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	05/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview and record review, the facility failed to ensure two of two sampled residents (Resident 2 and Resident 29) received care in a manner that maintained/enhanced dignity and respect by failing to ensure:1. Activity Assistant (AA) and Certified Nursing Assistant (CNA) 2 did not refer to Resident 2 and Resident 29, who needed assistance with meals, as Feeders (dehumanizing term for elderly individuals needing feeding assistance, can be a derogatory, objectifying term). 2. CNA 2 did not stand up when feeding Resident 29 during lunch. This failure had potential to negatively affect Resident 2 and Resident 29 sense of dignity and respect, for Resident 29 to feel rushed while eating. Findings: 1. During a review of Resident 29's admission Record, the admission record indicated the facility admitted the resident on 7/10/2025 with diagnoses that included but not limited to dysphagia (difficult swallowing), unspecified dementia (a progressive state of decline in mental abilities) and severe protein-calorie malnutrition (severe deficiency and/or poor absorption of protein, calories and nutrients) During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool) dated 3/17/2026, the MDS indicated that Resident 29 had severe cognitive (the mental ability to make decision of daily living). The MDS indicated Resident 29's needed maximum assist for activities of daily living (ADL - eating, oral hygiene, toileting, upper body assist, sitting to lying, lying to sitting), and was dependent on staff for personal hygiene, lower body dressing, putting/taking off footwear, sitting to standing and tub/shower transfer. During a review of Resident 2's admission Record, the admission record indicated the facility admitted the resident on 3/7/2026 with diagnoses that included but not limited to dementia, cerebral infarction (loss of blood flow to a part of the brain), pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and severe protein-calorie malnutrition During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 needed maximum assist with ADL, for eating and oral hygiene and was dependent on staff for toileting, upper body assist, sitting to lying, lying to sitting, personal hygiene, lower body dressing, putting/taking off footwear, sitting to standing and tub/shower transfer. During a meal observation and concurrent interview with AA on 4/28/2026 at 12:18 pm, in the dining area, Resident 29 was observed sitting on a chair while CNA 3 was standing up and assisting Resident 29 with lunch meal. AA referred and stated that Resident 29 is a feeder. During an interview on 05/01/2026 at 8:50 am, with CNA 2, CNA 2 stated that Resident 2 is a feeder and needed assistance to eat during all meals. During a concurrent interview and record review with Director of Nursing (DON) on 04/30/2026 at 9:37 am, the State Operation Manual (SOM - A Center for Medicare and Medicaid Services document that guides the assessment on compliance with federal regulations for Medicare and Medicaid-certified nursing facilities) was reviewed. DON did not answer when asked if residents should be referred as feeders After reviewing the SOM, DON stated Staff should address the residents with their name and not call them feeder/s It (feeder) can make the residents feel bad and negatively affect their dignity. During a review of the facility's policy and procedures (P&P) titled Dignity dated 11/2024, the P&P indicated, Staff shall speak respectfully to residents at all times, including addressing the resident by (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his or her name of choice and not labelling or referring to the resident by his or her room number, diagnosis or care needs. 2. During a review of Resident 29's admission Record, the admission record indicated the facility admitted the resident on 7/10/2025 with diagnoses that included but not limited to dysphagia (difficult swallowing), unspecified dementia (a progressive state of decline in mental abilities) and severe protein-calorie malnutrition. During the review of Resident 29's MDS dated [DATE], the MDS indicated Resident 29 had severe cognitive impairment. The MDS indicated Resident 29 needed maximum assist with ADL for eating, oral hygiene, toileting, upper body assist, sitting to lying, lying to sitting, and Resident 29 was dependent on staff for personal hygiene, During a meal observation and concurrent interview on 4/28/2026 at 12:18 pm, in dining area, Resident 29 was observed sitting on a chair while CNA 3 was standing up while assisting Resident 29 with eating lunch. CNA 3 stated that staff should not be standing up while assisting the residents with the meals. CNA 3 stated, It will make the residents feel bad; they won't like it. During an interview with DON on 4/30/2026 at 9:37 am, DON stated that staff must be sitting at resident's eye level when assisting residents with their meals. DON stated that feeding residents while standing up can affect resident's dignity negatively. During a review of the facility's policy and procedures (P&P) titled Dignity dated 11/2024, the P&P indicated, Resident will be assisted in maintaining and enhancing his or her self-esteem and self - worth.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, facility failed to promptly notify the physician and a resident representative when one of one sampled resident (Residents 2) had a change in condition (COC - a clinical document used to record, assess, and report any sudden changes in a resident's physical, mental, or psychological status in order to ensure appropriate medical treatment can be started safely) evidenced by:1. When Resident 2 experienced six 6 pounds (lbs-unit of measurement) in 3/2026.weight loss2. When Resident 2 developed a pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) This deficient practiced violated the rights of Resident 2 and the resident's representative and had the potential to delay the necessary/essential treatment and medical care and for Resident 2. Findings: During a review of Resident 2's admission Record, the admission record indicated the facility admitted the resident on 3/7/2026 with diagnoses that included but not limited to dementia, cerebral infarction (loss of blood flow to a part of the brain), pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and severe protein-calorie malnutrition (severe deficiency and/or poor absorption of protein, calories and nutrients). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/7/2026, the MDS indicated Resident 2 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 2 needed maximum assistance with activities of daily living (ADL), for eating and oral hygiene and was dependent on staff for toileting, upper body assist, sitting to lying, lying to sitting, personal hygiene, lower body dressing, putting/taking off footwear, sitting to standing and tub/shower transfer. During a concurrent telephone interview and record review on 04/30/2026 at 11:05 am, with Registered Dietician (RD). Resident 2's weights and Vitals Summary record was reviewed from 10/2025 to 4/2026. The monthly weight record indicated the following weights for Resident 2:On 10/10/2026 Resident 2 weighed 122 pounds (lbs - unit of measurement)On 11/25/2025 Resident 2 weighed 104 lbs. Resident 2 lost 18 lbs - 14.75 percent (% - unit of measurement) weight loss in a month. On 12/5/2025 Resident 2 weighed 104 lbsOn 1/13/2026 Resident 2 weighed 112 lbsOn 2/20/2026 Resident 2 weighed 106 lbs. Resident 2 lost 6 lbs (5.35 perecnt [%]) weight loss in a month. On 3/31/2026 Resident 2 weighed 113 lbs During the same interview and record review, RD stated and confirmed that the facility did not inform resident's family in 2/2026 when the resident lost 6 lbs (5.35%) in a month of weight. RD stated, Not notifying family can negatively affect resident coz if family know they can bring food or encourage resident to eat. Family won't be happy when not notified. It will make resident feel upset/sad. RD stated and confirmed that the facility did not inform resident's physician in 2/2026 when the resident lost 6 lbs (5.35% in a month) of weight. RD stated, Not notifying physician can affect the resident negatively. Resident can continue to lose weight and the resident's health can decline further which can lead to hospitalization, and even potentially death. During a concurrent interview and record review with Infection Preventionist/Treatment Nurse (IP/TP) on 04/30/2026 at 8:14 am, reviewed Resident 2's Skin Assessment document from 7/2025 to 4/2026. IP/TP verified following skin assessments:1. Resident 2 developed a pressure injury on 7/22/2025. Resident 2's mid-back pressure injury progressed to stage - 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). Measurement: 4.6 x 4.1 x 0.5 cm. No undermining (the destruction of tissue or ulcer extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface) or tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) was noted. 