

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W. Second Avenue Escondido, CA 92025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that four out of five sampled residents (Residents 2, 10, 19 and 49) were free from unnecessary psychotropic (affecting brain activities associated with mental processes and behavior) medications when: 1. For Resident 10, the facility did not implement resident specific non-pharmacological interventions (NPIs, behavioral treatments that do not involve medications) for the use of clonazepam (medication used to treat anxiety), mirtazapine (medication used to treat depression), risperidone (antipsychotic medication that balances certain chemicals in the brain to help a person feel calmer and think clearly), buspirone (medication used to treat anxiety) and sertraline (medication used to treat depression).2. For Resident 49, the facility did not implement resident specific NPIs for the use of duloxetine (medication used to treat depression), lamotrigine (medication used to treat mood disorders), trazodone (medication used to treat depression) and clonazepam.3. For Resident 2, the facility did not have a stop date regarding the as needed use of lorazepam (medication used to treat anxiety)4. For Resident 19, the facility did not have non-pharmacological interventions in place. These failures had the potential for residents to receive unnecessary psychotropic medications which can lead to side effects, such as sedation and falls, and a decline in psychosocial (how a person feels about themselves and their environment) well-being. 1. A review of Resident 10's medical records indicated the following physician's orders: clonazepam 0.25 milligrams (mg, unit of measure) daily for anxiety (a condition characterized by excessive worry and unease) m/b (manifested by) restlessness, repetitive questions, initiated 11/6/24; clonazepam 0.5 mg at bedtime, for anxiety m/b restlessness, repetitive questions, initiated 5/20/21; mirtazapine 15 mg at bedtime for depression (a condition characterized by persistent sadness) m/b poor intake (of food) less than 50%, dated 8/17/25; risperidone 0.25 mg daily for schizophrenia (a condition characterized by an inability to distinguish between reality and one's own thoughts) m/b paranoid delusions thinking people are talking about her, initiated 11/6/24; risperidone 0.5 mg at bedtime for schizophrenia m/b paranoid delusions (symptoms of schizophrenia in which one has unfounded suspicions of others) thinking people are talking about her, initiated 8/30/24; buspirone 5 mg by mouth three times a day for anxiety m/b yelling out, initiated 10/17/24; and (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sertraline 50 mg daily for depression m/b verbalizing feeling sad, initiated 12/12/24. A review of Resident 10's Medication Administration Record (MAR), dated 9/2025, indicated there was no documentation of NPIs by nursing staff for the use of Resident 10's five psychotropic medications. A review of Resident 10's undated care plan indicated NPIs will be provided with, .mental health activities.dance, music, art, exercise, leisure, recreation, orientation, education and/or skill building activities, as well as group and individual activities, such as watching the animal planet.movies, and pet therapy. During a concurrent interview and record review with the Director of Nursing (DON) on 9/10/25 at 4:31 P.M., the DON was asked if there were any NPIs on Resident 10's MAR. The DON stated, I know what you mean &ndash; redirection, offer snacks.those things. The DON confirmed there were no NPIs on the MAR; the facility did not implement NPIs for the use of Resident 10's psychotropic medications. 2. A review of Resident 49's medical records indicated the following physician's orders: Duloxetine Delayed Release (DR, designed to release slowly) 60 mg capsule every evening for depression m/b self-isolation, refusing to care, initiated 2/9/24; lamotrigine100 mg daily for schizoaffective disorder bipolar type (a condition that has symptoms of schizophrenia and bipolar disorder. Bipolar disorder, a condition characterized by a drastic shift in moods) m/b angry outburst without provocation, re-ordered 10/4/24; trazodone 50 mg at bedtime for depression m/b insomnia, difficulty sleeping, dated 3/4/25; and clonazepam 1 mg twice a day for diagnosis of anxiety m/b verbalizing feeling nervousness, dated 4/9/25. A review of Resident 49's MAR, dated 9/2025, indicated there was no documentation of NPIs by nursing staff for the use of Resident 49's four psychotropic medications. A review of Resident 49's undated care plan indicated NPIs would be provided with therapeutic activities such as dance, music, art, exercise, leisure, recreation, orientation, education and/or skill building activities. During an interview with the DON on 9/11/25 at 2:23 P.M., the DON stated, .before we start antipsychotics, we need non-pharmacological] approaches. Activities, calm environment, nourishment to make sure it's not behavior. Drugs would be the last resort, unless it's an emergency. During a telephone interview with the Consultant Pharmacist (CP) on 9/11/25 at 11:02 A.M., the CP stated she and other healthcare staff discuss NPIs at monthly meetings. The CP stated the nurse practitioner monitors NPI and encourage[s] staff to maintain a structured environment to manage orientation and agitation. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, reviewed 7/2022, indicated, .10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Findings: (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's admission Record , Resident 2 was admitted to the facility on [DATE] with diagnoses which included Schizoaffective disorder (a mental illness that could affect thoughts, mood and behavior) and Major Depressive Disorder. A review of Resident 2's Minimum Data Set(MDS-a federally mandated assessment tool) dated 7/22/25 indicated Resident 2's Brief Interview for Mental Status (BIMS) score was 15 which indicated Resident 2's cognition (thought process) was intact. A review of Resident 2's order summary report indicated Resident 2 was on the following psychotropic medications (drugs that affect mental processes and behaviors): Fluoxetine 20 mg 1 capsule by mouth daily for depression Lorazepam 0.5 mg (anti-anxiety) 1 tablet by mouth every 12 hours as needed for anxiety Trazodone (anti-depressant) 50 mg by mouth at bedtime for depression. A review of Resident 2's medical record did not indicate non-pharmacological interventions and a stop date for Lorazepam were in placed for the use of psychotropic medications. On 9/9/25 at 3:30 P.M., an interview and record review with Licensed Nurse (LN) 1 was conducted.LN 1 stated there is no stop date for Resident 2's lorazepam as needed medication. LN 1 stated it was important to have a stop date for psychotropics as needed orders to evaluate if the medication was effective. 2 4) Per the facility's admission Record , Resident 19 was admitted to the facility on [DATE] with diagnoses which included Bipolar Disorder (mood swings that range from slows of depression to elevated periods of emotional highs) and Major Depressive Disorder. A review of Resident 19's MDS dated [DATE] indicated Resident 19 had a BIMS score of 15 which indicated Resident 19's cognition was intact. A review of Resident 19's order summary report indicated the following psychotropic medications: Aripiprazole 15 mg by mouth at bedtime for Schizophrenia Lorazepam 0.5 mg by mouth twice a day for Anxiety Sertraline 150 mg by mouth daily for Depression Divalproex 500 mg 3 tablets by mouth twice a day for Schizoaffective Disorder. A review of Resident 19's medical record did not indicate non-pharmacological interventions were in place for the use of psychotropic medications. On 9/9/25 at 3:30 P.M., an interview and record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated there were no non-pharmacological interventions either in the Medication Administration Record (MAR), Order Summary Report, or in the care plan for Resident 2 and Resident 19's use of psychotropic medications. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/25 at 10:28 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the non-pharmacological interventions were important and that she expected the licensed staff to have used non-pharmacological interventions first before administration of the psychotropic medications routine or as needed. The DON stated non-pharmacological interventions addressed the root cause of conditions, reduced the need for drugs and enhanced quality of life of the residents. The DON stated Resident 2's lorazepam should have a stop date to evaluate its effectiveness and update the Physician for continued use or not. A record review of the facility's dated 7/2022 policy titled, Psychotropic Medication Use indicated,10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications .12. Psychotropic medications are not prescribed or given on a PRN basis .a. PRN orders for psychotropic medications are limited to 14 days.