STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to implement care plans for two of 42 residents for: 1. Dialysis (a process to remove waste products from the blood stream, Resident 16) and, 2. Substance use disorder and nicotine dependence (Resident 151). As a result, Resident 16 and Resident 151's care needs, goals and interventions were not addressed or communicated to staff members for continuity of care. Cross reference: F698 Findings: 1. Resident 16 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (irreversible kidney damage) and dependence on dialysis, per the facility's Admission Record. On 10/7/24 at 9:30 A.M., a concurrent observation and interview was conducted with Resident 16. Resident 16 was in bed, with a dialysis access site visible on her left upper arm. Resident 16 stated she went for dialysis on Mondays, Wednesdays and Fridays. Per Resident 16, she returned to the facility around 3 P.M. after dialysis was completed. On 10/10/24 at 8:10 A.M., a concurrent interview and observation of Resident 16 was conducted in her room. Resident 16 was sitting in bed, with her dialysis access site visible on her left arm. Resident 16 stated she had gone to dialysis the previous day and returned as usual around 3 P.M. Per Resident 16, a Licensed Nurse (LN) had removed the dialysis dressing from her access site a few minutes earlier. Resident 16 stated the dressing was often removed the morning after dialysis. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 8:29 A.M., a concurrent interview and record review was conducted with LN 12. LN 12 stated she had just removed the dressing from Resident 16's dialysis access site. LN 12 stated the dressing should have been removed four to six hours after Resident 16 returned from dialysis the previous day, somewhere between 7 P.M. and 9 P.M. LN 12 stated at that time, the P.M. shift nurse should have assessed the site for bleeding or signs of infection, which was a part of the after-dialysis assessment. LN 12 stated leaving the dressing on the dialysis site could cause pressure on the site and could cause problems with future dialysis treatments. LN 12 stated a care plan was used to communicate the specific care needs for each resident, so a care plan for dialysis would be important for Resident 16. LN 12 was unable to locate a care plan for dialysis in Resident 16's medical record. On 10/10/24, a record review was conducted. According to the Minimum Data Set (MDS, an assessment tool), dated 9/3/24, Resident 16's Brief Interview of Mental Status (BIMS) score was 15, indicating intact cognition. According to Resident 16's physician's orders, dated 9/12/24, dialysis treatments were scheduled every Monday, Wednesday and Friday. The physician's orders indicated to remove the dialysis dressing four to six hours after the dialysis treatment, and to inform the physician of any changes to the dialysis access site. No care plan for dialysis was identified for Resident 16. On 10/10/24 at 11:36 A.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the nurses needed to assess the dialysis access site upon return from dialysis and when removing the dressing. Per the DON, one of the places LNs could look for guidelines to care and treatment was the care plan. The DON stated a care plan would be important for every diagnosis Resident 16 had, as the care plan was a guide to the caregivers and provided goals and interventions to meet the goals. The DON was unable to locate a care plan related to dialysis for Resident 16. On 10/10/24 at 4:37 P.M., a concurrent interview and record review was conducted with LN 11. LN 11 stated she had been assigned to Resident 16 the previous day during her shift of 3-11 P.M. LN 11 stated she had forgotten to remove the dialysis dressing from Resident 16's arm. LN 11 stated she had assessed the site with the dressing on but had not returned to remove the dressing or view the site for signs of infection. Per LN 11, the care plan could be a useful tool for communicating dialysis needs between shifts and caregivers. LN 11 was unable to locate a care plan for dialysis in Resident 16's medical records. Per an undated facility policy, titled Comprehensive Person-Centered Care Planning, It is the policy of this facility .shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs .includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care . 2.Resident 151 was admitted to the facility on [DATE] with diagnoses that included substance use disorder per the facility Admission Record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the skilled nursing referral intake summary form dated 9/18/24 indicated Resident 151 had a current history of substance use disorder, and nicotine dependency which was treated at the hospital with a nicotine patch. On 10/09/24 at 3:26 P.M. an interview and concurrent record review were conducted with the Director of Nursing (DON). The DON stated, The care plan for polysubstance abuse (use of more than one substance) has interventions like avoid rearranging the furniture that are not related to the diagnosis. The nurse could have written specific interventions. The care plan for psychosocial wellbeing could have been more specific. A review of the undated facility policy titled Comprehensive Person-Centered Care Planning indicated, . includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care .The care plan will include the minimum healthcare information necessary to properly care for a resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to provide pain management for one of two residents (Resident 200) reviewed for pain management when pain medication was not administered per physician's order for severe pain. This failure had the potential to prevent Resident 200 from receiving adequate pain relief. Findings: According to the Admission Record, Resident 200 was admitted to the facility on [DATE] with diagnoses that included cancer and acute appendicitis (a condition in which the appendix becomes inflamed, causing pain). On 10/8/24 a review of Resident 200's Physician's Orders, dated 7/26/24, indicated to monitor pain level using the following pain scale: 0= No Pain, 1-3=Mild, 4-6= Moderate, 7-10= Severe. On 10/8/24 a review of Resident 200's Physician's Orders, dated 