DEPARTMENT OF HEALTH AND HUMAN SERVICES POC Accepted on 12/25/2024
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. BUILDING _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING AND REHABILITATION CENTER	8647 FENWICK STREET. SUNLAND, CA 91040

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident and a Complaint. FRI Number: CA00934611 Complaint Number: CA00934662 The inspection was limited to the specific complaint and FRI investigated and does not represent the findings of a full inspection of the facility. There was one deficiency issued for the Facility Reported Incident: CA00934611 and Complaint: CA00934662. See F609.	F 000	New Vista Nursing & Rehabilitation Center makes every effort to comply with the State and Federal regulations and submits this response and Plan of Correction as part of the requirements under the State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider, its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be subsequent remedial measures as that concept is employed in Rule 407 of the Federal rules of evidence and California evidence code section 1151 and should be in any proceeding on that basis. This Plan of Correction is New Vista Nursing & Rehabilitations Center's credible allegation of compliance.	12/25/24
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

MARIA THERESA DIMAGGIO (DIMMAY)

TITLE: Executive Director

(X6) DATE: 12/25/24

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.

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F 609	Continued From page 1 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure an allegation of resident abuse (when staff intentionally prevents a resident from having contact with friends, family, or others) by facility staff was reported to the State Survey Agency (SSA) immediately, but no later than two hours after the allegation was made for one of three sampled residents. This deficient practice had the potential to result in a delay in the abuse allegation investigation. Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 12/31/2022 and re-admitted on 3/07/2023 with diagnoses that included schizophrenia (a chronic mental illness that affects how people think, feel, and behave) and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 1' s Minimum Data Set (MDS, a resident assessment tool), dated 10/04/2024, the MDS indicated Resident 1 was	F 609	Immediate corrective action: The alleged incident was not reported to the facility Administrator when it allegedly happened and was only known when the California Department of Health (CDPH) surveyor was in the facility for an unrelated follow-up visit. As soon as the alleged incident was reported to the Administrator, the facility conducted its immediate reporting and investigation per facility protocol. SOC 341 form was submitted to the CDPH and Office of LTC Ombudsman via facsimile on 12/10/24 and acknowledged receipt the same day via the Transmission Verification Report at 15:42 (CDPH) and 15:44 (Ombudsman). The Los Angeles Police Department (LAPD) Officer #43479 was in the facility on 12/10/24 at 14:55 after the Social Services Director (SSD) reported the alleged incident. The LAPD Officer indicated that he will not escalate it to further investigation after the alleged victim was interviewed and wrote on his business card "No evidence of neglect". Residents and staff interviews were immediately conducted per facility protocol. The Certified Nursing Assistant (CNA) who was identified on the anonymous note handed to the CDPH surveyor as a witness to the alleged incident was interviewed via telephone by the Administrator and SSD and denied witnessing the alleged incident. The Social Services Assistant (SSA) who handed the note to the CDPH surveyor was also interviewed by the Administrator, SSD and Director of Staff Development (DSD) on 12/10/24 at approximately 2:30 pm to get more details about the alleged incident. She	12/25/24

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F 609	Continued From page 2 severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 1 required setup or clean-up assistance with eating, and supervision with personal hygiene. During a review of Resident 1's Situation, Background, Assessment, Recommendation Report (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/11/2024, the report indicated it was reported that Resident 1 was locked inside the family room. The report indicated staff assessed the resident's psychosocial wellbeing related to the allegation; physician made aware with order for psychologist consultation. During a review of Resident 1's Care Plan for Psychosocial Well-being, initiated 12/11/2024, the care plan indicated there was an allegation of isolation. The care plan indicated a goal that the resident will be able to interact with family, and other residents or staff daily. The care plan indicated an intervention to have a psychology consult and follow up. During a concurrent observation and interview in the Station Two Hallway, on 12/10/2024 at 11:30 a.m., observed Social Services Assistant (SSA) hand surveyor a piece of folded up paper. The paper indicated that the Director of Nursing (DON) locked Resident 1 in the family room, it happened in the afternoon and was witnessed by Certified Nursing Assistant 1 (CNA 1). The SSA stated on 12/9/2024 at around 1 p.m., a CNA reported to her on the phone that the DON locked	F 609	stated that she was not a witness to the alleged incident, and there was no mention of any date and time of its occurrence during its discussion in passing with an unnamed CNA who told her about it. She preferred not to name the CNA she discussed it with even if she was reminded that they were both mandated reporters and they were both in violation of the facility policies and procedures on Abuse. She stated that she was aware of the facility policies and procedures on Abuse and being a mandated reporter. She confirmed that she attended in-service trainings on Abuse. When asked why she did not report the alleged incident to the facility Abuse Coordinator (Administrator), she remained quiet. The SSA was given a written warning on 12/24/24 for Violation of Company Rules/Policy. Failure to report knowledge of an alleged abuse incident towards a resident per facility policies and procedures which delayed its investigation and reporting to appropriate agencies. She is no longer an employee of the facility effective 01/01/2025.	12/25/24