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide pharmacy services in accordance with accepted standards of practice when:1. Random controlled medication (medications with a high abuse potential) use audit for five of six sampled residents (Residents 3, 7, 25, 40 and 55) showed that medications were signed out of the controlled drug record (CDR, count sheet used to track controlled medications), but were not documented on the Medication Administration Record (MAR) to indicate they were administered to the residents. This failure had the potential for diversion (unlawful distribution or use), mismanagement of controlled medications, and the potential to not meet the needs of the residents in the facility. 2. Medications were not available for two of five sampled residents (Residents 2 and 42) when they were scheduled to be administered. This failure had the potential for Resident 2 to experience high blood pressure and Resident 42 to experience heartburn and pain.3. Two diabetes medications (metformin and glipizide- medications used to control blood sugar) were not administered per manufacturers' specifications for one of five residents (Resident 49). This failure had the potential for Resident 49 to not get the full therapeutic benefit of her medications.4. Insulin (medication for diabetes, to control blood sugar) was not administered as ordered for one of five sampled residents (Resident 49). This failure had the potential for Resident 49 to experience hypoglycemia (low blood sugar).Findings:1. During an inspection of the North Medication Cart with Licensed Nurse (LN) 2 on 9/8/25 at 2:58 P.M., the CDRs for six random residents receiving PRN (as needed) controlled medications were requested for review.a) A review of Resident 7's clinical record indicated he had active orders for oxycodone (a controlled medication used to manage pain), including oxycodone 5 milligram (mg, unit of measure) tablet - give one tablet by mouth every 6 hours as needed for moderate pain, dated 6/29/25. During a concurrent interview and record review with the Director of Nursing (DON) on 9/9/25 at 10:31 A.M., a review of Resident 7's CDR for oxycodone 5 mg and August 2025 MAR indicated the nursing staff signed out of the CDR, but did not document the medication administration on one occasion: 8/30/25 at 9:22 P.M. The DON confirmed there was no documentation on the MAR on 8/30 at 9:22 P.M. and stated, I'm not showing anything. The DON stated it should have been documented on the MAR. b) A review of Resident 25's clinical record indicated he had an order for oxycodone-acetaminophen (a controlled medication used to manage pain) 10/325 mg tablet - give two tablets by mouth every 6 hours as needed for moderate to severe pain, dated 7/27/25.During a concurrent interview and record review with the DON on 9/9/25 at 10:33 A.M., Resident 25's CDR for oxycodone-acetaminophen 10/325 mg, and MAR dated August 2025 and September 2025 were reviewed. The CDR indicated the nursing staff signed out tablets of oxycodone-acetaminophen 10/325 mg, but did not document the medication administration on the following days: 8/28/25 at 2:15 A.M. - one tablet was signed out of the CDR and there was no documentation on the [DATE]/1/25 at 2:25 A.M. - two tablets were signed out of the CDR and there was no documentation on the MAR The DON confirmed these deficiencies. Regarding the 8/28 2:15 A.M. dose, the DON stated the CDR documentation was .signed once, and that she could not find it documented on the MAR. The DON stated, It should have been entered. The DON stated, No documentation. None, regarding the 9/1 2:25 A.M. dose. c) A review of Resident 3's clinical record indicated she had active orders for hydrocodone-acetaminophen (a controlled medication used to manage pain), including hydrocodone-acetaminophen 10/325 mg, give one tablet by mouth every 4 hours as needed for severe pain, dated 3/23/25.During a concurrent interview and record review with the DON on 9/9/25 at 10:39 A.M., Resident 3's CDR for hydrocodone-acetaminophen 10/325 mg and MAR for August 2025 and September 2025 were reviewed. Resident 3's CDR indicated nursing staff signed out one tablet of hydrocodone-acetaminophen 10/325 mg for administration, but did not document on the MAR on six occasions:8/24/25 at 5:07 A.M.8/24/25 at 11:30 P.M.8/25/25 at 4:50 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A.M.8/26/25at 4:10 A.M.8/28/25 at 5:20 A.M.9/4/25 at 5:10 A.M.The DON confirmed this deficiency and could not find any documentation of administration on Resident 3's August 2025 and September 2025 MAR for the above dates and times. The DON stated, That's odd. I don't see anything. The DON stated the administrations should have been documented to make sure .patients won't be overmedicated, have records that the residents received pain meds and to make sure we followed the doctor's order. The DON stated there are risks to improper documentation, possibly drug diversion. Counts should coordinate.d) A review of Resident 40's clinical record indicated she had an active order for oxycodone-acetaminophen 10/325 mg, give one tablet by mouth every 4 hours as needed for moderate to severe pain, dated 2/13/25.During a concurrent interview and record review with the DON on 9/9/25 at 10:48 A.M., Resident 40's CDR for oxycodone-acetaminophen 10/325 mg and MAR for August 2025 and September 2025 were reviewed. Resident 40's CDR indicated nursing staff signed out one tablet of oxycodone-acetaminophen 10/325 mg for administration, but did not document on the MAR on nine occasions:8/24/25 at 9 P.M.8/25/25 at 9 P.M.8/26/25 at 9:51 A.M.8/26/25 at 2:30 P.M.8/29/25 at 8:32 P.M.9/2/25 at 5:30 P.M.9/4/25 at 5:35 A.M.9/6/25 at 9:30 A.M.9/6/25 at 3:00 P.M.The DON confirmed these deficiencies and could not find any documentation of administration on Resident 40's August 2025 and September 2025 MAR for the above dates and times. The DON stated, Not documented. Not documented, not given. I don't see it.e) A review of Resident 55's clinical record indicated she had an active order for morphine (a controlled medication used to manage pain) 15 mg, give one tablet by mouth every 6 hours as needed for breakthrough pain, dated 4/6/25.During a concurrent interview and record review with the DON on 9/9/25 at 10:56 A.M., Resident 55's CDR for morphine 15 mg and August 2025 MAR were reviewed. Resident 55's CDR indicated nursing staff signed out one morphine 15 mg tablet for administration, but did not document on the MAR on 5 occasions:8/15/25 at 7:30 P.M.8/22/25 at 1:10 A.M.8/22/25 at 9:48 A.M.8/22/25 at 9:00 A.M.8/25/25 at 12:00 A.M.The DON stated, .that's weird.I'm trying to see if there's more I can show you. The DON confirmed she could not find documentation for administration of Resident 55's morphine 15 mg on the MAR for 8/15, 8/22 and 8/25 for the above times. The DON stated proper documentation was important and the entries on the CDR and MAR must match.During an interview with the DON on 9/11/25 at 2:36 P.M., the DON stated nursing staff were expected to document administrations in both the CDR and MAR.A review of the facility's policy and procedure (P&P) titled, Controlled Substances, reviewed 2024, indicated, .Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration (MAR, Accountability Record) . 4) Initials of the nurse administering the dose. 2. a) During a medication administration observation on 9/9/25 at 11:17 A.M., LN 31 was observed preparing and administering nine medications for Resident 42. LN 31 stated she did not have Resident 42's tenth medication, hydralazine 25 mg, in stock for the morning dose.A review of Resident 42's clinical record indicated she had an active order since 8/13/25 for hydralazine oral tablet 25 mg. Give 1 tablet by mouth three times a day for HTN [hypertension, high blood pressure] . b) During a medication administration observation on 9/9/25 at 3:58 P.M., LN 32 was observed preparing and administering medications to Resident 2. LN 32 stated two of Resident 32's medications were out of stock for the evening dose: calcium carbonate and diclofenac gel.A review of Resident 2's clinical record indicated she had an active order since 8/31/25 for calcium carbonate tablet 600 mg. Give 1 tablet by mouth two times a day for indigestion/GERD [gastroesophageal reflux disease, acid reflux] . The review also indicated Resident 2 had an active order, reordered 9/6/25, for diclofenac external gel 1% (concentration of drug in gel) - Apply to right knee topically two times a day for pain management.During an interview with the DON on 9/11/25 at 2:34 P.M., the DON stated nurses need to check the availability of medication upon accepting the med cart. The DON stated medication ordering was important. The DON stated nurses were to call the pharmacy and, if a medication is unavailable, nurses should call the physician (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for a hold or ask for a substitute.A review of the facility's P&P titled, Pharmacy Services Overview, revised 4/2019, indicated, .4. Residents have sufficient supply of their prescribed medications and receive medications.in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. 