2. Resident 2 developed Sacrococcyx (very bottom area of the spine) pressure injury on 08/03/2025, with presence of foul odor. Pressure injury - unstageable (a severe pressure injury where the true depth and damage cannot be seen because the wound base is completely covered with dead tissue). Measurement: 6.2 x 9.5 cm. No undermining or tunneling was noted.During the same interview (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and record review, IP/TP agreed and verified that the family was not notified of the change in resident's pressure injury. IP/TP stated, Not notifying family, resident can feel ignored. Family can feel resident is being ignored.During an interview on 4/30/2026 at 2:26 pm with Director of Nursing (DON), DON stated, Not informing a family member/representative regarding resident's change of condition, can make them (family) feel bad and they will think that they are being ignored (by facility). During a review of the facility's policy and procedures (P&P) titled, Change of Condition revised on 12/2025, P&P indicated, The facility notifies the physician and resident representative of a significant change in resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). During a review of the facility's P&P titled, Physician Notification revised on 12/2025, P&P indicated, The facility notifies the physician and resident representative of a significant change in resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, and interview, the facility failed to ensure a comfortable, homelike environment for one out of five residents sampled (Resident 20). This failure resulted in Resident 20 not being unable to concentrate, rest, or sleep due to the continuous loud noises and conversations outside of the resident's door. Resident 20 was not allowed to close the door to reduce the noise level. Findings: A review of Resident 20's admission record, indicated the facility initially admitted Resident 20 on 3/25/2026 with diagnoses of, but not limited to, hypertension (high blood pressure), heart failure (a condition where the heart muscles become too weak to pump blood efficiently throughout the body), and hyperlipidemia (a condition of having too many fats in the blood), A review of Resident 20's minimum data set (MDS- a resident assessment tool), dated 4/6/2026, indicated Resident 20's cognitive function (the mental ability to make decisions of daily living) was moderately impaired (able to make minor decisions concerning care, alert to situation and oriented to place and time). During a concurrent observation and interview on 4/28/2026 at 8:53 am, Resident 20's room was open. During an interview, Resident 20 stated that he is not able to think or concentrate during the day or the night because of the excessive noise coming from the hallway of the facility. Resident 20 stated he asked the facility staff on several occasions to close the door to his room so that he could have some peace of mind and rest. However, the facility staff told him that the door to his room could not be closed due to the facility's policy. While inside Resident 20's room, the writer heard loud and constant noise/activity from facility staff and visitors coming from the hallway just outside the resident's room. During observation with the resident's door temporarily closed, the noise level was considerably lower to nearly silent and Resident 20 stated the noise level was acceptable with the door closed. During an interview on 4/30/2026 at 9:19 AM, Certified Nursing Assistant (CNA) 5 stated that if a resident requested to have the room door closed, CNA 5 would clear the request with the charge nurse prior to closing the door for resident safety. However, CNA 5 stated that she would not close the door upon a resident's request because of resident safety. During an interview on 4/30/2026 at 10:16 am LVN 4 stated a resident cannot close the door to his or her room because of resident safety. LVN 4 stated if the door to the resident's room is closed staff cannot observe the residents. During an interview on 4/30/2026 at 10:23 am, Registered Nurse Supervisor (RNS) 1 stated due to the fact that there is another roommate the door to a resident's room cannot be closed. RNS 1 stated that the door can be closed, depending on the circumstance if there is a single person/resident in the room. RNS 1 stated she would check with the resident's roommate if the residents are alert and oriented to see if they (residents) agree to close the door. However, RNS 1 stated that she would not be able to close the door all the way. During an interview on 04/30/2026 10:29 am, Director of Nursing (DON) stated, if a resident was in a single room and the resident asks to close the door, I would be able to close the door partially, but not all the way. DON stated that if a resident has a roommate, the staff cannot close the door all the way if the resident asks to have the door closed due to noise. The DON stated per her nursing judgment, it would be best not to close the door to the resident's room for resident safety. During a review of the facilities policy titled Safe Environment with revision date: January 2025 indicated:Policy Statement:The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely.Definitions:Comfortable Sound Levels: do not interfere with resident's hearing and enhance privacy when privacy is desired and encouraged interaction when social participation is desired. Of particular concern to comfortable sound levels is the residents' control over unwanted noise.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) related to Pre -admission Screening and Resident Review (PASRR -a safety check done before someone enters a Medicaid-certified nursing home to ensure the facility can meet their specific needs, or if they would be better served in the community) was accurately documented [NAME] to the facility's policy and procedure (P&P) titled Accuracy of Assessments, dated 1/2025 for one of six sampled residents (Resident 42). This deficient practice had the potential to negatively affect Resident 42's plan of care and delivery of necessary care and services. A review of Resident 42's admission Record indicated the facility admitted Resident 42 on 4/24/2022, and readmitted resident 42 on 12/28/2025 with diagnoses including major depressive disorder (a serious mental health condition characterized by a persistent low mood, deep sadness, or a loss of interest in activities), Bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 42's Minimum Data Set (MDS - resident assessment tool) dated 5/9/2025, indicated Resident 42 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 42 required substantial/maximal to setup/clean up assistance from staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. The MDS further indicated that .is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? . 0, No. A review of Resident 42's PASRR dated 6/8/2024 indicated .results of level I screening: Level I -positive . reason code: Suspected mental illness.A review of Resident 42's Health and Physical exam (a comprehensive health exam of a patient) dated, 7/30/2025 indicated . diagnosis of bipolar and schizophrenia. During a concurrent interview and record review on 5/1/2026, at 11:41 A.M., with the minimum data set (MDS) nurse, Resident 42's MDS assessment dated [DATE] section A, PASRR dated 6/8/2024 and H&P dated 7/30/2025, were reviewed. MDS Nurse stated the MDS section A indicated that Resident 42 had no mental illness, however, the PASRR level I assessment dated [DATE] indicated that resident 42 was positive for mental illness. MDS nurse stated that MDS assessments need to be accurate to ensure that a good impression of the type of care that the residents require is being portrayed. MDS nurse stated that the MDS was inaccurate because it indicated that resident did not have mental illness when however, resident had a diagnosis of major depressive disorder and schizophrenia. During an interview on 5/1/2026, at 12:37 P.M., with the Director of nursing (DON), the DON stated that the MDS assessment is a comprehensive assessment which includes all the interdisciplinary team's input to set the residents individualized care plan and interventions. The DON nurse stated that the MDS needs to be accurate so the facility staff can give the resident the right individual interventions and ensure that the is collaboration between the facility and the Center for Medicaid/Medicare (CMS). The DON stated if the MDS is inaccurate, the resident may not get the proper interventions they need and wrong information being sent to CMS. A review of the facility's P&P, titled, Accuracy of Assessments, revised 1/2025, indicated,Policy Statements:The MDS assessment must accurately reflect the residents' status including: .Intent:To ensure each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.Definition:Accuracy of Assessment: The appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional abilities, and psychosocial status using the RAI.GUID ELINESFacilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.5. The assessment must represent an accurate picture of the residents' status during the observation period of the MOS.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for one of five sampled residents (Resident 8), the facility failed to:1.Complete the Preadmission Screening and Resident Review (PASRR - a screening evaluation used to determine whether placement in a long-term care facility is appropriate for the resident) Level I (a tool that helps identify possible serious mental illness and/or intellectual/development disability) assessment when Resident 8's re-admitted to the facility on [DATE].2. Notify the mental health authority promptly after admitting Resident 8 to the facility on 1/26/2026 with diagnoses of schizoaffective disorder with bipolar type (a rare type of mental illness that has symptoms of both schizophrenia [a serious mental illness characterized by disturbances in thought] and symptoms of bipolar [extreme highs-mania and severe lows-depression]), generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday things-such as health, finances, or family-lasting for at least six months), and Down syndrome (a genetic condition occurring when a person is born with an extra copy of chromosome (genes- which are instructions that determine physical traits and guide growth) 21, resulting in 47 chromosomes instead of the usual 46). These deficient practices of failing to complete PASRR Level I assessment and notify the mental health authority promptly related to the diagnoses of schizoaffective disorder with bipolar type, generalized anxiety disorder, and Down syndrome, placed Resident 8 at increased risk of not identifying possible serious mental illness and not provide interventions tailored to Resident 8's specific nursing care and needs. Findings: During a review of Resident 's face sheet (admission Record - a document containing demographic and diagnostic information) indicated, Resident 8 was admitted to the facility on [DATE], and was re-admitted on [DATE] and again on 1/26/2026 with the following medical diagnoses: schizoaffective disorder with bipolar type, generalized anxiety disorder, and Down syndrome. During a review of Resident 8's History and Physical (H&P - a physician's complete patient examination) dated 1/28/2026, indicated, Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set, (MDS - a resident assessment tool) dated 2/04/2026, indicated, Resident 8 had moderately impaired cognition (make poor decisions, cues and supervisions required). During a review of Resident 8's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on using psychotropic medication, Risperdal (risperidone - use to treat symptoms of bipolar disorder