STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. BUILDING _____ B. WING _____	05/13/2020

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

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident's call light was within reach for one of three sampled residents (Resident 3). This deficient practice placed the resident at risk of inability to summon health care workers as needed to receive assistance that may include urgent care. Findings: A review of Resident 3's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident 3's Minimum Data Set (MDS- as assessment and care screening tool) dated 10/21/19, indicated the resident had the ability to sometimes make self-understood and had the ability to sometimes understand others. The MDS indicated Resident 3 requires total dependence from staff with bed mobility, transfer, dressing, eating, toilet use and personal hygiene. During observation on 2/5/20 at 8:58 a.m., Resident 3 was seen laying down in her bed inside the resident's room. Resident 3's call light was seen on the floor to the right side of the bed, and out of Resident 3's reach. During an interview on 2/5/20 at 9:11 a.m., Certified Nursing Assistant 1 (CNA 1) was asked to come in to Resident 3's room. CNA 1 verified Resident 3's call light was on the floor and out of reach from Resident 3. CNA 1 stated Resident 3's call light should not have been on the floor and instead should have been within Resident 3's reach. CNA 1 further stated the purpose of the call light is for the resident to call for assistance when needed. A review of the facility's Policy and Procedure titled, Answering Call Light dated 11/30/18 indicated it is the facility's policy to meet the resident's needs and requests within an appropriate time frame. The call light is the only mechanism at the resident's bedside whereby residents are able to alert nursing personnel to their needs. All residents will have a call light in place at all times.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician's order for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 receiving medication at the wrong time. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Physician's Order dated 1/20/20 indicated to administer [MEDICATION NAME] (a medication used for the treatment of [REDACTED]. During a concurrent interview and record review on 3/31/20 at 10:25 a.m., the Administrator (Admin) verified that the Narcotic and Hypnotic Record (NHR- accountability record of medications that are considered to have a strong potential for abuse) for Resident 1 indicated [MEDICATION NAME] 40 mg = 4 ml was administered at 4:15 p.m. on 1/21/20. The Admin stated the licensed nurse should have followed the physician's order and should have administered [MEDICATION NAME] 40 mg = 4 ml at 9:00 p.m. and not at 4:15 p.m. A review of the facility document titled, Corrective Action Notice signed on 1/24/20 indicated On 1/21/20, the employee administered [MEDICATION NAME] 40 mg to the resident at 4:15 p.m. The physician's order for the medication is [MEDICATION NAME] 40 mg by mouth at bedtime. The employee went ahead and administer the [MEDICATION NAME] without calling the Primary Physician. The Corrective Action Notice further stated this action may have caused negative reaction to the resident's other medications and overall medical condition. A review of the Policy and Procedure titled, Medication Administration General Guidelines dated 8/1/08 indicated Medications are administered in accordance with written orders of the attending physician. Medications are administered at the time they are prepared.
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident was seen and examined by a physician upon admission for one of three sampled residents (Resident 1). This deficient practice had the potential to result in an undetected decline in medical, health or psychosocial condition and can lead to a delay in necessary care, treatment and services. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 1's clinical records, there was no documented evidence found Resident 1 was seen and examined by a physician upon admission and during the entirety of the Resident 1's stays in the facility. Resident 1's clinical records also indicated a blank History and Physical (H&P) Examination Form which was not signed by a physician in the facility. During a concurrent interview and record review on 4/29/20 at 8:40 a.m., the Director of Nursing (DON) stated that she could not find any documentation in Resident 1's clinical record indicating the Attending Physician, and/or any physician of the facility conducted a face-to-face evaluation of Resident 1. The DON stated a physician from the facility must do an initial assessment of the resident within 72 hours upon admission. The DON verified that there was no H&P completed by any physicians of their facility. A review of the Policy and Procedure titled, Physician Services: Initial Physician Visit dated 11/1/18 indicated the Attending Physician will complete a resident assessment, including a written report of a history and physical examination [REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Narcotic and Hypnotic Record (NHR- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Record (MAR) for one of three sampled residents (Resident 1). This deficient practice placed the resident at risk for unsafe medication administration and resulted to inaccurate reconciliation of the controlled medication. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's physician's orders [REDACTED]. During a concurrent interview and record review on 3/31/20 at 10:25 a.m., the Administrator (Admin) verified the NHR for Resident 1 indicated [MEDICATION NAME] 40 mg = 4 ml by mouth was administered on 1/21/20 at 4:15 p.m. However, during a review of Resident 1's MAR there was no documented evidence [MEDICATION NAME] 40 mg = 4 ml was administered by mouth on 1/21/20 at 4:15 p.m. The Admin stated the licensed nurse should have also documented on the MAR after administering the medication. A review of the Policy and Procedure titled, Controlled Medications dated 11/28/18 indicates when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record (Narcotics and Hypnotics Record and the Narcotic Liquid Sheet and the Medication Administration Record the following: 1. Date and Time of Administration 2. Amount Administered 3. Signature of Nurse Administering the Dose, completed after the medication is actually administered. A review of the Policy and Procedure titled, Medication Administration-General Guidelines dated 8/1/08 indicated the individual who administered the medication records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications review the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. BUILDING _____ B. WING _____	**05/13/2020**

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

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) medication report off-duty without first recording the administration of any medications.
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident's call light was functioning for one of three sampled residents (Resident 2). This deficient practice placed the resident at risk of inability to summon health care workers as needed to receive assistance that may include urgent care. Findings: A review of Resident 2's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS- as assessment and care screening tool) dated 12/6/19, indicated the resident had the ability to sometimes make self-understood and had the ability to sometimes understand others. The MDS indicated Resident 2 was totally dependent from staff with bed mobility and transfers and requires extensive assistance from staff with dressing, toilet use and personal hygiene. During an observation on 2/5/20 at 8:58 a.m., Resident 2 was heard from the hallway yelling out for help. A light indicator attached on the wall above the doorway was not lit up at this time. Resident 2 was lying in bed holding the call light pressing on the red button while verbally yelling for help. During an observation and concurrent interview on 2/5/20 at 9:11a.m., Certified Nursing Assistant 1 (CNA 1) verified that the call light is pressed for Resident 2 and the light above the door way was not lit. CNA 1 stated when the call button is pushed the light above the doorway lights up and the bell sounds at the nursing station. CNA 1 stated the call bell was not ringing at the nurse station. CNA 1 is unsure of when the call light had stopped working. CNA 1 stated that when a call light is not working the resident will not be able to call for help. During an interview on 2/5/20 at 9:40a.m., Licensed Vocational Nurse 1 (LVN1) stated that the light above the door would indicate that a resident is calling for help. A review of the facility's Policy and Procedure titled, Answering Call Light dated 11/30/18 indicated it is the facility's policy to meet the resident's needs and requests within an appropriate time frame. The call light is the only mechanism at the resident's bedside whereby residents are able to alert nursing personnel to their needs. All residents will have a call light in place at all times.