3. A review of Resident 49's clinical record indicated she had active orders for the following diabetes medications:a) glipizide 5 mg - give one tablet by mouth two times a day for diabetes.Give with food (7:30 A.M. and 5:30 P.M.), dated 9/5/25b) metformin 1000 mg - give one tablet by mouth two times a day (9 A.M. and 5 P.M.) for diabetes, dated 8/10/25.A review of Resident 49's September 2025 MAR indicated she received glipizide at 7:30 A.M. and 5:30 P.M. and metformin was administered at 9 A.M. and 5 P.M.During an interview with the DON on 9/10/25 at 3:53 P.M., the DON was asked about the facility's mealtime schedules. The DON stated breakfast was served at 7:30 in the morning and confirmed that dinner service started at 5 P.M. The DON confirmed that glipizide was ordered to be given with food twice daily and metformin was scheduled to be given at 9 A.M. and 5 P.M.During a telephone interview with the Consultant Pharmacist (CP) on 9/11/25 at 10:18 A.M., the CP stated, metformin is advised to be taken with food to avoid GI [gastrointestinal, stomach or digestive] issues. Regarding glipizide, the CP confirmed that she recommended adding the additional direction, give with food on 9/3/25 and it was accepted on 9/5/25. The CP stated glipizide is preferred to be given before a meal to reduce the risk of hypoglycemia [low blood sugar]. At least 20-30 minutes prior to food. The CP stated the directions should have been specified. I do see it. I should have specified to give 20-30 minutes prior to a meal. Sorry.A review of metformin drug information provided by the facility, indicated, administer with a meal (to decrease GI upset) .A review of glipizide drug information provided by the facility, indicated, administer 30 minutes before a meal.to achieve the greatest reduction in postprandial hyperglycemia [post-meal blood sugar spike] .A review of the facility's P&P titled, Consultant Pharmacist Services Provider Requirements reviewed 2024, indicated, The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services This includes, but is not limited to.assisting the facility in defining schedules for administering medications to maximize the effectiveness.A review of the facility's P&P titled, Medication Therapy revised 4/2007, indicated, .the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether.the dosage is appropriate.the frequency of administration.[is] appropriate. 4. A review of Resident 49's clinical record indicated she had a physician's order for insulin lispro (medication used to control blood sugar) - inject 5 units (unit of measure) subcutaneously (into fat under the skin) with meals for diabetes, hold for glucose (blood sugar) below 150, ordered 8/10/25. A review of Resident 49's MAR dated September 2025 indicated Resident 49 was administered insulin lispro on two occasions despite having blood sugar below 150: 9/5/25 at 7 A.M. blood sugar 137 9/6/25 at 5 P.M. blood sugar 135During an interview with the DON on 9/10/25 at 3:53 P.M., the DON verified the administrations. The DON stated the doses should've been held because the order says less than 150. The DON stated nurses should follow doctors' orders.it is insulin and could lead to low blood sugar.A drug review of the medication, insulin lispro, on Daily Med, a drug resource site, updated 6/17/25, indicated, excess insulin administration may cause hypoglycemia and hypokalemia [low potassium] (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f, accessed 9/14/25).A review of the facility's P&P titled, Diabetes - Clinical Protocol, revised 9/2017, indicated, .4. The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record and care plan.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the facility medication error rate did not exceed five percent or greater, when observation of 42 opportunities during medication administration resulted in five errors. The calculated medication error rate was 11.9%. This failure resulted in: - Placing Resident 29 at risk of not breaking down and absorbing nutrients from food when Licensed Nurse (LN) 1 crushed and administered pancrelipase (digestive enzymes used to break down food during digestion) Delayed Release (DR, designed to release medication slowly over a period). Placing Resident 29 at risk of inadequate pain relief when LN 1 crushed and administered gabapentin (medication used for pain). - Placing Resident 42 at risk of high blood pressure when LN 31 did not administer hydralazine (a medication used to treat high blood pressure). - Placing Resident 2 at risk for heartburn, indigestion and upset stomach when LN 32 did not administer calcium carbonate (medication used to decrease acid in the stomach). Placing Resident 2 at risk for inadequate pain relief when LN 32 did not administer diclofenac gel (medication used to treat pain). Findings: - During a medication administration observation on 9/8/25 at 10:30 A.M., LN 1 was observed preparing and administering a total of ten medications for Resident 29. LN 1 stated Resident 29 received most of his medications through his gastrostomy tube (G-tube, a device used to administer food and medications to individuals with difficulty swallowing). LN 1 prepared nine medications for G-tube administration, including the following two capsules (medications that are enclosed in a shell): pancrelipase oral capsule DR particles 12000 units (unit of measure) - give 1 capsule enterally (through the G-tube) every 12 hours as needed for digestive enzyme supplement, originally dated 8/24/24, and gabapentin oral capsule - give 400 milligrams (mg, unit of measure) via G-tube three times a day for dx (diagnosis of) leg pain, originally dated 8/11/25. LN 1 opened each capsule and poured the granules (medicine that is inside capsules) into separate medicine cups. LN 1 then crushed each medication separately, mixed the individually crushed medicine with water and administered the medications through Resident 29's G-tube. During an interview with LN 1 on 9/9/25 at 10:06 A.M., LN 1 confirmed he opened each capsule, crushed them separately and mixed each medication with water. During an interview with the Director of Nursing (DON) on 9/9/25 at 11:11 A.M., the DON stated nurses should refer to the package insert (product labeling information for healthcare professionals and patients) or call the pharmacy if they are not sure how to administer a medication. During an interview with the Consultant Pharmacist (CP) on 9/11/25 at 10:18 A.M., the CP stated, it's best to sprinkle the contents [of pancrelipase DR capsule] into applesauce. The CP stated, the studies [research on the medication] say to avoid crushing. The CP stated gabapentin capsules can be opened, mixed with purified water [water that is free from impurities], but not crushed to dissolve (the incorporation of a solid into a liquid) prior to administration. The CP stated, The studies show it's better to mix with water. I don't see any studies for crushing the capsule. The CP stated she can go over [medication administration] if nurses call with a question. A review of pancrelipase DR capsule drug information provided by the facility, indicated, Open capsule and sprinkle contents onto 15 mL [milliliters, unit of measure] commercially available applesauce or bananas. Stir gently and wait 15 minutes. A review of gabapentin capsule drug information provided by the facility, indicated, Open capsule(s) and disperse contents in 10 to 30 mL purified water; draw up mixture into enteral dosing syringe and administer via feeding tube. A review of the facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures reviewed 2024, indicated, .sustained release [designed to release slowly] capsules and enteric coated [designed to dissolve in the small intestine instead of the stomach] capsules should not be crushed. Consult the prescriber and pharmacist for alternative formulations and doses. 6.a) .Check the manufacturer's instructions or contact the pharmacist if there are questions about any medications. - During a medication administration observation on 9/9/25 at 11:17 A.M., LN 31 was observed preparing and administering nine medications for Resident 42. LN 31 stated she did not have Resident 42's tenth medication, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W. Second Avenue Escondido, CA 92025	