and schizophrenia) for schizophrenia, with a initiation date of 2/21/2026, indicated, Resident 8's CP goal indicated Resident 8 will be free from drug related complications including movement disorder (conditions that causes either increase movements or reduced or slow movements), discomfort, hypotension (low blood pressure), gait (walk) disturbance, constipation, or cognitive (thinking, remembering, judging and problem solving)/behavioral (actions, reactions, or functioning, often in response to social, psychological, or environmental stimuli) impairment. The CP intervention included to monitor and document for side effects and effectiveness. During an interview on 5/01/2026 at 2:32 PM with the MDS Coordinator (MDS - a licensed nurse who is adequately assessing nursing home residents' needs and coordinating personalized, resident-driven care based on those assessments), MDS stated when Resident 8's PASARR Level 1 was not completed when Resident 8 was admitted to the facility. MDS Coordinator stated that Resident 8 might not get the medical treatment [Resident 8] needs. MDS Coordinator stated that the Director of Nursing (DON) and MDS Coordinator share the responsibility in ensuring PASARR Level I is completed during a resident's of admission at the facility. During an interview on 5/01/2026 at 2:43 PM with the DON, DON stated that Resident 8's medical diagnoses and intellectual development (ID /or cognitive development - refers to the growth of a a person's ability to think, reason, and understand the world) would quality for a PASARR Level I screening. During a review of the facility's policy and procedures (P&P - explains the rules and presents them in a logical framework while procedures outline the (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	step-by-step implementation of various tasks) titled Preadmission Screening and Resident Review (PASARR) with a revision date of 1/2025, indicated, PASARR process requires all applicants to Medicaid-certified nursing facilities be screened for possible serious mental d/o, intellectual disabilities, and related conditions; referred to Level I identification completed prior to admission to a nursing facility and if the facility identifies the admitting agency did not complete the Level I screen, facility staff will immediately initiate the screen.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop/initiate a comprehensive care plan for constipation within seven days of admission on e of four residents (Resident 49) who was receiving medications for constipation (having fewer than three bowel movements per week, characterized by hard, dry, or lumpy stools that are difficult or painful to pass). This deficiency had the potential for the facility to not meet the needs and necessary services for Resident 49 and also the potential for hospitalization. Findings: During a review of Resident 49's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 49 was admitted to the facility on [DATE] with the following diagnoses: acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral (acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral), difficulty in walking, essential (primary) hypertension (high blood pressure), heart failure (when heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), hyperlipidemia (high cholesterol [fat] in the body), moderate protein-calorie malnutrition (not enough protein [animal and plant foods] and calories [energy from food] consumed into the body), neuralgia and neuritis (Neuralgia - is intense, shock-like nerve pain), pain in left knee and unspecified atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 49's Physician Order Summary Report (a condensed, organized document summarizing a patient's key medical information, including diagnoses, treatments, current medications, test results, and follow-up instructions) dated 2/06/2026, the Report indicated medication orders as follows:Famotidine 40 milligrams (mg-unit dose measurement) tablet, give one tablet by mouth one time a day for gastroesophageal reflux disease (GERD - a condition where stomach acid frequently flows back into the esophagus, irritating its lining) to relieve heartburn. Docusate Sodium 100 mg tablet to give one tablet by mouth one time a day for bowel movement and to hold if diarrhea given as a stool softenerPolyethylene glycol powder 1 packet by mouth every 24 hours as needed for constipation. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/09/2026, indicated, Resident 49 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS also indicated that Resident 49 used mobility devices (helps a person walk or move from place to place when one has a disability or injury) such as walker and a wheelchair to get around. During a review of Resident 49's history and physical (H&P - a physician's complete patient examination) dated 2/27/2026 indicated, Resident 49 had the capacity to understand and make decisions. During a review of Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 4/10/2026 at 1:18 AM, indicated Resident 49 refused to take medications for bowel management, and to drink water. During a review of Resident 49's care plans (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), there was no care plan for constipation for Resident 49. During a concurrent interview and record review on 4/30/2026 at 3:07 PM with licensed vocational nurse (LVN) 5,Resident 49's medical chart was reviewed. LVN 5 stated and confirmed that there was no care plan for Resident 49's constipation. LVN 5 stated, I don't know why did not write a care plan for (Resident 49's) constipation. LVN 5 also stated, it's no good to not have bowel movement.[Resident 49] will have abdominal pain, bowel obstruction, and it's not good if [Resident 49] don't go to the bathroom. During a concurrent interview and record review on 5/01/2026 at 1:38 PM with the Registered Nurse Supervisor (RNS) 1, Resident 49's medical chart was reviewed. RNS 1 stated and confirmed that there was no care plan for Resident 49's constipation. When asked the potential harm to Resident 49 when a care plan for constipation was not written, RNS 1 stated we failed to address her problems, her needs. During a review of the facility's policy and procedures (P&P - policy explains the rules and (continued on next page)

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	555849	A. Building B. Wing	05/01/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Develop-Implement Comprehensive Care Plans with a revision date of 1/2025 indicated that the care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences. During a review of the facility's P&P titled admission of a Resident with a revision date of 1/2025 indicated, care plans should be started on admission. During a review of the facility's P&P titled Comprehensive Care Plans-Timing with a revision date of 1/2025 indicated, each resident has a comprehensive care plan developed within seven days after completion of the comprehensive assessment and comprehensive care plan must be completed.no more than 21 days after admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, facility failed to develop and implement a care plan for weight loss for two of two sampled residents (Resident 2 and Resident 49) according to the facility's policy and procedures (P&P) titled Develop-Implement Comprehensive Care Plans dated 1/2026.This deficient practice had potential to failure in the delivery of necessary care and services for Resident 2 and Resident 49. Findings: 1.During a review of Resident 2's admission Record, the admission record indicated the facility admitted the resident on 3/7/2026 with diagnoses that included but not limited to dementia (a decline in cognitive function—including memory, language, and problem-solving—severe enough to interfere with daily life), cerebral infarction (stroke-loss of blood flow to a part of the brain), pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and severe protein-calorie malnutrition (severe deficiency and/or poor absorption of protein, calories and nutrients) During a review of Resident 2's Minimum Data Set (MDS – a resident assessment tool) dated 3/7/2026, the MDS indicated Resident 2 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 2 needed maximum assistance with activities of daily living (ADL) for eating and oral hygiene and was dependent on staff for toileting, upper body assistance, sitting to lying, lying to sitting, personal hygiene, lower body dressing, putting/taking off footwear, sitting to standing and tub/shower transfer. During a concurrent telephone interview and record review on 04/30/2026 at 11:05 am, with Registered Dietician (RD), Resident 2's care plan on weight loss initiated on 2/13/2026 and the Weights and Vitals Summary, dietician notes, care plan, nurses progress notes and record from 10/2025 to 4/2026 were reviewed. A care plan was not developed in 11/2025 after Resident 2 lost 18 pounds (lbs – unit of measurement) of weight. A care plan was developed in 2/2026 for weight loss but not implemented. The care plan interventions included to monitor Resident 2's weight weekly with a target date of 5/24/2026. The monthly weight record indicated the facility weighed Resident 2 monthly. However, the facility did not weigh Resident 2 weekly from 2/13/2026 to 4/30/2026 as per the care plan. The monthly weights and Vitals Summary record indicated the following weights for Resident 2: On 10/10/2026 Resident 2 weighed 122 pounds On 11/25/2025 Resident 2 weighed 104 lbs. Resident 2 lost 18 lbs. On 12/5/2025 Resident 2 weighed 104 lbs On 1/13/2026 Resident 2 weighed 112 lbs On 2/20/2026 Resident 2 weighed 106 lbs. Resident 2 lost 6 lbs. On 3/31/2026 Resident weighed 113 lbs.During the same interview and record review, RD stated and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed there was no care plan initiated or implemented for Resident 2's weight loss. RD stated Resident 2 had 14.75 percent (% - unit of measurement) weight loss. RD stated by there was no care plan initiated for Resident 2 for weight loss and not initiating a care plan, can affect the resident negatively. Resident can continue to lose weight and the resident's health can decline further which can lead to hospitalization, and even potentially death. During an interview on 4/30/2026 at 2:26 pm with Director of Nursing (DON), DON stated that no care plan initiated and implemented upon significant weight loss can affect resident's health negatively. DON stated that considering Resident 2's comorbidities (resident with 2 or more illness at the same time), resident's health can further decline which can lead to more pressure ulcers, hospitalization and even lead to death. During a review of the facility's policy and procedures (P&P) titled Weight Management dated 12/2024, the P&P indicated, the weight management committee will review and update the resident's care plan as indicated. During a review of the facility's P&P titled Develop-Implement Comprehensive Care Plans dated 1/2026, the P&P indicated, Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. 