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F 609	Continued From page 3 Resident 1 in the family room because the resident was yelling. The SSA stated she did not know what day the alleged incident occurred. When asked who reported the alleged incident, the SSA stated she would not tell the name of the CNA (unnamed CNA). During a second interview with the SSA on 12/10/2024 at 11:50 a.m., she (SSA) stated the unnamed CNA told her that the incident had occurred after they had left the facility at 4:30 p.m. The SSA stated it happened after 4:30 p.m. but before dinner at 5:00 p.m. The SSA stated she (SSA) did not know what day of the week it was. The SSA stated she (SSA) thought this was abuse and should be reported right away. The SSA stated the Administrator (ADM) is the first person they are required to notify. The SSA stated the ADM was busy and she did not tell the ADM because she (SSA) was not present during the alleged incident and did not witness it. During an interview and record review with the ADM on 12/11/24 with 2:26 p.m., reviewed the facility's policy and procedure "Abuse Prevention/Investigation/Reporting and Resolution." The ADM stated an allegation of abuse should be reported to the Department of Public Health no later than two hours. The AADM stated the SSA notified her (ADM) that the unnamed CNA notified the SSA of the alleged abuse incident on 12/10/2024 (Adm did not indicate the time). The ADM stated the process is to report any alleged abuse to the ADM immediately. The ADM stated the SSA and the unnamed CNA should have reported the alleged incident to the ADM immediately as soon as they were aware of the alleged incident so that they could report timely to the Department of Public	F 609	Facility Protocol was initiated, and the following were taken by the facility: 1. Notification of attending physician and resident representative 2. Change of Condition (COC)/Situation Background Appearance Review (SBAR) 3. The accused was not in the facility for three days pending investigation 4. Interview and monitoring of the alleged victim to ensure that he felt safe, and no psychological disturbance observed related to the alleged incident. 5. The alleged victim was seen and examined by his attending physician on 12/11/24 without any significant changes in his psychological status. 6. The Psychiatrist conducted a telehealth visit on 12/13/24. There were no significant changes in his psychological status and denied the alleged incident when asked. 7. The SSD provided emotional support and continued to observe for any psychological changes for 72 hours. 8. On 12/11/24, the DSD conducted an in-service training of staff regarding facility Abuse policies and procedures with focus on reporting of any suspected abuse incident for immediate investigation. Identification of Potentially Affected Residents: On 12/11/24, staff in-service training was conducted by the DSD regarding the facility's policies and procedures on Abuse with focus on its immediate reporting to ensure compliance with reporting to appropriate agencies and facility investigation.	12/25/24

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F 609	Continued From page 4 Health. During a review of the facility's policy and procedure titled, "Abuse Prevention/Investigation/Reporting and Resolution," last reviewed 2/29/2024, the policy indicated any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse as follows: All alleged violations involving abuse, neglect, exploitation, or mistreatment, will be reported by the facility Administrator, or his/her designee, to the State licensing/certification agency responsible for surveying/licensing the facility. The policy indicated abuse will be reported immediately, but later than two (2) hours if the alleged violation involves abuse.	F 609	During the in-service training, no new allegations of abuse were reported. On 12/10/24, six (6) staff members who worked during the assumed alleged incident were interviewed and there were no residents reported affected by the allegation of abuse. They all indicated that they have knowledge of the facility's policies and procedures of abuse, aware of who the facility Abuse coordinator is and acknowledged receiving ongoing training on recognizing and reporting of any allegation of abuse. On 12/12/24, four (4) random residents were interviewed and indicated that they have no knowledge of the alleged incident and have no knowledge of any resident being mistreated in any way. They also indicated on reporting procedures to take if they have any knowledge of any mistreatment towards any resident. While all residents have the potential to be affected by the same deficient practice, based on interviews conducted with staff and residents, there were no residents identified affected by the deficient practice. Preventive measures/Systemic Changes: The DSD and DON will conduct ongoing in-service training of staff to ensure compliance.	12/25/24

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