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hydralazine 25 mg, in stock for the morning dose.A review of Resident 42's clinical record indicated she had an active order since 8/13/25 for hydralazine oral tablet 25 mg. Give 1 tablet by mouth three times a day for HTN [hypertension, high blood pressure] . 3. During a medication administration observation on 9/9/25 at 3:58 P.M., LN 32 was observed preparing and administering medications to Resident 2. LN 32 stated two of Resident 32's medications were out of stock for the evening dose: calcium carbonate and diclofenac gel.A review of Resident 2's clinical record indicated she had an active order since 8/31/25 for calcium carbonate tablet 600 mg. Give 1 tablet by mouth two times a day for indigestion/GERD [gastroesophageal reflux disease, acid reflux] . The review also indicated Resident 2 had an active order, reordered 9/6/25, for diclofenac external gel 1% (concentration of drug in gel) - Apply to right knee topically two times a day for pain management.During an interview with the DON on 9/11/25 at 2:34 P.M., the DON stated nurses need to check the availability of medication upon accepting the med cart. The DON stated medication ordering was important. The DON stated she expected nurses to call the pharmacy and, if a medication was unavailable, nurses should call the physician for a hold or ask for a substitute.A review of the facility's P&P titled, Pharmacy Services Overview, revised 4/2019, indicated, .4. Residents have sufficient supply of their prescribed medications and receive medications.in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility failed to identify and develop an effective quality assessment and performance improvement plan (QAPI- a data driven proactive approach to improvement used to ensure services are meeting quality standards) in the following areas related to:1) cross reference F 755- Pharmacy services- the facility failed to ensure the control drug record (CDR) matches the medication administration record (MAR) of controlled drugs of the residents for five out of six residents reviewed. 2) cross reference F 677- ADL care provided for dependent residents- the facility failed to provide nail care assistance for two out of 17 residents reviewed. These failures had the potential to affect the resident's health and condition. On 9/11/25 at 3:45 P.M., a QAPI meeting with the Director of Nursing (DON) and the Administrator (ADM) was conducted. The ADM stated fingernail trimming and the controlled drug record not matching the medication administration record was new to us. The DON stated it was important to identify issues affecting the residents in the facility. A review of the facility's policy and procedure (P&P), titled Quality Assurance and Performance Improvement (QAPI) Program, dated 2/2020 was conducted. The P&P indicated, . 2.the QAPI describes the process for identifying and correcting quality deficiencies. Key components of this process include.c. Identifying and prioritizing quality deficiencies.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control standards of practice when an air vent blew out dust balls during meals in the dining room. This deficient practice had the potential to contaminate residents' food and affect the residents' respiratory status. Findings: During the dining room meal observation on 9/8/25 at 11:30 AM, there were 15 residents seated around eight separate tables. The air conditioner was on and a round air vent in the ceiling was directly above a table with residents. The air vent blew out three dust balls and the Activity Director (AD) swept up the dust balls from the floor. The air vent was observed with gray dust above a table with residents. At 11:51 A.M. a staff member brought the meal cart which was also near the air vent with gray dust. Staff proceeded with passing out meal trays with the cart wide open and the round dusty air vent blew air from the ceiling. Another observation in the dining room was conducted on 9/9/25 at 7:36 A.M. The air conditioner was on and the air vent still had gray dust. An interview and concurrent observation was conducted on 9/9/25 at 10:48 A.M. with the Facilities Director (FD). The FD checked the round air vent in the ceiling at the dining room. The FD stated the air vent was dusty. The FD stated the air condition unit was installed last Friday, 9/5/25 and it was expected for the vents to blow out dust. The FD stated the other vents had a filter, but the round air vent did not have a filter. The FD stated he notified staff to let him know when residents will be in the dining room so he can shut off the round vent. The FD stated it was important for air vents to be clean to prevent dust from getting into residents' food and prevent residents from inhaling dust. The FD further stated inhaling dust can lead to respiratory problems. During an interview on 9/11/25 at 9:16 A.M. with the AD, the AD stated she swept the dust bunnies that fell from the air vent in the dining room. The AD stated residents should be in a clean environment. The AD stated dust from the air vent could be inhaled by residents while they were eating in the dining room and any foreign material in residents' food may cause illness. During an interview on 9/11/25 at 3:14 P.M. with the Director of Nursing (DON), the DON stated residents could inhale the dust from the air vent in the dining room which could lead to respiratory distress. A review of the facility's undated policy and procedure (P&P) titled, Infection Prevention and Control Program was conducted. The P&P indicated, An infection prevention and control program [IPCP] is established and maintained to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. A review of the facility's P&P titled, Grounds, revised May 2008 was conducted. The P&P indicated, Facility grounds shall be maintained in a safe and attractive manner. Maintenance shall be responsible for keeping grounds free of litter.		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W. Second Avenue Escondido, CA 92025	
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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 provide an alternative call light system to one of 17 sampled residents (Resident 68). This failure had the potential for Resident 68 to experience a delay in care. Findings: According to the admission Record, Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease (a movement disorder that worsens over time) and generalized muscle weakness. During a review of Resident 68's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/29/25, Resident 68 had a Brief Interview of Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 9 which indicated moderate cognitive impairment. On 9/8/25 at 8:24 A.M., an observation was conducted. Resident 68 was observed laying in bed and stated, I'm ready to get up.I'm waiting to eat breakfast, I can't use my hands. Resident 68 was observed with both hands bent and unable to fully open. Resident 68 had a push button call light (a button used for residents to request assistance from staff) on his bed. On 9/8/25 at 12:22 P.M., an interview was conducted with Resident 68's family member (FAM) 1. FAM 1 stated Resident 68 was unable to use his call light because he had hand contractures [stiffening/shortening at the joint, that reduces the joint's range of motion] and therefore could not always press the button. On 9/9/25 at 10:37 A.M., an interview was conducted with the Occupational Therapist (OT) 1. OT 1 stated Resident 68 had contractures to both hands .because of increased tone related to Parkinson's Disease. OT 1 stated Resident 68 was not able to consistently use the push button call light when he needed to call for assistance. On 9/10/25 at 1:08 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated if Resident 68 was unable to consistently use the push-button call light when he needed assistance, the facility should have accommodated his needs. The DON stated, he needs to have something that he can tap. A review of the facility's policy titled Call System, Residents dated September 2022 indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident and documented in the care plan.		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W. Second Avenue Escondido, CA 92025	
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to provide a written notice and duration of bed hold for one of three residents (Resident 65) reviewed for bed hold notice. This failure had the potential for the resident and/or resident's representative to not have information regarding bed hold rights. Per the facility's admission Record, Resident 65 was admitted to the facility on [DATE] with diagnoses which included, chronic kidney disease (a condition in which the kidneys gradually lose their ability to filter waste products from the blood). A review of the progress notes dated, 6/25/25 indicated, Resident 65 was transferred to the acute hospital due to wounds on his buttocks.A review of Resident 65's medical record indicated, there was no documentation to confirm Resident 65 was notified of the bed hold when Resident 65 was transferred to the acute hospital.A review of Resident 65's Minimum Data Set (MDS-a federally mandated assessment tool) dated, 6/7/25 indicated, Resident 65's brief interview for mental status (BIMS- cognitive screening to assess residents' cognitive function) was 15 which indicated Resident 65's cognition (thought process) was intact.On 9/10/25 at 3:36 P.M., an interview with the Director of Staff Development (DSD) was conducted. The DSD stated it was important to offer Resident 65 and his family representative options for a bed hold.On 9/11/25 at 10:55 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated nursing staff, or the Social Service Director would follow up and offer a bed hold when residents were transferred to the acute care facility. The DON stated it was important to offer a bed hold to Resident 65 or his family representative regardless of the insurance. A review of the facility's policy dated 3/2022, titled Bed-Holds and Returns, Policy and Interpretation,1.all residents /representatives are provided written information regarding the facility bed-hold policies which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave).b. at the time of transfer.		