2. During a review of Resident 49's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 49 was admitted to the facility on [DATE] with the following diagnoses: acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral (acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral), difficulty in walking, essential (primary) hypertension (abnormally high blood pressure not caused by a medical condition), heart failure (when heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), hyperlipidemia (high cholesterol [fat] in the body), moderate protein-calorie malnutrition (not enough protein [animal and plant foods] and calories [energy from food] consumed into the body), neuralgia and neuritis (Neuralgia is intense, shock-like nerve pain. Neuritis is the actual inflammation of a nerve), pain in left knee and unspecified atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 49's Physician Order Summary Report (a condensed, organized document summarizing a patient's key medical information, including diagnoses, treatments, current medications, test results, and follow-up instructions) dated 2/06/2026 was reviewed. The physician order summary report indicated Resident 49 was receiving the following medications: Famotidine 40 milligrams (mg- unit dose measurement) mg tablet to give one tablet by mouth one time a day for gastroesophageal reflux disease (GERD - a condition where stomach acid frequently flows back into the esophagus, irritating its lining). Docusate sodium 100 mg tablet to give one tablet by mouth one time a day for bowel movement and to hold if diarrhea given as a stool softener. Polyethylene glycol powder 1 packet by mouth every 24 hours as needed for constipation. During a review of Resident 49's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 2/09/2026, indicated, Resident 49 was cognitively intact (a person's thinking (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reasoning abilities are functioning properly and are not significantly impaired). The MDS also indicated that Resident 49 used mobility devices (helps a person walk or move from place to place when one has a disability or injury) such as walker and a wheelchair to get around. During a review of Resident 49's history and physical (H&P – a physician's complete patient examination) dated 2/27/2026 indicated, Resident 49 had the capacity to understand and make decisions. During a review of Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 4/10/2026 at 1:18 AM, Resident 49 refused to take medications for bowel management, and to drink water. During a review of Resident 49's care plans (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), there was no care plan for constipation for Resident 49. During a concurrent interview and record review on 4/30/2026 at 3:07 PM with licensed vocational nurse (LVN) 5, Resident 49's medical chart was reviewed. LVN 5 stated and confirmed there was no care plan for Resident 49's constipation. LVN 5 stated, I don't know why i did not write a care plan for (Resident 49's) constipation. LVN 5 also stated it's no good to not have bowel movement.[Resident 49] will have abdominal pain, bowel obstruction, and it's not good if [Resident 49] don't go to the bathroom. During a concurrent interview and record review on 5/01/2026 at 1:38 PM with the Registered Nurse Supervisor (RNS) 1, Resident 49's medical chart was reviewed. RNS 1 stated and confirmed there was no care plan for Resident 49's constipation. When asked the potential harm to Resident 49 when a care plan for constipation was not written, RNS 1 stated, we failed to address her problems, her needs. During a review of the facility's policy and procedures (P&P – policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Develop-Implement Comprehensive Care Plans with a revision date of 1/2025 indicated that, the care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences. During a review of the facility's P&P titled admission of a Resident with a revision date of 1/2025 indicated, care plans should be started on admission. During a review of the facility's P&P titled Comprehensive Care Plans-Timing with a revision date of 1/2025 indicated, each resident has a comprehensive care plan developed within seven days after completion of the comprehensive assessment and comprehensive care plan must be completed.no more than 21 days after admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to initiate/develop a comprehensive care plan within seven days after re-admission for one of four residents (Resident 25) who was on oxygen therapy. This deficiency had the potential for Resident 25 to experience undesired health effects related to the administration of oxygen not limited to hypoxia (a dangerous medical condition where body tissues or organs do not receive enough oxygen, potentially causing severe damage or death within minutes), hospitalization and death. Findings: During a review of Resident 25's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 25 was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses: acute kidney failure), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition marked by a lack of healthy red blood cells or hemoglobin, reducing oxygen flow to body organs, which causes fatigue, weakness, pale skin, and shortness of breath), acute metabolic acidosis (a serious condition characterized by an excess of acid in the blood often caused by kidney failure, severe diarrhea, or uncontrolled diabetes), unspecified dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), heart failure unspecified (when heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), presence of cardiac and vascular implant and graft (cardiac implants refer to devices placed inside the heart or chest to regulate or support heart function, while cardiac grafts are blood vessels used to bypass blocked arteries or vein), muscle weakness, and dependence on supplemental oxygen (a)medical treatment providing extra oxygen to people whose blood oxygen levels are too low). During a review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) sign-in sheet dated 2/24/2026 indicated, facility staff were educated on management of resident with respiratory symptoms. During a review of Resident 25's history and physical (H&P - a physician's complete patient examination) dated 2/27/2026 indicated, Resident 25 had the capacity to understand and make decisions. During a review of Resident 25's Physician Order Summary Report (a condensed, organized document summarizing a patient's key medical information, including diagnoses, treatments, current medications, test results, and follow-up instructions), the Report did not indicate an order for supplemental oxygen after Resident 25 was re-admitted to the facility on [DATE]. During a review of Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 4/08/2026 at 11:22 PM, indicated Resident 25 was on 3 liter per minute (LPM - unit of measurement) of oxygen via nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen directly into a patient's nostrils). During a review of Nursing Progress Notes dated 4/10/2026 at 1:18 AM, Resident 25 was on 2 LPM of oxygen via nasal cannula. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 4/13/2026, indicated, Resident 25 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS also indicated that Resident 25 was on continuous oxygen therapy while a resident at the facility. The MDS also indicated that Resident 25 used mobility devices (helps a person walk or move from place to place when one has a disability or injury) such as walker and a wheelchair to get around. The MDS also indicated that Resident 25 needed moderate to maximal assistance with toileting hygiene (maintaining cleanliness before and after using the toilet) due to muscle weakness. During a review of Resident 25's physician progress notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 4/16/2026 indicated, Resident 25 was improving with current treatment of supplemental (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen at 2.5 Liters per minute (LPM - oxygen flow rates are measured in LPM, determining how much supplemental oxygen a device delivers to a patient). During a review of Resident 25's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), there was no care plan on providing supplemental oxygen to Resident 25. During an observation on 4/28/2026 at 8:58 AM with Resident 25, Resident 25 was receiving supplemental oxygen at 3 LPM per nasal cannula. During a concurrent observation, interview, and record review on 4/28/2026 at 11:34 AM with a licensed vocational nurse (LVN) 1, Resident 25 was observed in the room receiving 3 LPM of supplemental oxygen via a nasal cannula. LVN 1 reviewed physician's order for supplemental oxygen after Resident 25's readmission on [DATE], LVN 1 stated there is no order. LVN 1 stated I did not check [Resident 25's] oxygen saturation (measures the percentage of oxygen-carrying hemoglobin in the blood) this morning. LVN 1 stated oxygen is a medication and that LVN 1 did not check a physician's order for providing supplemental oxygen to Resident 25. LVN 1 stated LVN 1 assumed there was an order from a physician. LVN 1 also stated Resident 25 may become over oxygenated (occurs when tissues and organs are exposed to an excess supply of oxygen, usually from supplemental oxygen, hyperbaric therapy, or ventilators, leading to oxygen toxicity) and may have an altered mental status (AMS - a broad, non-specific term describing a change in a person's baseline awareness, cognition, or consciousness). During a concurrent observation, interview and record review on 4/28/2026 at 12:22 PM with a Respiratory Therapist (RT), Resident 25 was observed in the room receiving 