmed that LVN 4 crushed the above five medications together. The DON stated crushing together is considered compounding (the process of combining, mixing, or altering ingredients to create a new medication). The DON confirmed that the medication Proscar must not be crushed. The DON admitted that each medication cart should have had a list of Do not crush medication list, which would work as a point of reference for the nurses administering medications. A review of the facility's P&P titled, Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The same P&P indicated, the individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. A review of facility's list titled Medications Not To Be Crushed, reviewed on of ,d+[DATE], indicated, Proscar (Finasteride) medication not to be crushed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of manufacturer's guidelines, undated, indicated under warnings and precautions that, tablets (medication) are coated and will prevent contact with active ingredients during normal handling, provided the tablets have not been broken or crushed. A review of facility's Job Description, titled, CHARGE NURSE, reviewed on [DATE], indicated under responsibilities, that charge nurse will: o Maintain an acceptable standard of nursing practice and professional decorum. o Knowledge and implementation of the Facility's policies and procedures. o Maintain department records in a complete and orderly manner. o Prepare, administer, and document medications, tests upon which the administration of the medication are dependent and perform treatments according to the physician 's orders and- as directed by the facility's policies and procedures when treatment nurse not assigned.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43454 Based on observation, interview, and record review, the facility failed to post in a visible and prominent place daily the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care per shift for three of three sampled days (3/23/2024, 3/24/2024, and 3/25/2024). This deficient practice resulted in the actual staffing information not being readily accessible and available to residents and visitors and had the potential to cause inadequate staffing. Findings: On 3/23/2024 at 8:50 a.m., a projected, not an actual DHPPD (Direct Care Services Hours Per Patient Day) was observed at Nursing Station 1. On 3/24/2024 at 9:32 a.m., a projected, not the actual hours was observed at Nursing Station 1. On 3/24/2024 at 9:29 a.m., a projected, not the actual hours was observed at Nursing Station 1. During an interview with Director of Infection Preventionist Nurse/Director of Staff and Development (IPN/DSD) on 3/24/2024 at 4:28 p.m., IPN/DSD stated, the facility posts and include only projection hours in the DHPPD daily and not the actual hours. DSD stated, I is unsure if the actual hours should also be posted. During a follow-up interview with DSD on 3/25/2024 at 7:06 p.m., DSD stated, DSD checked facilty's policy and procedures and that the actual hours should also be posted on the NHPPD. A review of the facility's policy and procedures (P&P) titled, Posting Direct Care Daily Staffing Numbers reviewed on 2/22/2024, indicated, our facility will post on a daily basis for each shift nurse staffing daily, including the number of nursing personnel responsible for providing direct care to residents . the information recorded on the form shall include the following: the actual time worked during that shift for each category and type of nursing staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure: 1.Pharmaceutical services included procedures to ensure the medications used from the emergency kit (e-kit - secured container or secured electronic system containing drugs which are used for either immediate administration to residents or in an emergency or as a starter dose) located in Medication room [ROOM NUMBER] were ordered and replaced as soon as possible per facility's policy. 2.Ensure professional standards of practice for medication administration were used when administering medications to 1 out of 16 sampled residents (Resident 15). On 3/24/2024 at 9:28 a.m., LVN4 was observed crushing Apixaban 2.5mg (anticoagulant used to reduce the risk of stroke and blood clots), Proscar 5mg daily, metoprolol (used alone or in combination with other medications to treat high blood pressure) 25mg, aspirin (used to treat mild to moderate pain, inflammation, or arthritis. It also lowers your risk of heart attack) 81 mg, and Loratadine (used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and other allergies) 10 mg together. 3.Ensure Resident 15's the medication Proscar was not crushed per manufacturer's guidelines. This deficient practice had the potential for harm to residents due to: 1. Lack of availability of medications leading to delays in the timely administration of medications in the event of an emergency. 2. Physical and chemical incompatibilities between medications, loss of effectiveness, and worsening of medical conditions. Findings: 1. During a concurrent interview and observation of Medication room [ROOM NUMBER] with Registered Nurse 2 (RN 2) on 3/24/2024 at 9:36 a.m., the Refrigerated e-kit, intramuscular injectables (IM) e-kit and IM-oral (PO) e-kit medications were observed opened and unsealed. RN 2 stated medications from the e-kit were used for residents during an emergency but was unable to determined which medications were used. RN 2 was unable to stated when the E-kit was opened and what medications were use because the E-kit pharmacy log was not properly completed. During a follow-up interview with RN 2 on 3/24/2024 at 10:02 a.m., RN 2 stated licensed nurses had to request a replacement of the E-kit from the pharmacy. RN 2 stated if medications and e-kit were not reorder and replaced on time, facility staff would not have medications that residents could need during an emergency. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility's policy and procedures (P&P) titled Medication Ordering and Receiving from Pharmacy reviewed on 2/22/2024, indicated as soon as possible, the nurse was to record the medication used from the E-kit on the medication order form and the nurse was to call the pharmacy for replacement of the kit/dose and flag the kit with a color-coded lock to indicate the need for replacement. 45524 2. A review of Resident 15's admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including Benign Prostatic Hyperplasia (BPH- a condition in men in which the prostate gland is enlarged and not cancerous), secondary hypertension (when the pressure in your blood vessels is too high [140/90 mmHg or higher] and is caused by another medical condition), and hyperlipidemia (also known as dyslipidemia or high cholesterol, means you have too many lipids (fats) in your blood). A review of Resident 15's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 2/9/2024, indicated Resident 15 was mildly impaired (people have more memory or thinking problems than other people their age) and was depended for most of his (Resident 15's) activities of daily living. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 4 on 3/24/2024, at 9:28 a.m., LVN 4 was observed crushing the following 5 medications: Apixaban 2.5mg (anticoagulant used to reduce the risk of stroke and blood clots) Proscar 5mg daily metoprolol (used alone or in combination with other medications to treat high blood pressure) 25mg. aspirin (used to treat mild to moderate pain, inflammation, or arthritis. It also lowers your risk of heart attack) 81 mg. Loratadine (used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and other allergies) 10 mg. LVN 4 placed the 5 pills in a plastic pouch used for medications which was then placed in a pill crusher (a metal tool used to crush pills at the same time). LVN 4 stated that medications had to be crushed one at a time to be sure which medications a resident may or may not have taken. LVN 4 stated that the medication Proscar should not have been crushed per manufacture's guidelines because it was teratogenic (relating to or causing developmental malformations). LVN 4 confirmed that it would be impossible to explain which medications were being administered after being crushed together. During a concurrent observation and interview with the Director of Nursing (DON) on 3/24/24, at 9:30 a.m., the DON confirmed that LVN 4 crushed the 5 medications together. The DON stated that crushing medications together was considered compounding (the process of combining, mixing, or altering ingredients to create a new medication). The DON confirmed that the medication Proscar should not be crushed. The DON stated each medication cart should have had a list of Do not crush medication list, which would work as a point of reference for the nurses' administering medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility's P&P titled Administering Medications, indicated Medications shall be administered in a safe and timely manner, and as prescribed. The P&P indicated, the individual administering the medication had to check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. A review of a facilities lists titled Medications Not To Be Crushed, with a review date of 1/12, indicated Proscar was on the list as one of the medications that could not be crushed. A review of manufacture's guidelines for Proscar indicated under warnings and precautions that the tablets were coated to prevent contact with active ingredients during normal handling, providing the tablets had not been broken or crushed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to do a Gradual Dose Reduction (GDR, an attempt to decrease or discontinue psychotropic [acting on the mind] medication after no more than three months from the start date of the psychotropic medication, unless clinically contraindicated) for 2 of 16 sampled residents (Residents 10 and 21). These deficient practices had the potential to result in overuse of an antipsychotic medication, without monitoring for the effectiveness and/or ineffective of the medication and can lead to adverse (negative) drug reactions. Findings: A review of Resident 21's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of Resident 21's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 2/10/2024, indicated that Resident 21 had moderately impaired cognition (ability to think and make decisions) and required moderate assistance from facility staff for mobility such as sit to stand, toilet transfer and tub/shower transfer. A review of Resident 21's Order Summary Report dated 12/4/2024, indicated the physician ordered the following: i. Haloperidol (medication used to treat nervous, emotional, and mental conditions) oral tablet 10 milligram (mg - unit of measurement) - give 1 tablet by mouth two times a day (BID) for schizophrenia. ii. Mirtazapine (medication used to treat depression) oral tablet 15 mg - give 1 tablet by mouth at bedtime (HS) for depression. iii. Haloperidol - monitor with hashmark every shift for episodes of schizophrenia manifested by angry outbursts. A review of the facility's Pharmacist Consultant Monthly Regimen Review (MRR) for Resident 21, dated 2/21/2024, indicated the Pharmacist Consultant recommended; Resident (190) has been on Haloperidol 10mg BID and Mirtazapine 15mg QHS and GDR is due if medically warranted. Please evaluate if a dose reduction is warranted at this time. Under Physician/Prescriber Response box option if Physician Agree, Disagree, or Other, (section required to be completed by the physician) there was no check mark if the physician agree or disagree with the Pharmacist recommendation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/2024 at 8:39 p.m., Registered Nurse 2 (RN 2) stated the pharmacist went to the facility monthly and checked on the resident's medications and provided a monthly recommendation. RN 2 stated facility staff was supposed to follow up and that both GDR and MRR recommendations should be done by notifying and clarifying the orders with the physician. RN 2 stated Resident 21's GDR recommendations by the Pharmacist was not followed up with the Physician. RN 2 stated it should have been done since residents were at risk for unnecessary medications and other issues while taking those medications. A review of a facility's policy and procedures (P&P) titled Tapering Medications and Gradual Drug Dose Reduction reviewed on 2/22/2024, indicated Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 45524 A review of Resident 10's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), schizoaffective disorder (a mental health condition with symptoms of both schizophrenia and mood disorders), and secondary hypertension (high blood pressure that's caused by another medical condition). A review of Resident 10's Order Summary Report dated 3/25/2024 indicated the physician ordered the following: i. Clonazepam (medication used for the acute treatment of panic disorder, epilepsy, and nonconvulsive status epilepticus) 0.5 mg, take 1 tablet by mouth at bedtime for anxiety. ii. Fluphenazine (antipsychotic medication used to treat schizophrenia and psychotic symptoms such as hallucinations, delusions, and hostility) 10 mg, give 1 tablet by mouth three times a day for schizophrenia. A review of the facility's Pharmacist Consultant Monthly Regimen Review (MRR) for Resident 10, dated 2/21/2024, indicated the Pharmacist Consultant recommended Resident 10 has been on clonazepam 0.5 mg QHS and fluphenazine 10 mg three times a day and GDR is due if medically warranted. Please evaluate if a dose reduction is warranted at this time. Under Physician/Prescriber Response box option if Physician Agree, Disagree, or Other, there was no check mark if the physician agree or disagree with the Pharmacist recommendation

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observations and record reviews, the facility failed to staff did not crush medications together for five of 31 opportunities during medication administration for one of 16 sampled residents (Resident 15). This deficient practice resulted in medication error of 16 percent (%). Mmedication error rate should be less than 5%. Cross Reference F755 Findings: A review of Resident 15's admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including Benign Prostatic Hyperplasia (BPH- a condition in men in which the prostate gland is enlarged and not cancerous), secondary hypertension (when the pressure in your blood vessels is too high [140/90 mmHg or higher] and is caused by another medical condition), and hyperlipidemia (also known as dyslipidemia or high cholesterol, means you have too many lipids (fats) in your blood). A review of Resident 15's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 2/9/2024, indicated, Resident 15 had mildly impaired (people have more memory or thinking problems than other people their age) cognition (ability to make decisions of daily lving) and was dependent for activities of daily living (ADL-- bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a concurrent medication administration observation by Licensed Vocational Nurse 4 (LVN 4) and interview with LVN 4 on 3/24/2024, at 9:28 a.m., LVN 4 was observed crushing the following medications together: 1. Apixaban 2.5mg (anticoagulant used to reduce the risk of stroke and blood clots) 2. Proscar (medication to treat enlarged prostate gland) 5mg daily 3. Metoprolol (used alone or in combination with other medications to treat high blood pressure) 25mg. 4. Aspirin (used to treat mild to moderate pain, inflammation, or arthritis. It also lowers your risk of heart attack) 81 mg. 5. Loratadine (used to temporarily relieve the symptoms of hay fever (allergy to pollen, dust, or other substances in the air) and other allergies) 10 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 4 placed all five medications in a clear plastic pouch and crushed the medications using a pill crusher (a metal tool used to crush pills at the same time). LVN 4 stated that medications must be crushed separately and one at a time because one may be unaware which medications a resident has taken or not taken. LVN 4 stated Proscar should not have been crushed per manufacture's guidelines because it was teratogenic (relating to or causing