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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 ensure a baseline care plan was developed for 2 of 17 residents (Residents 2 and 19) reviewed for baseline care plans. This failure had the potential for Resident 2 and Resident 19 to not receive appropriate care. Findings:1) Per the facility's admission Record , Resident 2 was admitted to the facility on [DATE] with diagnoses which included Schizoaffective Disorder(a mental illness that could affect thoughts, mood and behavior) and Major Depressive Disorder.A review of Resident 2's minimum data set (MDS-a federally mandated assessment tool) dated, 7/22/25 indicated, Resident 2's Brief Interview for Mental Status (BIMS) score was 15 which indicated Resident 2's cognition (thought process) was intact.A review of Resident 2's order summary report indicated, Resident 2 was on the following psychotropic medications (drugs that affect mental processes and behaviors): Fluoxetine 20 mg 1 capsule by mouth daily for depression; Lorazepam 0.5 mg (anti-anxiety) 1 tablet by mouth every 12 hours as needed for anxiety; Trazadone (anti-depressant) 50 mg by mouth at bedtime for depression.A review of Resident 2's medical record did not indicate a care plan for these psychotropic medications. 2) Per the facility's admission Record , Resident 19 was admitted to the facility on [DATE] with diagnoses which includes Bipolar Disorder (mood swings that range from slows of depression to elevated periods of emotional highs) and Major Depressive Disorder.A review of Resident 19's MDS dated [DATE] indicated Resident 19 had a BIMS score of 15 which indicated Resident 19's cognition was intact.A review of Resident 19's order summary report indicated the following psychotropic medications: Aripiprazole 15 mg by mouth at bedtime for Schizophrenia Lorazepam 0.5 mg by mouth twice a day for Anxiety Sertraline 150 mg by mouth daily for Depression Divalproex 500 mg 3 tablets by mouth twice a day for Schizoaffective Disorder. A review of Resident 2's medical record did not indicate a care plan for these psychotropic medications. On 9/11/25 at 10:28 a.m., an interview and record review with the Director of Nursing (DON) was conducted. The DON stated the care plans were important and that licensed staff were expected to develop and document on Resident 2 and Resident 19's medical record. The DON also stated the care plan was a basis and evidence of the care and acted as a communication of the care being provided. A review of the facility's Policy titled ,Care plans, Comprehensive Person-Centered dated 3/2022 indicated , Policy and Interpretation.2. the comprehensive person -centered care plan is developed within 7 days.and no more than 21 days after admission.		

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 17 residents (Resident 10 and Resident 49), who needed to carry out activities of daily living (ADL- self-care activities such as grooming, bathing, and toileting), received assistance with nail care (cleaning, trimming and/or filing of nails). As a result of this deficient practice, residents' fingernails were long and had the potential for skin injury and infection. Findings:1. Resident 10 was admitted to the facility on [DATE] with diagnoses including dementia (an impairment of brain function, such as memory loss and judgment) and chronic pain according to the facility's admission Record. During an interview and observation on 9/8/25 at 8:09 A.M., Resident 10 was in her room sitting at the edge of bed with breakfast tray calling out, Hello, hello, hello. Resident 10's fingernails were observed to be long and with gray debris under the nails. Resident 10's right forefinger nail was observed to be jagged. Resident 10 stated the nail on the right forefinger was sharp. Resident 10 stated she had asked someone to trim her nails and nobody had done it. A review of Resident 10's ADL care plan was conducted. The ADL care plan initiated on 12/11/17 indicated, at risk for Self- care Deficit As Evidenced by: Needs 1 person assistance with ADLs.Personal Hygiene - One person physical assist required. An observation was conducted on 9/9/25 at 9:58 A.M. Resident 10 was heard from the hallway calling out, I need someone. Resident 10 was sitting at the edge of the bed with breakfast tray. Resident 10's fingernails were still long with gray debris underneath. An interview and concurrent observation on 9/9/25 at 2:04 P.M was conducted with Certified Nurse Assistant (CNA) 31 in Resident 10's room. CNA 31 stated Resident 10's fingernails were long and dirty. CNA 31 stated Resident 10 can get an infection and scratch herself because of the long and dirty fingernails. CNA 31 stated all residents' fingernails were supposed to be trimmed on Sundays. During a joint observation and interview on 9/9/25 at 3:19 P.M. with Licensed Nurse (LN) 32, LN 32 stated Resident 10's fingernails were long and should be trimmed. LN 32 stated fingernails were trimmed weekly during showers for good hygiene. 2. Resident 49 was admitted to the facility on [DATE] with diagnoses including fibromyalgia (a health condition that causes pain and tenderness throughout the body) and dyspnea (difficulty breathing) according to the facility's admission Record. During an interview and observation on 9/8/25 at 8:26 A.M., Resident 49 was sitting up in bed with breakfast tray on her lap. Resident 49's fingernails were observed to be long. Resident 49 stated nobody had offered to trim her fingernails and would like them trimmed. A review of Resident 10's ADL care plan was conducted. The ADL care plan initiated on 11/24/23 indicated, at risk for Self-Care Deficit As Evidenced by impaired gait [walking] and mobility, muscle weakness.Personal Hygiene - One person physical assist required. A concurrent observation and interview on 9/9/25 at 2:04 P.M. was conducted with CNA 31. CNA 31 stated Resident 49's fingernails were long and should be trimmed to prevent infection and scratching herself. CNA 31 stated all residents' fingernails were supposed to be trimmed on Sundays. During a joint observation and interview on 9/9/25 at 3:20 P.M. with Licensed Nurse (LN) 32, LN 32 stated Resident 10's fingernails were long and should be trimmed. LN 32 stated fingernails were trimmed weekly during showers for good hygiene. An interview on 9/11/25 at 10:25 A.M. was conducted with the Director of Staff Development (DSD- a licensed nurse certified for staff training). The DSD stated nailcare should be done on shower days and every Sunday. The DSD stated if a resident had diabetes (a condition in which the body has trouble controlling blood sugar), the CNA should notify the Licensed Nurse. The DSD further stated it was important to trim residents' fingernails for infection control and prevent residents from digging into their hands. During an interview on 9/11/25 at 3:14 P.M. with the Director of Nursing (DON), the DON stated residents' fingernails should be trimmed on shower days and on Sundays for resident dignity and infection control. A review of the facility's policy and procedure (P&P) titled, Fingernails/Toenail, Care of, revised February 2018 was conducted. The P&P indicated, The purpose of this procedure are to clean (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nail bed, to keep nails trimmed, and to prevent infections. Review the resident's care plan to assess for any special needs of the resident.