3 LPM of supplemental oxygen via a nasal cannula. RT stated there is no order anywhere for supplemental oxygen after reviewing Resident 25's Physician Orders. RT stated I didn't read the doctor's order because it's a repeat every day. I thought it's there again today. When asked what is wrong with giving Resident 25 supplemental oxygen without a doctor's order, RT replied maybe it might kill her. During an interview on 4/28/2026 at 12:35 PM with the Registered Nurse Supervisor (RNS) 1, RNS 1 stated, if there is no order [for supplemental oxygen from a physician], you are not following the protocol of the order. During a concurrent interview and record review on 4/28/2026 at 12:47 PM with MDS, MDS stated, I am sure I saw it. I might have found it somewhere. There is probably an order when asked if there was a physician order for supplemental oxygen for Resident 25. After reviewing the Physician's Order with MDS for supplemental oxygen, MDS stated I can't find any orders here. MDS stated that the staff did not obtain an order from the physician. The physician will determine the right amount of oxygen to give. We (staff) have to do our care within our scope of practice. During a review of Nursing Progress Notes dated 4/29/2026 at 7:22 AM, Resident 25 was on 3.5 LPM of oxygen via nasal cannula. During a concurrent interview and record review on 5/01/2026 at 12:58 PM with LVN 1, LVN 1 stated, there was no care plan for O2 administration. When asked why LVN 1 did not initiate a care plan for O2 administration, LVN 1 stated I was not aware that there is no order for an O2. LVN 1 stated when a care plan was not created, Resident 25 could die, improper administration, becomes hypoxic (a dangerous medical condition where body tissues or organs do not receive enough oxygen, potentially causing severe damage or death within minutes) quickly. During a concurrent interview and record review on 5/01/2026 at 1:19 PM with RNS 1, RNS 1 stated as one of the RNS, I will do the initial care plan. RNS 1 stated without a care plan for O2 administration, staff may not meeting [Resident 25's] needs, we neglect the patient. I would say we failed to give the proper treatment.may lead to distress. During a review of the facility's policy and procedures (P&P - explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Develop-Implement Comprehensive Care Plans with a revision date of 1/2025 indicated that, the care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences. During a review of the facility's P&P titled admission of a Resident with a revision date of 1/2025 indicated, care plans should be started on admission. During a review of the facility's P&P titled Comprehensive Care Plans-Timing with a revision date of 1/2025 indicated, each resident has a comprehensive care plan developed within seven days after completion of the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive assessment and comprehensive care plan must be completed.no more than 21 days after admission. During a review of the facility's P&P titled Physician Medication Orders with a revision date of 1/2025 indicated, medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure a change in condition (COC - a clinical document used to record, assess, and report any sudden changes in a resident's physical, mental, or psychological status in order to ensure appropriate medical treatment can be started safely) assessment was completed and appropriate interventions implemented for one of one sampled resident (Resident 2) who had diagnosis of severe protein-calorie malnutrition (severe deficiency and/or poor absorption of protein, calories and nutrients) when Resident2 experienced 5.35 percent (% - unit of measurement) weight loss in a month. This deficient practice had potential to failure in the delivery of necessary care and services for Resident 2's highest practicable physical well-being. Findings: During a review of Resident 2's admission Record, the admission record indicated the facility admitted the resident on 3/7/2026 with diagnoses that included but not limited to dementia, cerebral infarction (loss of blood flow to a part of the brain), pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and severe protein-calorie malnutrition (severe deficiency and/or poor absorption of protein, calories and nutrients). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/7/2026, the MDS indicated Resident 2 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 2 needed maximum staff assistance with activities of daily living (ADL), for eating/drinking and oral hygiene and was dependent on staff for toileting, upper body assist, sitting to lying, lying to sitting, personal hygiene, lower body dressing, putting/taking off footwear, sitting to standing and tub/shower transfer. During a concurrent telephone interview and record review on 4/30/2026 at 11:05 am, with Registered Dietician (RD). Resident 2's weights and Vitals Summary was reviewed from 10/2025 to 4/2026. The monthly weight record indicated the following weights for Resident 2:On 10/10/2025 Resident 2 weighed 122 pounds (lbs - unit of measurement)On 11/25/2025 Resident 2 weighed 104 lbs. Resident 2 lost 18 lbs - 14.75 percent weight loss in a month. On 12/5/2025 Resident 2 weighed 104 lbsOn 1/13/2026 Resident 2 weighed 112 lbsOn 2/20/2026 Resident 2 weighed 106 lbs. Resident 2 lost 6 lbs (5.35 percent (%-unit of measurement) weight loss. On 3/31/2026 Resident weighed 113 lbs. During the same interview and record, RD stated and confirmed that the facility did not initiate a COC in 2/2026 when Resident 2 lost 6 lbs (5.35% in a month). RD stated not initiating a COC, can affect the resident negatively. Resident can continue to lose weight and the resident's health can decline further which can lead to hospitalization, and even potentially death. During an interview on 04/30/2026 at 2:26 pm with Director of Nursing (DON), DON stated that the facility did not initiate a COC when Resident 2 experienced significant weight loss. DON stated that weight loss can affect a resident's health negatively. DON stated that considering Resident 2's comorbidities (resident with 2 or more illness at the same time), resident's health can further decline which can lead to more pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence), hospitalization and even lead to death. During a review of the facility's policy and procedures (P&P) titled, RD Assessment revised on 12/2025, P&P indicated that, unplanned weight loss greater than 5% in a month is severe weight loss. During a review of the facility's P&P titled, Change of Condition revised on 12/2025, P&P indicated that, There is need to alter treatment significantly and notifies the physician and resident representative for any significant change in resident's physical, mental or psychosocial status.

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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. Based on interview and record review, the facility failed to ensure that low air loss mattress (LAL -a medical-grade mattress that prevents and treats pressure ulcers [bedsores] by constantly blowing air through tiny holes in the fabric, keeping the patient's skin cool and dry) guidelines were adhered to for maximal effectiveness of the LAL mattress and resident comfort in accordance with the facility's policy and procedures (P&P) titled Low Air Loss Mattress revision date 11/2024, for one of one sampled residents (Resident 7). This deficient practice had the potential to significantly compromise Resident 7's safety, leading to serious skin breakdown, infection, increased discomfort and possibly hospitalization. Findings: A review of Resident 7's admission Record indicated the facility admitted Resident 7 on 10/7/2025 with diagnoses including pressure ulcer (PU - localized damage to the skin and/or underlying tissue usually over a bony prominence) of sacral (a large, triangular-shaped bone at the very base of your spine) region, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), and protein-calorie malnutrition (a serious condition where the body does not get enough protein, calories, or nutrients, causing it to break down its own tissues for energy). A review of the physician order dated 2/24/2026, indicated check for LAL mattress for wound management .settings are based on residents' weight. A review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2026, indicated Resident 7 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 7 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. MDS further indicated that Resident 7 has one unstageable PU. During an observation on 4/28/2026, at 7:24 A.M., in Resident 7's room, LAL mattress setting indicated 320 pounds (lbs -unit of measure), the label on the LAL mattress pump indicated that resident 7 as of 4/17/26 is 89 lbs. During a concurrent observation and interview, on 4/28/2026, at 7:39 A.M., with Treatment Nurse (TN), in Resident 7's room, the LAL mattress was set at 320 lbs. The TN stated that Resident 7's has a sacral coccyx pressure ulcer and that the LAL should be set at 89lbs based on resident current weight but is currently set at 320lbs. The TN stated that having the resident on a LAL mattress is to prevent friction, which can cause the wound to get bigger and may not be beneficial to the resident causing the wound to get bigger. The TN stated that the resident LAL mattress should be soft and fluffy, and setting of 320 will cause it to be dense and hard. During an interview, on 5/1/2026, at 12:43 P.M., with the Director of Nursing (DON), the DON stated that LAL mattress is set to the resident's current weight to ensure the effectiveness of the LAL mattress. The DON stated that having the LAL mattress settings on a higher than the required setting may lead to worsening of the wound, delaying the resident wound healing and ultimately adversely affection the psychosocial wellbeing of the resident. A review of the facility's P&P, titled, Low Air Loss Mattress revision date 11/2025, indicated,POLICY STATEMENTThe facility has guidelines to provide residents with a low air loss mattress to reduce skin irritation and breakdown; and to allow maximal effectiveness of the low air loss mattress when a physician orders such therapy.PURPOSETo provide staff with guidelines for residents with low air loss mattresses for maximal effectiveness of the air mattress, and patient comfort.GUIDELINES.12. For maintenance, cleaning, settings and care, the facility shall follow the manufacturers' guidelines. A review of the Operators Manual, Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System, undated, indicated,.Operating Instructions.Step 6Determine the patient's weight and set the control knob to that weight setting on the control unit.