developmental malformations). LVN 4 confirmed that it would be impossible to explain which medications were being administered after being crushed together. During a concurrent observation and interview with Director of Nursing (DON) on 3/24/24, at 9:30 a.m., DON confirmed that LVN 4 crushed the above five medications together. The DON stated crushing together is considered compounding (the process of combining, mixing, or altering ingredients to create a new medication). The DON confirmed that the medication Proscar must not be crushed. The DON admitted that each medication cart should have had a list of Do not crush medication list, which would work as a point of reference for the nurses administering medications. A review of facility's policy and procedures (P&P) titled, Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The same P&P indicated, the individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. A review of facility's list titled Medications Not To Be Crushed, reviewed on of 1/12, indicated, Proscar (Finasteride) medication not to be crushed. A review of manufacturer's guidelines, undated, indicted under warnings and precautions that the tablets are coated and will prevent contact with active ingredients during normal handling, provided the tablets have not been broken or crushed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43261 Based on observation, interview, and record review the facility failed to ensure one of two sampled residents (Resident 34's) Levalbuterol hydrochloride (HCL) (Xopenex-medication being given via inhalation [inhaling medication in the form of gas or vapor] used to treat or prevent bronchospasm [when muscles that line the airways in the lungs becomes tighten) Nebulizer was disposed of within two weeks after opening per manufacturer's policy. This deficient practice had the potential to compromise the safety and effectiveness of medication, resulting in medication errors when administered to Resident 34, and placed the resident at risk for respiratory difficulty. Findings: A review of Resident 34's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), urinary tract infection (UTI-infection in the urinary system [kidneys, bladder, or urethra]) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should). A review of Resident 34's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 3/5/2024, indicated Resident 34 had severe impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 34's Order Summary Report (OSR) dated 3/1/2024, indicated an order for levalbuterol hcl inhalation nebulization (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) solution 1.25 milligram (mg) per 0.5 milliliter (ml), inhale orally via nebulizer every four hours as needed for CHF, shortness of breath and wheezing (whistling sound when airway is partially blocked during inhalation). During a concurrent observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 3/24/2024 at 7:53 p.m., observed Resident 34's opened foil pouch of levalbuterol hcl, dated 3/8/2024. LVN 3 stated that per manufacturer's policy of levalbuterol hcl vials had to be discarded within two weeks from the time the foil pouch was opened. A review of levalbuterol hcl's package inserts, undated, indicated that per manufacturer's policy, when levalbuterol hcl solution foil pouch was opened, vials had to be used within two weeks. A review of facility's policy and procedure (P&P), titled, Storage of Medications, reviewed on 2/22/2024, P&P indicated that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. P&P also indicated that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner.

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	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 3/23/24 when: 1. Cook used small scoop size to serve Baked Ziti (pasta with tomato and cheese sauce baked and topped with breadcrumbs) for five residents on mechanical soft finely chopped (Ground) diet (consists of foods that are moist, ground, chopped or easily mashed required little chewing) while five residents were mechanical soft finely chopped diet received 1/2 cup of Baked Ziti instead of 1 cup. 2. 17 Residents on mechanical soft diet (ground and chopped) did not receive garlic toast bread texture in form that met their needs when they received garlic toast without additional 1-2 tsp (teaspoons) of margarine to adequately moisten the bread. This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake and choking in 17 of 38 residents on mechanical soft diet who received food from the kitchen. Findings: According to the facility lunch menu on 3/23/24, the following items would be served on mechanical soft and finely chopped diet: Baked Ziti (chopped and finely chopped/ground) (pasta with tomato and cheese sauce baked and topped with breadcrumbs) (1 cup); Garden Zucchini (1/2 cup); garlic toast with margarine (1 slice); cut melon; milk, coffee, and beverages of choice. During an observation of the tray line service for lunch on 3/23/24, at 11:40 a.m., for residents who were on mechanical soft finely chopped diet, the cooks served baked ziti using the #8 scoop yielding 4 ounces (oz) or 1/2 cup instead of 1 cup per menu. During an interview with cook (cook 1) and (cook 2) on 3/23/2024, at 1:00 p.m. cook1 stated he served one scoop of #8 yielding 1/2 cup instead of double scoop. Cook1 stated he made a mistake. Cook 2 stated the residents on finely chopped diet received less food for lunch when they received 1/2 cup of baked ziti instead of 1 cup. During a concurrent interview and review of the facility menu, cook 2 stated the mechanical soft diet finely chopped is titled as Ground on the daily menu. Cook 2 stated we should serve 1 cup of baked ziti. During an interview with Dietary Supervisor (DS) on 3/23/2024 at 1:15 p.m. DS stated the residents on mechanical soft finely chopped diet (ground) received less food. DS stated less intake could cause weight loss in residents. DS stated cooks should always follow the menu and the portion guide when serving food. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the recipe for Baked Ziti indicated combine all the cooked pasta, ricotta and mozzarella cheeses with the tomato sauce, transfer into a pan, top with parmesan cheese, breadcrumbs, melted margarine, bake at 350 [degree] and then serve 1 cup (2x #8 scoops). A review of the Daily Cook's Menu - Meal: Noon dated 3/23/2024 indicated, baked ziti for mechanical soft diet finely chopped/ ground to serve 1 cup. 2.During an observation of meal preparation on 3/23/2024 at 11:40 a.m. Cook 2 sliced the toasted and seasoned sliced toast in half. During a concurrent interview, cook 2 stated the toast were for today's (3/23/24) lunch, they are flavored with butter, garlic, parsley flakes and toasted in oven. During an observation of the tray line service for lunch on 3/23/2024 at 11:45 a.m., the residents who were on mechanical soft diet received two pieces of the toasted garlic toast. During a concurrent observation and review of menu, the menu indicated to serve garlic toast with margarine for residents on mechanical soft diet. During an interview with cook1 and cook2 on 3/23/2024, at 1:00 p.m., cook2 stated the garlic toast has butter on it. Cook 2 said they did not add extra margarine to garlic toast for the residents on mechanical soft diet. During a concurrent interview with DS and review of garlic toast recipe on 3/23/2024 at 1:15 p.m., DS stated the garlic toast had butter on top there was no need for extra margarine. However, after having reviewed the recipe for garlic toast, DS stated the recipe requires additional margarine on the toast for residents on mechanical soft diet to adequately moisten the bread. DS further stated that it is important for the residents on mechanical soft diet to receive toast that is moistened. DS stated dry bread could result in choking of residents. A review of the recipe for Garlic Toast indicated spread garlic butter on each slice of bread, bake until toasted .for chopped/ground diet serve with 1-2 tsp margarine to adequately moisten. A review of the Daily Cook's Menu - Meal: Noon dated 3/23/2024 indicated, for mechanical soft chopped/ground diet, serve garlic toast with margarine.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. One large bowl of vanilla flavored pudding was stored on the same shelf next to raw shelled eggs and three (3) cartons of raw liquid eggs. 2. One small cup stored inside dried chicken base powder container and the cup in contact with the powdered chicken base. 3. Three (3) large containers of Vanilla flavored nutrition supplement with manufactured instruction to use within 3 days once opened were stored in the refrigerator with open dates of [DATE], [DATE], [DATE] exceeding safe storage period for the nutritional supplements. 4. Ice machine was not maintained in sanitary manner and the inside compartment of the ice machine was observed having gray and orange color residue. 5. Food brought to residents from outside of the facility, including leftovers stored in the resident food refrigerator were not labeled and dated. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 38 of 38 residents who received food and ice from the facility, six (6) residents who received nutritional supplements and in the residents who had food stored in the resident refrigerator. Findings: 1. During an observation in the kitchen on [DATE] at 8:30 a.m., there was a large bowl of vanilla pudding stored on same shelf next to raw shelled eggs and three cartons of open liquid eggs in the reach in refrigerator. During a concurrent interview with cook (cook1) on [DATE] at 8:45 a.m., cook1 stated the vanilla pudding was prepared yesterday and it should not have been stored on the bottom shelf next to raw eggs. Cook1 removed the pudding and stored it on the top shelf next to ready to eat food. During an interview with Dietary Supervisor (DS) on [DATE] at 9:50 a.m., DS stated ready to eat products should be stored separately from raw food. DS discarded the vanilla pudding. A review of facility policy titled Food Storage (undated), indicated, Cooked foods must be stored above raw foods to prevent contamination. 2. During an observation in the kitchen on [DATE] at 8:30 a.m., there was one bulk dry food storage container with chicken base powder in which a small plastic cup stored in the container was touching the chicken base powder. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DS on [DATE] at 9:50 a.m., DS stated scoops or cups should not be on the food. DS removed the plastic cup and further stated scoops and cups in the container could result in cross contamination of the food. A review of facility policy titled Food Storage (undated), indicated, scoops must be proved for bulk foods (such as sugar, flour, dried vegetables, and spices). Scoops are not to be stored in food. A review of the 2022 U.S. Food and Drug Administration (FDA) Food Code titled In-Use utensils, Between-Use Storage Code ,d+[DATE].12 indicated, During pauses in Food operation or dispensing, Food preparation and dispensing utensils shall be stored: (E) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour or cinnamon. 