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure intake and output (I & O- the measurement of the fluids that enter the body and the fluids that leave the body) was documented and monitored for one of 17 sampled residents (Resident 68). This failure placed Resident 68 at risk for edema (swelling), retaining fluid in the lungs or dehydration (loss of body fluids). Findings: According to the admission Record, Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Congestive Heart Failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently) and Parkinson's Disease (a movement disorder that worsens over time). During a review of Resident 68's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/29/25, Resident 68 had a Brief Interview of Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 9 which indicated moderate cognitive impairment. The MDS further indicated Resident 68 was dependent on staff for eating/drinking and for toileting. During a review of Resident 68's Care Plan dated 8/28/25, the Care Plan indicated Resident 68 had Parkinson's Disease. The goal indicated, The resident will maintain optimal status and quality of life within limitations through review date. The resident will remain free of further s/sx [signs and symptoms], discomfort or complications related to Parkinson's disease through review date. The intervention indicated, Monitor and document intake and output as ordered. On 9/9/25 at 2:34 P.M. an interview was conducted with the Director of Staff Development (DSD). The DSD stated the assigned Certified Nursing Assistants (CNAs) were responsible for tracking and documenting Resident 68's fluid intake every shift. The DSD stated the assigned Licensed Nurse was responsible for documenting Resident 68's total fluid intake and output in the Electronic Medical Record on the P.M. shift. The DSD stated it was important to track and document Resident 68's intake and output because Resident 68 had CHF, which could result in fluid overload (too much fluid in the body). The DSD further stated, We don't want [Resident 68] to get pneumonia. [Resident 68] also has a history of dehydration and cannot drink by himself. On 9/10/25 at 3:41 P.M., a concurrent interview and record review was done with Licensed Nurse (LN) 12. LN 12 stated Resident 68's intake and output should have been documented in the Electronic Medication Administration Record (EMAR), but she did not see that it was documented since admission. LN 12 stated, For [Resident 68] we haven't been checking or documenting his intake and output. On 9/11/25 at 1:08 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that Licensed Nurses tracked Resident 68's intake and output as ordered by the physician. The DON stated it was important that Resident 68's intake and output were documented, to make sure [Resident 68] is not retaining fluids, or getting dehydrated. We don't want fluid overload. If [Resident 68] retains more fluid he could have shortness of breath and decline in condition. A review of the facility's policy titled Fluid Intake and Output revised July 2017 indicated, The facility will monitor intake and output as ordered by the physician.		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W. Second Avenue Escondido, CA 92025	
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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide Restorative Nursing Assistant (RNA- a program to restore abilities or maintain function) program intervention with a hand splint (a device used to immobilize and keep the hand in one position) for one of 17 sampled residents (Resident 68). This failure had the potential for Resident 68 to experience further hand stiffening and/or skin breakdown. Findings: According to the admission Record, Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease (a movement disorder that worsens over time) and generalized muscle weakness. On 9/8/25 at 8:19 A.M., an observation was made in Resident 68's room. Resident 68 had a red plastic device in his right hand. Both hands were stiffened and maintained in a semi-closed position. On 9/8/25 at 12:22 P.M., an interview was conducted with Resident 68's family member (FAM) 1. FAM 1 stated Resident 68's hands were contracted [stiffened] because of Parkinson's Disease. FAM 1 stated Resident 68's family members visited daily and placed splints in Resident 68's hands to make sure he did not experience any other contractures. On 9/8/25 at 3:02 P.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 68's family members applied the hand splints to Resident 68's hands when they visited. LN 11 stated Resident 68 did not have a physician's order for the splints, and she did not see the splints addressed in Resident 68's care plan. LN 11 stated, [Resident 68] needs the splints to prevent his hands from being contracted further and to prevent skin breakdown. LN 11 stated Resident 68 should have a physician's order for hand splints. On 9/9/25 at 10:37 A.M., an interview was conducted with Occupational Therapist (OT) 1. OT 1 stated a Joint Mobility Screen (an assessment for the ability to move joints) was conducted for Resident 68 on 8/26/25. OT 1 stated according to Resident 68's Joint Mobility Screen, Resident 68 was not able to fully extend his hands due to having contractures. OT 1 stated Resident 68 should have had splints ordered for both hands to prevent further loss of movement, and to protect Resident 68's hands from skin breakdown. OT 1 stated the family had improvised and were not applying actual hand splints, but a device that was designed to be used to modify eating utensils. On 9/11/25 at 1:08 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated if a resident was admitted with contractures, OT needed to assess and a hand splint should have been ordered for Resident 68. The DON stated, The family is so involved.[the physician's order for the splint] somehow got missed. My expectation is that a splint be ordered when it's identified that a resident has a contracture. The DON further stated it was important for Resident 68 to have a physician's order and care plan for the hand contractures, .to avoid skin breakdown and losing mobility. Especially with the elderly, we want to prevent immobility and skin problems. A review of the facility's policy and procedure titled Splints and Positioning Devices, revised July 2017 indicated, Splints and Positioning Devices.To Prevent or reduce contractures.Any resident assessed with a need will be screened by the Rehab team including a qualified specialist in Rehab devices.After the screening is done,the physician will be notified and an order will be obtained.The device will be applied as ordered, and documented on the residents Care Plan and RNA [Restorative Nursing Assistant] notes.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision with feeding in one of 17 residents (Resident 43) reviewed for activities of daily living (ADL- self-care activities such as feeding, grooming, bathing, and toileting) assistance. This failure had the potential to affect Resident 43's health and well being. Findings: Per the facility's admission Record, Resident 43 was admitted to the facility on [DATE] with diagnoses which included Dementia (progressive state of decline in mental abilities) and Parkinson's disease (a progressive disease of the nervous system). On 9/8/25 at 12:10 P.M., an observation was conducted during lunchtime in the main dining room. Resident 43 was seated in a reclined position on a wheelchair. Resident 43 was served a lunch tray far from her reach with the cover removed and left untouched. On 9/09/25 at 3:15 P.M., an interview and record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated Resident 43 gets agitated if staff gets close to her. LN 1 stated Resident 43's care plan indicated supervision and touching assistance with eating. LN 1 stated it was important to provide assistance with meals for Resident 43 to prevent possible weight loss and other complications such as choking. A review of the minimum data sheet (MDS- a federally mandated assessment tool) dated 6/6/25 indicated Resident 43's brief interview for mental status (BIMS) score was 04 which indicated Resident 43 had severe cognitive impairment. A review of Resident 43's MDS section GG-functional abilities dated 6/6/25 indicated Resident 43 required supervision and touching assistance with eating. A review of Resident 43's undated care plan indicated supervision and touching assistance with eating as one of the interventions. On 9/11/25 at 10:40 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated she had asked the speech therapist to reevaluate Resident 43 with regards to assistance with eating and speech. The DON stated it was important to provide Resident 43 supervision and touching assistance to prevent weight loss and possible complications such as choking . A review of the facility's policy titled Activities of Daily Living (ADL), Supporting, dated 3/2018 indicated, Appropriate care and service will be provided for residents who are unable to carry out ADLs independently . Dining (meal and snacks).