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Implement the recommendations of the facility's Registered Dietician (RD - a food and nutrition expert who has completed extensive training to help people manage their health through eating)according to the facility's policy and procedures (P&P) titled Assisted Nutrition and Hydration, dated 1/2025 when Registered Dieticians (RD - a food and nutrition expert who has completed extensive training to help people manage their health through eating) for one of three sampled residents (Resident 7).This deficient practice had the potential to cause worsening weigh loss and possibly hospitalization for Resident 7.2. Ensure that staff changed enteral feeding formula (a method of delivering liquid nutrition directly into the stomach or small intestine when a person cannot eat or swallow safely) and the enteral feed tubing (a flexible tube for delivering nutrient-rich liquid formula directly into the stomach or small intestine) after 24 hours for one of one sampled resident (Resident 38) according to the facility's policy and procedures (P&P) titled the facility's P&P titled, Care Plan revised 12/2025.This deficient practice had potential for Resident 38 to suffer abdominal discomfort and infection. Findings: 1.A review of Resident 7's admission Record indicated the facility admitted Resident 7 on 10/7/2025 with diagnoses including pressure ulcer (PU - localized damage to the skin and/or underlying tissue usually over a bony prominence) of sacral (a large, triangular-shaped bone at the very base of your spine) region, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), and protein-calorie malnutrition (a serious condition where the body does not get enough protein, calories, or nutrients, causing it to break down its own tissues for energy). A review of the VCSL-Nutritional Care -V2 notes dated 2/23/2026, indicated. low body weight, low body max index (BMI simple numerical score based on your height and weight that tells you if you are in a healthy weight range) . BMI low indicating potential nutritional risk . interventions 1. Prostat (highly concentrated liquid protein supplement) sugar free (SF) 30 cubic centimeters (cc -unit of measure in liquid) every day/100 calorie (Cal. - unit of measurement for energy)/ 15 grams (gm -unit of measure in weight) protein (meet estimated needs to promote wound healing). 2. Increase Jevity 1.5 (nutrient-dense liquid formula designed for tube feeding) to 55 cc per hour for 20 hours, 1100 cc per1650 calories (promote weight gain and wound healing) . A review of Resident 7's physician order dated 2/27/2026 indicated Pro stat (a concentrated, hydrolyzed collagen medical food designed for rapid absorption to treat wounds, muscle loss, and protein-energy malnutrition) one time a day . A review of Resident 7's physician order dated 2/27/2026 indicated enteral feed Jevity 1.5 to infuse (administer) at 55 cubic centimeters (cc-unit of measurement) per hour (hr) cc/hr . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 7's Minimum Data Set (MDS – resident assessment tool) dated 3/10/2026, indicated Resident 7 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 7 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. MDS further indicated that Resident 7 has one unstageable PU. During a concurrent telephone interview and record review on 4/30/2026, at 1:13 P.M., with the RD, the RD stated that on 2/23/2026, the RD recommended that resident 7's Jevity 1.5 be increased from 50cc's to 55 cc's and start resident on Prostat 30 cc's as well for weight loss. The RD stated that RD recommendations are supposed to be carried out per standard of practice within 72 hours of being given. The RD stated that Resident 7 had recommendations from 2/23/2026 were not carried out until 2/27/2026. The RD stated that not carrying out the RD recommendations timely may potentially lead to more weight loss, and possibly hospitalization. During a concurrent interview and record review, on 5/1/2026, at 8:40 A.M., with Licensed Vocational Nurse (LVN) 2, Resident 7's electronic record was reviewed. LVN 2 stated that Resident 7 had RD recommendations given on 2/23/2026 to increase Jevity 1.5 from 50 cc's to 55 cc's and to start resident 7 on Prostat 30cc's daily. LVN 2 stated that RD recommendations are carried out immediately upon receipt. LVN 2 stated that Resident 7's RD recommendations from 2/23/2026 were not carried out until 2/27/2026 according to the orders in the chart. LVN 2 stated that not following RD recommendations timely may lead to a compromise in the resident's health because the resident is not getting the right nutrients leading to a decline in physical health, confusion and decreased mobility. During an interview, on 5/1/2026, at 12:47 P.M., with the Director of Nursing (DON), the DON stated that RD recommendations need to be carried out within 3 days of being provided, preferably carried out immediately within the day. The DON stated that not increasing the tube feeding formular rate and stating resident on Prostat per RD recommendations may lead to weight loss, delay in wound healing and malnutrition. A review of the facility's P&P, titled Assisted Nutrition and Hydration, dated 1/2025, indicated, POLICY To provide facility personnel with guidelines to ensure that a resident maintains acceptable parameters of nutritional status is offered sufficient fluid intake to maintain proper hydration and health; and is offered a therapeutic diet when ordered. Note: Assisted nutrition and hydration. (Includes nasogastric and gastrostomy Include percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids. INTENT The intent of this requirement is ta provide staff guidelines to ensure that the resident maintains, to the extent possible, acceptable parameters ol nutritional and hydration status and that the facility: Provides nutritional and hydration core and services to each resident, consistent with the rewidens comprehensive assessment. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recognizes, evaluates, and addresses the needs ol every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration; and Provides a therapeutic diet that considers the resident's clinical condition, and preferences, when there is a nutritional indication. Guidelines: The facility assists the residents to maintain, to the extent possible, acceptable parameters of n nutrition I and hydration status . The interdisciplinary team provides nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment. 9. The facility follows professional standards of practice recommending . 2. During a review of Resident 38's MDS dated [DATE], indicated Resident 2 had severe cognitive impairment. The MDS indicated that Resident 38 needed maximum assist for activities of daily living (ADL - eating, oral hygiene, toileting, upper body assist, sitting to lying, lying to sitting, personal hygiene, lower body dressing, putting/taking off footwear and sitting to standing), and was dependent on staff for tub/shower transfer. During an observation on 4/28/2026 at 7:24 am, Resident 38 was observed in bed and was connected to enteral feeding (a method of delivering nutrients, fluids and medications in liquid form into the stomach or small intestine through a soft flexible tube to someone who is not able to eat or drink safely which was connected to a feeding pump. The enteral feeding was turned off. The enteral feeding was labeled with a date of4/26/2026 and timed 9 p.m. During an interview with License Vocational Nurse (LVN) 3 on 04/28/2026 at 1:20 pm, LVN 3 stated, G-tube feeding should have changed and G-tube feeding tube should be labeled with date and time because, we (staff) will not know when to change it. Using gastric tube (G-tube) feeding for longer than 24 hours can cause abdominal discomfort or an infection. During an interview with Director of Nursing (DON) on 04/30/2026 at 9:37 am, DON stated that the enteral feeding must be discarded after 24 hours of opening and the enteral feeding tubing must be changed after 24 hours of opening. DON stated that using Enteral formula for longer than 24 hours can cause abdominal issues and infection. During the review of the facility's policy and procedures (P&P) titled, Care Plan revised 12/2025, indicated that, is not clear about how often enteral feeding and enteral feed tubing should be changed, and enteral feeding/tubing care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order for supplemental oxygen (O2) administration for one of four sampled residents (Resident 25), the facility failed to : This deficiency had the potential for Resident 25 to experience undesired health effects related to the administration of oxygen not limited to hypoxia (a dangerous medical condition where body tissues or organs do not receive enough oxygen, potentially causing severe damage or death within minutes), hospitalization and death. Findings: During a review of Resident 25's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 25 was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses: acute kidney failure), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition marked by a lack of healthy red blood cells or hemoglobin, reducing oxygen flow to body organs, which causes fatigue, weakness, pale skin, and shortness of breath), acute metabolic acidosis (a serious condition characterized by an excess of acid in the blood often caused by kidney failure, severe diarrhea, or uncontrolled diabetes), unspecified dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), heart failure unspecified (when heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), presence of cardiac and vascular implant and graft (cardiac implants refer to devices placed inside the heart or chest to regulate or support heart function, while cardiac grafts are blood vessels used to bypass blocked arteries or vein), muscle weakness, and dependence on supplemental oxygen (a)medical treatment providing extra oxygen to people whose blood oxygen levels are too low). During a review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) sign-in sheet dated 2/24/2026 indicated, facility staff were educated on management of resident with respiratory symptoms. During a review of Resident 25's history and physical (H&P - a physician's complete patient examination) dated 2/27/2026 indicated, Resident 25 had the capacity to understand and make decisions. During a review of Resident 25's Physician Order Summary Report (a condensed, organized document summarizing a patient's key medical information, including diagnoses, treatments, current medications, test results, and follow-up instructions), the Report did not indicate an order for supplemental oxygen after Resident 25 was re-admitted to the facility on [DATE]. During a review of Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 4/08/2026 at 11:22 PM, indicated Resident 25 was on 3 LPM of oxygen via nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen directly into a patient's nostrils). During a review of Nursing Progress Notes dated 4/10/2026 at 1:18 AM, Resident 25 was on 2 LPM of oxygen via nasal cannula. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool) dated 4/13/2026, indicated, Resident 25 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS also indicated that Resident 25 was on continuous oxygen therapy while a resident at the facility. The MDS also indicated that Resident 25 used mobility devices (helps a person walk or move from place to place when one has a disability or injury) such as walker and a wheelchair to get around. The MDS also indicated that Resident 25 needed moderate to maximal assistance with toileting hygiene (maintaining cleanliness before and after using the toilet) due to muscle weakness. During a review of Resident 25's physician progress notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 4/16/2026 indicated, Resident 25 was improving with current treatment of supplemental oxygen at 2.5 Liters per minute (LPM - oxygen flow rates are measured in LPM, determining how much supplemental oxygen a device delivers to a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient). During a review of Resident 25's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), there was no care plan on providing supplemental oxygen to Resident 25. During an observation on 4/28/2026 at 8:58 AM with Resident 25, Resident 25 was receiving supplemental oxygen at 3 liter per minute (LPM - unit of measurement) per nasal cannula (a flexible used to administer oxygen). During a concurrent observation, interview, and record review on 4/28/2026 at 11:34 AM with licensed vocational nurse (LVN) 1, Resident 25 was observed in the room receiving 3 LPM of supplemental oxygen via a nasal cannula. LVN 1 then reviewed physician's order for supplemental oxygen after Resident 25's readmission on [DATE], LVN 1 stated there is no order. LVN 1 stated, I did not check [Resident 25's] oxygen saturation (measures the percentage of oxygen-carrying hemoglobin in the blood) this morning (4/28/2026). LVN 1 stated oxygen is a medication and that LVN 1 did not check a physician's order for providing supplemental oxygen to Resident 25. LVN 1 stated LVN 1 assumed there was an order from a physician. LVN 1 also stated Resident 25 may become over oxygenated (occurs when tissues and organs are exposed to an excess supply of oxygen, usually from supplemental oxygen, hyperbaric therapy, or ventilators, leading to oxygen toxicity) and may have an altered mental status (AMS - a broad, non-specific term describing a change in a person's baseline awareness, cognition, or consciousness). During a concurrent observation, interview and record review on 4/28/2026 at 12:22 PM with a Respiratory Therapist (RT), Resident 25 was observed in the room receiving 3 LPM of supplemental oxygen via a nasal cannula. RT stated there is no order anywhere for supplemental oxygen after reviewing Resident 25's Physician Orders. RT stated, I didn't read the doctor's order because it's a repeat every day. I thought it's there again today. RT stated that administering supplemental oxygen to Resident 25 without a doctor's order, RT replied maybe it might kill her. During an interview on 4/28/2026 at 12:35 PM with the Registered Nurse Supervisor (RNS) 1, RNS 1 stated , if there is no order [for supplemental oxygen from a physician], you are not following the protocol of the order. During a concurrent interview and record review on 4/28/2026 at 12:47 PM with MDS, MDS stated, I am sure I saw it. I might have found it somewhere. There is probably an order when asked if there was a physician order for supplemental oxygen for Resident 25. After reviewing the Physician's Order with MDS for supplemental oxygen, MDS stated I can't find any orders here. MDS stated that the staff did not obtain an order from the physician. The physician will determine the right amount of oxygen to give. We (staff) have to do our care within our scope of practice. During a review of Nursing Progress Notes dated 4/29/2026 at 7:22 AM, Resident 25 was on 3.5 LPM of oxygen via nasal cannula. During a concurrent interview and record review on 5/01/2026 at 12:58 PM with LVN 1, LVN 1 stated there was no care plan for O2 administration. When asked why LVN 1 did not initiate a care plan for O2 administration, LVN 1 stated, I was not aware that there is no order for an O2. LVN 1 stated when a care plan was not created, Resident 25 could die, improper administration, becomes hypoxic (a dangerous medical condition where body tissues or organs do not receive enough oxygen, potentially causing severe damage or death within minutes) quickly. During a concurrent interview and record review on 5/01/2026 at 1:19 PM with RNS 1, RNS 1 stated, as one of the (RNS), I will do the initial care plan. RNS 1 stated without a care plan for O2 administration, staff may not meeting [Resident 25's] needs, we neglect the patient. I would say we failed to give the proper treatment.may lead to distress. During a review of the facility's policy and procedures (P&P - document explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Develop-Implement Comprehensive Care Plans with a revision date of 1/2025 indicated that, the care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences. During a review of the facility's P&P titled admission of a Resident with a revision date of 1/2025 indicated, care plans should be started on admission. During a review of the facility's P&P titled Comprehensive Care Plans-Timing with a revision date of 1/2025 indicated, each resident has a comprehensive care plan developed within seven days after completion of the comprehensive assessment and comprehensive care plan must be (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed.no more than 21 days after admission. During a review of the facility's P&P titled Physician Medication Orders with a revision date of 1/2025 indicated, medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation and interview, the facility failed to implement Health insurance portability and Accountability Act (HIPAA - protect sensitive health information from being shared without knowledge or consent) and to provide care in a manner that promoted and enhanced the resident's quality of life, dignity, respect and individuality for and ensure that care for one of three sampled Residents (Resident 54) according to the facility's policy and procedure (P&P) titled Dignity and Respect, dated 1/2025. This deficient practice resulted in the violation of HIPPA and dignity rights for Resident 54.Findings: A review of Resident 54's admission Record indicated the facility admitted Resident 54 on 4/17/2026 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), diabetes (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (persistent low mood, deep sadness, or a loss of interest in activities). A review of Resident 54's Minimum Data Set (MDS - resident assessment tool) dated 4/23/2026, indicated Resident 54 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 54 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. During an observation on 4/30/2026, at 8:19 A.M., in the hallway by the nursing station across from resident room [ROOM NUMBER], Licensed Vocational Nurse (LVN) 1, was seen preparing medications for Resident 54. Resident 54's information not limited to name and diagnoses was visible on the medication laptop on top of the medication cart (Med Cart). LVN 1 then proceeded to explain what the medications were for and then gave the medications to Resident 54 while several residents walked by LVN 1 and Resident 54. During an interview, on 4/30/2026, at 8:40 A.M., with LVN 1, LVN 1 stated that resident medications should be administered in the residents room and not in the hallway for Health insurance portability and Accountability Act (HIPAA - protect sensitive health information from being shared without knowledge or consent) purpose as well as residents privacy and dignity. During an interview, on 5/1/2026, at 12:57 P.M., with the Director of Nursing (DON), the DON stated that resident medication should be administered in the resident's room or in a private space to protect the dignity of the resident. The DON stated that if dignity and privacy is not provided to the resident, it may affect the residents' psychosocial wellbeing and violates HIPAA for the residents. A review of the facility's policy and procedures (P&P), titled titled Dignity and Respect, dated 1/2025, indicated,POLICY STATEMENTEach resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.INTENTTo provide staff with guidelines to ensure residents are treated with kindness, respect, and dignity.GUIDELINES1.The facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.5. Residents shall be treated with dignity and respect at all times.Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.15. Staff shall maintain an environment in which confidential clinical information is protected.