3. During an observation in the kitchen on [DATE] at 8:30 a.m. there were one large container of a sugar free vanilla flavored nutrition supplement (a calorie rich beverage) with an open date of [DATE], one large container of a no sugar added vanilla flavored nutritional supplements with an open date of [DATE] and one large container of regular vanilla flavored nutrition supplements with open date of [DATE] stored in the reach in refrigerator. During a concurrent interview and review of the manufacture's instruction for storage with cook1, the manufactures storage instructions indicated once open to use within 3 days. Cook1 stated the containers have been open more than 3 days ago and they[supplements] are expired. Cook1 stated expired nutritional supplements are not good because they are bad and should be discarded. During an interview with DS on [DATE] at 9:50 a.m., DS stated he did not know about the manufacturer's instructions for storage. DS also stated expired nutritional supplement products should not be used. A review of facility policy titled Food Storage (undated), All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen or discarded. A review of the 2022 U.S. FDA Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code #,d+[DATE].17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. 4. During an observation of the facility ice machine on [DATE] at 9:30 a.m., located in a small, locked room next to the kitchen, a clean paper towel swipe of the ice storage bin ceiling and behind the plastic covering the ice dispensing area produced a large amount of gray and orange color residue. The residue was located under the baffle (plastic board that hold the ice from falling out of the ice storage bin). The ceiling of the ice machine and where the ice is dispensed in the ice machine were covered with the gray and orange color residue. During a concurrent interview with Dietary Aide (DA 1) on [DATE] at 9:30 a.m., DA 1 stated the maintenance staff clean the ice machine. (continued on next page)

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	555849	A. Building B. Wing	03/25/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with DS on [DATE] at 10:30 a.m., DS stated the maintenance staff clean the ice machine once a month. During a concurrent review of the ice machine cleaning log on [DATE] at 10:30 a.m., DS said the last time the ice machine was cleaned was [DATE], more than one month ago. During a concurrent observation of the ice machine and interview with maintenance supervisor (MS) on [DATE] at 10:45 a.m., MS verified and stated the inside of the ice machine upper compartment was dirty and the ice not safe for consumption. MS disconnected the ice machine and discarded the ice from the ice machine. A review of facility's policy titled cleaning ice machine (undated) indicted, The ice machine will be cleaned monthly. Purpose: maintenance of the sanitary condition to prevent food contamination and the growth of disease producing organism and toxins. A review of the 2022 U.S. FDA Food Code titled Equipment Food-Contact Surfaces and Utensils Code # , d+[DATE].11, indicated, Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. 5.During an observation of the food in the resident refrigerator located in the activity/dining room on [DATE] at 9:15 a.m., there were one container of yogurt that was expired with date [DATE], one leftover food on a plate covered with a date of [DATE], a plastic container dated [DATE] that contained a muffin, blueberries, and yogurt in the refrigerator. There was also one leftover sandwich in a sandwich wraps with no label or date, one plastic bag containing fast food with no label or date stored in the refrigerator. There were two boxes of small sandwiches in the freezer with no label or date. During a concurrent interview with Activity Director (AD) on [DATE] at 9:15 a.m., AD stated the maintenance person checks the temperature of the refrigerator and freezer. AD stated when family brings food, the nurses will check the food to see if the diet is right then will label and date and store the food in the refrigerator. AD stated the food in the refrigerator is kept for three (3) days. AD said the food in the refrigerator were expired and no one had discarded them. During an interview with Director nursing (DON) on [DATE] at 10:00 a.m., DON stated when nurses receive food from family, they will date and label the food before storing them in the refrigerator. DON stated food is stored in the refrigerator for three (3) days then discarded. DON verified and stated the food in the refrigerator were stored beyond 3 days and some food did not have dates. A review of facility's policy titled Food Brought in for residents from outside sources, reviewed on [DATE] indicated, food or beverages brought in from outside will be labeled with the resident's name, room number and dated by nursing with the current date the items was brought to the facility for storage. All cooked or prepared food brought in for a resident and stored in the unit's refrigerator will be dated when accepted for storage and discarded after 24hours.