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide urology (specialty which deals with diseases of kidneys and bladder) follow up for one of two residents (Resident 4) reviewed for urinary catheter. This failure had the potential for Resident 4 to have a recurrent urinary tract infection (UTI-an infection affecting the kidneys, bladder or urethra) and other complications. Findings: Resident 4 was admitted to the facility on [DATE] with diagnoses including obstructive and reflux uropathy (problems with urine flow in the urinary tract due to structural or functional issues) according to the facility's admission Record. During an observation and interview on 9/9/25 at 10:04 A.M., Resident 4 was in her room sitting on a wheelchair with a urine bag hanging at the back of the wheelchair. Resident 4 stated she had a urine tube because she could not control her urine and was not able to walk to the bathroom. A review of Resident 4's physician's orders titled Order Summary was conducted. The Order Summary indicated, SupraPubic catheter [SPC-a surgically inserted catheter into the bladder] 18 French [catheter's size] 10 ML [milliliter] Balloon to Gravity Drainage every shift for Obstructive Uropathy. During an interview on 9/9/25 at 2:21 P.M. with Licensed Nurse (LN) 31, LN 31 stated Resident 4 was admitted with a SPC due to obstructive uropathy (problems with urine flow in the urinary tract due to structural or functional issues). LN 31 stated she did not know if Resident 4 was followed by a urologist. On 9/10/25 at 10:04 A.M. Resident 4 was observed sitting in front of her room sitting in the wheelchair. During an interview, Resident 4 stated she would like a physician to check if the urine tube (SPC) can be removed so she can practice walking again. Resident 4 further stated the SPC should be removed because she was also urinating on her brief. A concurrent record review and interview on 9/10/25 at 10:12 A.M. was conducted with LN 33. LN 33 reviewed physician's orders for Resident 4 and stated there was no order for a urology consultation for Resident 4. LN 33 stated a urology follow up was important to check Resident 4's SPC for any problems. During an interview on 9/10/25 at 10:26 A.M. with the case manager (CM), the CM stated Resident 4 had a urology appointment on 12/28/23 due to a urinary tract infection (UTI-bladder infection). The CM stated there was no other follow up after the 2023 appointment. An interview and joint record review on 9/10/25 at 11:35 A.M. was conducted with LN 31. LN 31 stated Resident 4's SPC was changed monthly by a registered nurse. LN 31 checked Resident 4's physician's orders and stated there was no physician's order to change Resident 4's SPC. LN 31 stated Resident 4 should be referred to a urologist for evaluation since Resident 4 was also urinating on her brief. LN 31 stated it has been a while since Resident 4 was seen by a urologist and the SPC can be removed. A review of Resident 4's medical records was conducted: Hospital history and physical dated 11/27/21 indicated, Sepsis [the body's extreme and life-threatening response to an infection]. Acute cystitis [inflammation of the bladder] Hospital progress note dated 5/27/21 indicated, Urinary tract infection [UTI-an infection affecting the kidneys, bladder or urethra], acute cystitis. SNF (Skilled Nursing Facility)/NF (Nursing Facility) to Hospital transfer form dated 6/5/25 indicated, Reason(s) for transfer Other: unable to change supra pubic catheter. SNF/NF to Hospital Transfer Form dated 10/19/24 indicated, Reason(s) for transfer Other: supra pubic cath. [catheter] change. Change in Condition Evaluation dated 11/1/24 indicated, Had moderate amount of vaginal bleeding with fresh blood. Change in Condition Evaluation dated 1/6/25 indicated, Urinary tract infection. Change in Condition Evaluation dated 5/24/25 indicated, C/O [complaints of] pressure in vaginal area. An interview with the Director of Nursing (DON) was conducted on 9/11/25 at 3:14 P.M. The DON stated Resident 4 needed urology follow up due to the long-term use of SPC with history of pain. The DON stated Resident 4 was at risk for UTI and routine urology follow up was needed to assess any bladder issues. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised on September 2014, the P&P indicated, The purpose of this procedure (continued on next page)		

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is to prevent catheter-associated urinary tract infections. The P&P did not provide guidance regarding urology consultation.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure nutrition interventions were implemented for one of 17 sampled residents (Resident 68). This failure had the potential to result in further weight loss and/or compromise Resident 68's health. Findings: According to the admission Record, Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease (a movement disorder that worsens over time) dysphagia (difficulty swallowing), nutritional anemia (a deficiency in nutrients essential for red blood cell formation). On 9/8/25 at 8:46 A.M., Certified Nursing Assistant (CNA) 13 was observed walking out of Resident 68's bedroom with his breakfast tray. CNA 13 stated Resident 68 only ate the oatmeal, but did not eat anything else on the tray. CNA 13 stated Resident 68 usually ate less than half of breakfast and lunch. During a review of Resident 68's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/29/25, Resident 68 had a Brief Interview of Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 9 which indicated moderate cognitive impairment. The MDS further indicated Resident 68 was dependent on staff for eating/drinking. A review of the Mini Nutritional assessment dated [DATE] indicated Resident 68 was at risk for malnutrition. A review of the Nutritional assessment dated [DATE] indicated, .[Resident 68 is noted with fair appetite, PO [oral intake] 25-50% .RD [Registered Dietitian] met with resident and his wife at bedside. Wife was encouraging him to eat his lunch and feeding him. She states he often tells her he is not hungry and she asks him to take a few bites anyway. He also has nutrition supplement [shake] that is provided by the VA [Veteran's Administration]. He typically has 1 per day. The Nutritional Assessment indicated resident's goal was to maintain the Goal Weight Range within 158-168 pounds with no unintended weight change. A review of Resident 68's care plan dated 8/26/25 indicated, [Resident 68] has nutritional problem or potential nutritional problem r/t [related to] dysphagia, CHF [Congestive Heart Failure].Goal.Weight maintenance within GWR [Goal Weight Range] 160- 170 # [pounds] no unintended weight change. A review of Resident 68's Weights and Vitals Summary indicated the following weights:163 lbs (pounds- a unit of measurement for weight) on 8/25/25159 lbs on 9/1/25149 lbs on 9/9/25149 lbs on 9/10/25 A review of the IDT (Interdisciplinary Team- a group of professionals with different areas of expertise) Weight Variance Notes dated 9/3/25 indicated Resident 68 had unplanned weight loss of 4 lbs, 2% from 8/25/25 to 9/1/25. The IDT Weight Variance Note indicated, IDT met to discuss weight variance. Resident noted with weight loss of 4# [pounds]/2% x 1 week.He has supplement of [nutritional shake].RD encouraged resident to increase supplement to 2x per day. The IDT note indicated the new recommendation of two nutritional shakes would have provided Resident 68 with 910 extra kcal (kilocalories- a unit of energy) per day. The IDT note indicated, record ml [milliliters-a unit of measurement] taken. On 9/10/25 at 9:38 A.M., a concurrent interview and record review was conducted with the Registered Dietitian (RD). The RD stated Resident 68 should have had a physician's order for the [nutritional shake], but it was never entered in Resident 68's electronic health record. The RD stated, .honestly it was just missed. The RD stated if the facility implemented the recommendation for 2 nutrition shakes daily, his weight loss would not have been so drastic. The RD stated it was important to implement weight loss interventions to avoid further weight loss. The RD stated, Losing weight is a downward spiral.[Resident 68] was at risk for losing muscle mass, and experiencing a decrease in function and ADL's.for the elderly population it is rarely beneficial to lose weight. During an interview with the Director of Nursing (DON) on 9/11/25 at 1:08 P.M., the DON stated, we should have implemented the shakes. The DON further stated it was important to implement interventions to prevent Resident 68 from experiencing more weight loss and to prevent decline in health. The DON stated, Further weight loss will decline him more, plus he could develop pressure injuries and have further health decline. A (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's policy titled Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol revised September 2017 indicated, The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparison over time. The physician will authorize appropriate interventions, as indicated. The physician and staff will monitor an individual's response to interventions.		