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of two staff (Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1) practiced infection control standards according to the facility facility's policy and procedures (P&P) titled Standard Precautions, dated 12/2025 when:1.CNA 1 did not remove a gown (personal protective equipment-PPE) when exiting a resident's isolation room (a specialized, private room designed to separate a patient from others to control the spread of infections or protect vulnerable patients).2. LVN 1 did not disinfect (the process of using chemicals or physical agent to kill/destroy bacteria and other very small living things that cause disease) the blood pressure machine (a device to monitor/check blood pressure) between residents. This deficient practice had the potential to spread infection in the facility leading to hospitalization.Findings: A review of Resident 6's admission Record indicated the facility admitted Resident 6 on 3/11/2026 with diagnoses including bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), and hypertension (HTN-high blood pressure). A review of Resident 6's Minimum Data Set (MDS - resident assessment tool) dated 3/17/2026, indicated Resident 6 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 6 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. A review of Resident 7's admission Record indicated the facility admitted Resident 7 on 10/7/2025 with diagnoses including pressure ulcer (PU - localized damage to the skin and/or underlying tissue usually over a bony prominence) of sacral (a large, triangular-shaped bone at the very base of your spine) region, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), and protein-calorie malnutrition (a serious condition where the body does not get enough protein, calories, or nutrients, causing it to break down its own tissues for energy). A review of Resident 7's MDS dated [DATE], indicated Resident 7 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 7 was dependent on staff with ADL (activities such as bathing, dressing and toileting a person performs daily) care. The MDS further indicated that Resident 7 has one unstageable PU. A review of Resident 8's admission Record indicated the facility admitted Resident 8 on 12/4/2023 and resident was readmitted [DATE] with diagnoses including bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), aphasia (a disorder that makes it difficult to speak), and HTN. A review of Resident 8's MDS dated [DATE], indicated Resident 8 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 8 was dependent on staff with ADL (activities such as bathing, dressing and toileting a person performs daily) care. During an observation on 4/28/2026, at 9:47 A.M, in the hallway by resident room [ROOM NUMBER], CNA 1 was seen exiting room [ROOM NUMBER] into the hallway wearing an isolation gown on. During an interview on 4/28/2026, at 9:48 A.M, with CNA 1, CNA 1 stated that the Isolation gown should have been taken off inside the resident's room before coming out for infection control. During an observation on 4/30/2026, at 8:12 A.M, LVN 1 was seen using a blood pressure machine between Resident 6 and Resident 8 without disinfecting it between residents. During an interview on 4/30/2026, at 8:40 A.M, with LVN 1, LVN 1 stated that BP machine needs to be disinfected between residents to prevent infection. LVN 1 stated that she should have disinfected the BP machine between Resident 6 and Resident 8 however, she did not. During an interview on 5/1/2026, at 12:06 P.M, with Treatment Nurse (TN), TN stated that personal protective equipment (PPE - specialized clothing or gear worn to prevent you from getting (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	05/01/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hurt, sick, or injured while working or doing a project) need to be doffed (removed or taken off) before leaving the residents room and perform hand hygiene after. TN stated that facility staff should not have PPE on in the hallway to prevent transmission of infection/infection control. The TN stated BP machines need to be disinfected before and after each use to kill bacteria and prevent infection. TN stated if BP machine is used without being disinfected between residents, it may lead to the residents being sick. During an interview on 5/1/2026, at 12:57 P.M, with the Director of Nursing (DON), the DON stated that facility staff need to remove the PPE in the resident's room and wash their hands. The DON stated that facility staff should not have PPE in the hallway because having PPE in the hallway can transmit bacteria to other residents and staff in the hallway. The DON further stated that facility staff expectations is that BP machines need to be sanitized after each resident use for infection control purposes and prevent any cross contamination. A review of the facility's P&P, titled Standard Precautions dated 12/2025, indicated,POLICY STATEMENT:Standard Precautions shall be used at all times, when coring for residents regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others.The facility shall make every effort to use the [NAME] restrictive approach to managing individuals with potentially communicable infections. Transmission-Based Precautions shall only be used when transmission cannot be prevented by less restrictive measures.INTENT,The staff will Transmission-Based Precautions whenever measures make stringent than Standard Precautions are needed to prevent or control the spread of infection.The Center' for Disease Control [NAME] established three types of Transmission-Based precaution (airborne, droplet and contact) have been established.Resident-Care Equipment1. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic rectal thermometer to a single resident (or cohort of residents) to avoid sharing between residents.2. Items that must be shared shall be cleaned and disinfected between resident use.3. PPE should be donned upon entering the room and properly discarding before exiling the resident room, to contain pathogens; and when staff will have contact with the patient or potentially affected surfaces in the resident's room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the licensed nursing staff failed to offer the influenza (flu) vaccine as required or appropriate to one of five sampled residents (Resident 38). This deficient practice placed Resident 38 increased risk of acquiring and transmitting the flu to other residents in the facility. Findings: A review of Resident 38's admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), difficulty swallowing and high blood pressure. A review of Resident 38's Minimum Data Set (MDS- a resident assessment tool) dated 4/10/2026, indicated the resident's cognition (ability to think and reason) was severely impaired. A review of Resident 38's Immunization Report, dated 5/4/2026, indicated Resident 38 last received the flu vaccine on 3/25/2025. During a concurrent interview and record review on 5/1/2026 at 10:56 AM, Resident 38 and Resident 38's immunization records were reviewed. The Infection Preventionist/Treatment Nurse (IP/TN) stated facility had not offered Resident 38 the flu vaccination during the last flu season. The IP/TN stated the flu shot is offered to all residents yearly. IP/TN further stated the flu vaccine is given to prevent the resident from becoming infected or spreading the infection in the facility. During an interview on 5/1/2026 at 1:03 PM, the Director of Nursing (DON) stated the facility inquires about the resident's vaccination status upon admission. The DON further stated the flu vaccine is offered yearly to prevent residents from becoming ill and to prevent infection. A review of the facility's policy and procedures (P&P) titled, Influenza and Pneumococcal Immunization, revised 1/2025, indicated, the facility maintains procedures for immunization against influenza and pneumococcal disease in accordance with national standards of practice to minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumonia. The P&P also indicated:- The facility vaccinates eligible residents with the influenza and/or the pneumococcal vaccine(s), unless the resident had previously received the vaccine, refused, or had a medical contraindication present. - Each resident or the resident's representative receives education regarding the benefits and potential side effects of immunization.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the licensed nursing staff failed to offer the Coronavirus Disease (COVID-19) vaccination to two of five sampled residents (Resident 2). This deficient practice placed Resident 2 at a higher risk of acquiring and transmitting the COVID-19 to other residents in the facility. Findings: A review of Resident 2's admission Record indicated the facility originally admitted the resident on 9/8/2021 and readmitted on [DATE], with diagnoses of dementia (a progressive state of decline in mental abilities), pressure Ulcer/injury Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and gastro-esophageal reflux disease (GERD-frequent heartburn). A review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/11/2026, indicated Resident 2 had severely impaired cognition (never/rarely made decisions). The MDS indicated the resident is dependent for toileting and personal hygiene. A review of Resident 2's Immunization Audit Report, dated 5/4/2026, indicated Resident 2 last received the COVID-19 vaccination 3/15/2024. During a concurrent interview and record review on 5/1/2026 at 11:30 AM, Resident 2's immunization records and progress notes were reviewed. The Infection Preventionist/Treatment Nurse (IP/TN) stated there was no record that Resident 2 was offered the updated COVID-19 vaccine or that Resident 2 declined the vaccination. IP/TN further stated the facility offers updated COVID vaccinations to all residents in order to prevent the resident from acquiring the infection. During an interview on 5/1/2026 at 1:03 PM, the Director of Nursing (DON) stated the facility offer the COVID-19 boosters on 3/10/2026. The DON further stated that the COVID vaccine is offered annually. The DON also stated COVID symptoms have a rapid onset and the vaccine protects the resident from having worse symptoms or hospitalizations. A review of the facility's policy and procedures titled, Infection Control - COVID-19 Immunizations, dated 1/2025, indicated:- All residents and/or resident representatives and staff shall be educated on the COVID-19 vaccine they are offered in a manner they can understand- Education covers the benefits and potential side effects of the vaccine including common reactions such as aches or fever, and rare reactions such as anaphylaxis.- The resident or resident representative shall be provided the opportunity to refuse the vaccine and to change their decision about vaccination at any time.