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	555849	A. Building B. Wing	03/25/2024

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 43261 Based on interview and record review, the facility failed to update the Facility Assessment (FA) annually to reflect staffing plan to meet the resident care needs by ensuring that Activity Director (AD) and Social Service Director (SSD) were included in the facility's staffing plan. This deficient practice may result in the facility failure to identify specific factors that would require a change to the assessment and had the potential to affect the resident care and decline in quality of care. Findings: During a concurrent interview and record review with the Director of Nursing (DON) on 3/25/2024 at 7:33 p.m. , FA was reviewed. FA indicated both AD and SSD were not in the staffing plan as a part of assessment. DON stated and verified missing staffing plan for AD and SSD. DON stated it is importance to have both AD and SSD staffing addressed in the FA. DON also stated FA is an overview of what resources that the facility can provide to the residents and both AD and SSD should be in the staffing plan. A review of facility's policy and procedures (P&P), titled, Facility Assessment (FA), reviewed on 2/22/2024, indicated that FA includes a detailed review of the resources available to meet the needs of the resident population. The P&P also indicated the team responsible for conducting, reviewing and updating the FA includes the following: Administrator A representative of the governing body Medical director Director of nursing services and Director or designee from the following department: (4) Social services. (5) Activity services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview, and record review, the facility failed to maintain accurate medical record in accordance with accepted professional standards and practices for eight of 16 sampled residents (Resident 1, 9, 21, 23, 24, 25, 189, and 190) by failing to ensure advance directive acknowledgment forms were easily accessible via residents' medical charts. These deficient practices had the potential to negatively impact the delivery of service given to Resident 1, 9, 21, 23, 24, 25, 189, and 190. Findings: 1. A review of Resident 1's Admission Record, indicated that Resident 1 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), urinary tract infection (UTI-infection in the urinary system [kidneys, bladder, or urethra]) and epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]). A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 3/15/2024, indicated Resident 1 has moderate impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). 2. A review of Resident 9's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition, DM, and recurrent depressive disorder (when a person has experienced depressive symptoms for most of the day, for more days than not over two years). A review of Resident 9's MDS, dated [DATE], indicated Resident 9 has severely impaired cognition for daily decision-making and requiring maximal assistance from staff for ADLs. 3. A review of Resident 21's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and difficulty in walking. A review of Resident 21's MDS, dated [DATE], indicated Resident 21 has moderately impaired cognition for daily decision-making and requiring supervision from staff for ADLs. 4. A review of Resident 23's Admission Record indicated the resident was admitted on [DATE] with diagnoses including encephalopathy, DM and dysphagia (difficulty swallowing food or liquid). (continued on next page)

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	555849	A. Building B. Wing	03/25/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 23's MDS, dated [DATE], indicated Resident 23 has moderately impaired cognition for daily decision-making and requiring maximal assistance from staff for ADLs. 5. A review of Resident 24's Admission Record indicated the resident was admitted on [DATE] with diagnoses including cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), hypertension (HTN-elevated blood pressure) and COPD. A review of Resident 24's MDS, dated [DATE], indicated Resident 24 has intact cognition for daily decision-making and requiring moderate assistance from staff for ADLs. 6. A review of Resident 25's Admission Record, indicated that Resident 25 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body) and DM. A review of Resident 25's MDS, dated [DATE], indicated Resident 25 has severely impaired cognition for daily decision-making and requiring maximal assistance from staff for ADLs. 7. A review of Resident 189's Admission Record, indicated that Resident 189 was admitted to the facility on [DATE] with diagnoses including encephalopathy, UTI and sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). A review of Resident 189's MDS, dated [DATE], indicated Resident 189 has severely impaired cognition for daily decision-making and requiring maximal assistance from staff for ADLs. 8. A review of Resident 190's Admission Record, indicated that Resident 190 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia, hemiparesis and cerebral infarction. A review of Resident 190's MDS, dated [DATE], indicated Resident 190 has intact cognition for daily decision-making and requiring maximal assistance from staff for ADLs. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 3/24/2024 at 4:14 p.m., Resident 1, 9, 21, 23, 24, 25, 189, and 190's medical charts were reviewed, indicated missing Advance Directive Acknowledgement Forms (ADAF). RN 1 stated that ADAF was supposed to be completed by the facility upon admission and be kept in resident's chart. During a concurrent interview and record review with the Social Service Director (SSD) on 3/25/2024 at 4:41 p.m., SSD provided Resident 1, 9, 21, 23, 24, 25, 189, and 190's ADAFs. SSD stated that it was all completed and was kept on her (SSD's) binder inside her office. SSD stated that she failed to ensure all ADAFs were easily accessible by not keeping a copy in residents' medical chart. During an interview with the Director of Nursing (DON) on 3/25/2024 at 7:45 p.m., DON stated that ADAF should be kept in resident's medical record for easy access when needed. A review of facility's policy and procedures (P&P), titled, Advance Directives, reviewed on 2/22/2024, P&P indicated that information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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	555849	A. Building B. Wing	03/25/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 45524 Based on interview, and record review, for two of 16 sampled residents (Residents 34 and 139), the facility failed to: 1. Implement its protocol for antibiotic (a substance used to kill bacteria and to treat infections) use. 2. Monitor actual antibiotic use by failing to initiate a surveillance log These deficient practices had the potential for Residents 34 and 139 to develop resistance (not effective to treat infection) to antibiotics from unnecessary and inappropriate antibiotic use. Findings: During a concurrent interview and record review of the antibiotic stewardship binder with the Infection Preventionist Nurse (IPN) on 3/24/24 4:10 a.m., the IPN confirmed and stated that the antibiotic surveillance log was not initiated to outline the antibiotics Residents 34 and 139 were receiving, including the dose, the frequency and how may times the residents had completed. The IPN stated that having a complete log in place was important because the log shows the trend and will also determine if the antibiotic order is not appropriate. The IPN stated staff may not know if the medication was necessary. The IPN stated the risk of not knowing the appropriateness of the ordered antibiotic had the potential for the resident to develop resistance to the antibiotic(s). During a concurrent interview and record review of the antibiotic stewardship binder with the Director of Nursing (DON) on 3/24/24 8:10 p.m., the DON confirmed and stated that there was no tracking log on file for ordered antibiotics. The DON stated not having antibiotic tracking log could result in administering unnecessary antibiotics to residents. A review of facility's policy and procedures titled Antibiotic Stewardship, revised 2/22/2024, indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The same P&P Indicated under Policy Interpretation and Implementation, indicated, if an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: a. Drug name b. Dose c. Frequency of administration d. Duration of treatment (1) Start and stop date, or (2) Number of days of therapy (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Route of administration; and f. Indications for use.

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	03/25/2024

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Vista Del Sol Care Center	11620 West Washington Blvd Los Angeles, CA 90066

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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 43261 Based on observation, interview and record review, the facility failed to ensure 10 out of 20 resident rooms met the square footage requirement of 80 square feet (sq. ft.) per resident. This deficient practice had the potential to result in inadequate useable and safe living space for the residents to move freely and for nursing staff to provide care to the residents. Findings: The facility submitted a written request for a continued room waiver on 3/24/2024. On 3/24/2024, the facility administrator (ADM) provided a copy of the Client Accommodation Analysis. A review of the Client Accommodation Analysis indicated 10 out of 20 rooms do not have at least 80 square feet per resident. The room waiver request and Client Accommodation Analysis indicated the following: Room # Beds Sq.Ft. Sq.Ft per resident 104 3 198.9 66.30 105 3 198.9 66.30 106 3 198.9 66.30 107 3 198.9 66.30 108 3 198.9 66.30 109 3 198.9 66.30 116 3 224.2 74.73 117 3 218.4 72.80 119 3 206.7 68.90 120 3 212.5 70.83 The minimum requirement for a 3-bedroom should be at least 240 sq. ft. per federal regulation. During the resident council meeting on 3/24/2024 at 11:29 a.m., the attendees did not voice any issues or concerns regarding the room size. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During multiple observations and interviews on 3/23/2024 to 3/25/2024, both residents and staff were observed and stated having enough space to move about freely inside the rooms. The nursing staff had safely provided care to the residents in the rooms with space for the beds, bedside tables, dressers, and resident care equipment. Continuance of room waiver is recommended.