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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 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 ensure a physician's order for oxygen was placed for one of three residents (Resident 2) reviewed .This failure had the potential to affect Resident 2's respiratory condition. Findings:Per the facility admission Record , Resident 2 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (absence of enough oxygen).On 9/8/25 at 8:26 A.M., an observation and interview was conducted with Resident 2. Resident 2 was on oxygen at 6 liters per minute via nasal cannula (a flexible tube with two prongs that fit into the nostrils). Resident 2 stated that she returned from the hospital last Friday, 9/5/25 due to pneumonia. Resident 2 stated she used oxygen continuously and cannot breathe without it. A review of Resident 2's Minimum Data Set (MDS- a federally mandated assessment tool) dated 7/22/25 indicated Resident 2's brief interview for mental status (BIMS) score was 14 which indicated Resident 2 had intact cognition (thought process). On 9/8/25 at 8:45 A.M., an interview and record review with Licensed Nurse (LN) 2 was conducted. LN 2 stated Resident 2 was on oxygen when she left for the acute hospital and came back last Friday. LN 2 stated there was no oxygen order on Resident 2's Order Summary Report. LN 2 stated Resident 2 should have an oxygen order in place. LN 2 stated it was important for Resident 2 to have an order for oxygen since Resident 2 used oxygen to be able to breathe and that it was included in Resident 2's plan of care. A review of Resident 2's Order Summary Report dated 9/5/25 did not indicate an oxygen order. On 9/11/25 at 10:34 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that any care provided to any resident needed a physician's order. The DON stated a physician's order would have prevented possible complications for Resident 2. A review of the facility's Policy titled, Oxygen Administration, dated October 2010 indicated, Verify that there is a physician's order for this procedure .Review the physician's orders.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the one of 17 residents (Resident 6) reviewed for food palatability was served meals that were palatable. As a result, Resident 6 refused his meals and was at risk for weight loss. Cross reference F805 Findings: Resident 4 was admitted to the facility on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD- when stomach contents flow back up into the tube that connects the mouth to the stomach) according to the facility's admission Record. During an observation and interview on 9/8/25 at 8:24 A.M. with Resident 4, Resident 4 stated he was on a puree diet, but the food did not taste good. Resident 4 stated the puree he received was gritty. During an interview on 9/10/25 at 9:17 A.M. with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 4 had complained about the food served to him because it was not prepared correctly. An interview and joint record review on 9/10/25 at 10:30 A.M. was conducted with the Registered Dietician (RD). The RD stated Resident 4 was on puree texture due to difficulty swallowing. The RD reviewed the nutritional care plan for Resident 4. The care plan initiated on 9/13/24 indicated Resident 4 was at risk for altered nutrition. He likes to mix his own thickened liquids in his room occasionally due to being unsatisfied with preparation from the diet dept. An observation and interview on 9/10/25 at 12:23 P.M. was conducted with Resident 4. Resident 4 was sitting up in bed with lunch tray in front of Resident 4. The lunch tray had two bowls of mashed potatoes and two bowls of puree eggs. Resident 4 stated the kitchen did not cook the puree foods correctly. The mashed potatoes was observed to not have a smooth consistency and Resident 4 stated the puree eggs had no flavor. During lunch test tray observation on 9/11/25 at 12:26 P.M., the test tray had puree mashed potatoes. The puree mashed potatoes were smooth in appearance that were not similar appearance to the mashed potatoes that Resident 4 received on his tray. During an interview on 9/10/25 at 2:46 P.M. with the Dietary Supervisor (DS), the DS stated Resident 4 had complained of food being gritty. The DS stated the kitchen staff did not follow the recipe for preparing puree food and staff should follow the recipe. An interview with the Director of Nursing (DON) was conducted on 9/11/25 at 3:14 P.M. The DON stated residents should receive the correct puree food consistency to prevent swallowing issues and refusals to eat which could lead to weight loss. A review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, revised October 2017 was conducted. The P&P indicated, Food and nutrition services will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure recipes were followed during the preparation of pureed foods. This failure placed the resident at risk for choking and/or aspiration (inhaling food into the lungs) and compromised the flavor and texture of the foods. Findings: On 9/10/25 at 10:20 A.M., a joint observation and interview was conducted with [NAME] 1 in the kitchen. [NAME] 1 stated she was preparing instant mashed potatoes for residents who were on a pureed diet. [NAME] 1 was observed pouring flaked potatoes from the manufacturer's bag into a stainless steel container. [NAME] 1 then poured approximately 1000 ml (milliliters- a unit of measurement) into the container. [NAME] 1 stated, I put in about [2000 ml of water]. [NAME] 1 was observed putting a white powdery substance into the container of mashed potatoes. [NAME] 1 stated, I put too much water [in the mashed potatoes]. This is to make it thicker. [NAME] 1 stated there is a recipe with instructions available, but she did not use it to prepare the mashed potatoes. On 9/10/25 at 10:41 A.M. a joint observation and interview was conducted with [NAME] 1. [NAME] 1 was observed preparing cooked chicken for the pureed diets. [NAME] 1 pointed to a binder on a top shelf and stated, The recipes to make pureed foods are there. but stated she did not use a recipe for pureed foods. [NAME] 1 was observed using a slotted spoon to place 5 scoops of diced chicken into a blender. [NAME] 1 stated one serving size was half a cup, but did not use exact measurements. [NAME] 1 stated the slotted spoon represented, about a half a cup. [NAME] 1 placed about 1000 ml of hot water into the blender and one white plastic teaspoon of broth mixture into the blender. [NAME] 1 stated she added thickener to the blender if the chicken mixture appeared too thin. [NAME] 1 stated, I usually just guess [the amount of thickener]. I just add in tablespoon to tablespoon. You know its thick enough if it's a jelly type of texture. On 9/10/25 at 11:30 A.M., a joint observation and interview was conducted with Dietary Aide (DA) 1 in the kitchen. DA 1 was observed placing 25 pieces of whole wheat bread into the blender, then added about 1000ml of water into the blender. DA 1 stated, I add about six teaspoons of thickener. I just guess [the amount of thickener]. we don't have a recipe for bread. 'On 9/10/25 at 12:26 P.M., a concurrent observation and interview was conducted with the Dietary Supervisor (DS) during food sampling of pureed foods for the test meal tray. The pureed mashed potatoes had a [NAME]/grainy texture. The pureed chicken had small chunks of chicken, and had a grainy texture. The DS stated the [NAME]/grainy texture was due to an excessive amount of thickener. The DS further stated it was his expectation that kitchen staff followed recipes when preparing pureed foods. The DS stated, We follow the recipe so we have consistency in flavor, quality, and texture. It's important because it's a safety issue for swallowing purposes. Food needs to be smooth with little or less granulation so [residents on pureed diets] can swallow it without any issues. The DS stated it was important to follow recipes to ensure all textures and consistencies are correct. During a review of the Production Recipe for Grilled Chicken, the recipe indicated, Grilled Chicken.Portion.#8 SCOOP.FOOD THICKENER BULK .2 Tablespoon 1 1/2 Teaspoon.Stock Chicken/Soup Base.1 1/4 Cup. Prepare Slurry.Add 1 oz slurry per portion and process until smooth. During a review of the Standard Recipe Report for Wheat Roll, the recipe indicated, Wheat roll.96.FOOD THICKENER BULK.24 Tablespoon.WATER OR JUICE 3 Quart. prepare slurry and process until smooth adding 1oz slurry per portion.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W. Second Avenue Escondido, CA 92025	
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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and review of the analysis of client accommodations , the facility failed to meet the required minimum square footage requirements of at least 80 square feet per resident (sq/ft/resident) in three resident rooms (6,8,and 11) This failure had the potential to impact resident care and quality of life. A record review was conducted from 9/8/25 through 9/11/25. The following resident rooms contained less than 80 square feet for each resident.Room Number Room Size6 accommodated 3 residents 216 (72 sq ft/ resident)8 accommodated 3 residents 216 (72 sq ft/ resident)11 accommodated 2 residents 138 (69 sq ft /resident) Additionally, observations were conducted. There were no observed quality of care , or quality of life concerns that negatively affected the residents residing in the identified rooms during the recertification survey visit. A continuance of the waiver (variation) from the requirements of code 42 of the federal regulations (cfr) sections 483.70 (d)(l)(ii) as granted, allowing less than 80 square feet per resident room, is hereby recommended. This recommendation is also made with the expectation that the facility will obtain a timely renewal of the current waiver granted by CMS.		