10/1/24 indicated Resident 200 had an order for Oxycodone HCl Oral Tablet 5 mg (milligrams) every four hours for moderate pain. Resident 200 had an order for Oxycodone HCl 10 mg every four hours for severe pain. A review of Resident 200's medication administration record indicated Resident 200 received Oxycodone 5 mg at the following dates and times: On 10/2/24 at 9:19 A.M. for 8 out of 10 pain level (severe). On 10/3/24 at 9:01 A.M. for 8 out of 10 pain level (severe). On 10/4/24 at 8:13 A.M. for 7 out of 10 pain level (severe). On 10/6/24 at 9:04 A.M. for 7 out of 10 pain level (severe). On 10/7/24 at 8:14 A.M. for 8 out of 10 pain level (severe). On 10/8/24 at 3:28 P.M. an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated she administered Oxycodone 5 mg to Resident 200 for 8 out of 10 pain on 10/2/24, 10/3/24, and 10/7/24. LN 1 stated she administered Oxycodone 5 mg, when she should have given Oxycodone 10 mg. LN 1 stated the physician's order was not followed for Resident 200. LN 1 stated it was important to follow the physician's order to ensure residents received adequate pain relief. On 10/10/24 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated his expectation was for Resident 200 to be given the appropriate dose of medication based on his pain scale. The DON stated Resident 200 was undermedicated for his pain level and, .the patient will still continue to have pain . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Pain Recognition and Management revised 12/23 indicated, It is the policy .to ensure that pain management is provided to residents who require such services .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to remove the dressing from a dialysis (treatment to remove waste from the body) access site for one of one residents reviewed for dialysis care (Resident 16). This failure had the potential to result in damage to the dialysis access site. Findings: Resident 16 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (irreversible kidney damage) and dependence on dialysis, per the facility's Admission Record. On 10/7/24 at 9:30 A.M., a concurrent observation and interview was conducted with Resident 16. Resident 16 was in bed, with a dialysis access site visible on her left upper arm. Resident 16 stated she went for dialysis on Mondays, Wednesdays and Fridays. Per Resident 16, she returned to the facility around 3 P.M. after dialysis was completed. On 10/10/24 at 8:10 A.M., a concurrent interview and observation of Resident 16 was conducted in her room. Resident 16 was sitting in bed, with her dialysis access site visible on her left arm. Resident 16 stated she had gone to dialysis the previous day and returned as usual around 3 P.M. Per Resident 16, a Licensed Nurse (LN) had removed the dialysis dressing from her access site a few minutes earlier. Resident 16 stated the dressing was often removed the morning after dialysis. On 10/10/24 at 8:29 A.M., an interview was conducted with LN 12. LN 12 stated she had just removed the dressing from Resident 16's dialysis access site. LN 12 stated the dressing should have been removed four to six hours after Resident 16 returned from dialysis the previous day, somewhere between 7 P.M. and 9 P. M. LN 12 stated at that time, the P.M. shift nurse should have assessed the site for bleeding or signs of infection, which was a part of the after-dialysis assessment. LN 12 stated leaving the dressing on the dialysis site could cause pressure on the site and could cause problems with future dialysis treatments. On 10/10/24, a record review was conducted. According to the Minimum Data Set (MDS, an assessment tool), dated 9/3/24, Resident 16's Brief Interview of Mental Status (BIMS) score was 15, indicating intact cognition. According to Resident 16's physician's orders, dated 9/12/24, dialysis treatments were scheduled every Monday, Wednesday and Friday. The physician's orders indicated to remove the dialysis dressing four to six hours after the dialysis treatment, and to inform the physician of any changes to the dialysis access site. According to the Medication Administration Record (MAR), LN 11 documented she had removed the dialysis dressing on 10/9/24, during the P.M. shift (3-11 P.M.). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Facility/Dialysis Center Nursing Communication Record, dated 10/9/24 with no time indicated, LN 11 documented the dialysis dressing was in place, had no bleeding, and had no signs or symptoms of infection at the dialysis access site. On 10/10/24 at 11:15 A.M., an interview was conducted with LN 13. LN 13 stated she was assigned to Resident 16 and was familiar with her care. LN 13 stated she had given report to LN 11, regarding Resident 16's dialysis treatment and return to the facility. LN 13 stated it was the responsibility of the P.M. nurse to assess the dialysis site and remove the dressing four to six hours after return from dialysis. LN 13 stated it was necessary to remove the dressing to check for bleeding, and to assess the site for any damage or bleeding. LN 13 stated failing to complete the assessment could cause damage to the dialysis access site. On 10/10/24 at 11:36 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the nurses needed to assess the dialysis access site upon return from dialysis and when removing the dressing. Per the DON, the expectation was for all nurses to follow the physician's orders to keep the residents safe. On 10/10/24 at 4:37 P.M., an interview was conducted with LN 11. LN 11 stated she had been assigned to Resident 16 the previous day during her P.M. shift of 3-11 P.M. LN 11 stated she had forgotten to remove the dialysis dressing from Resident 16's arm. LN 11 stated she had assessed the site with the dressing on but had not returned to remove the dressing or view the site for signs of infection. LN 11 could not explain why she had documented she completed the dressing removal in the MAR. Per LN 11, failing to remove the dressing could cause infection or compress the dialysis access site. Per a facility policy, revised December 2023 and titled Dialysis (Renal), Pre-and Post-Care, It is the policy of this facility to .Assess and maintain patency of renal dialysis access .Post-Dialysis Care: 1. Dialysis access should be assessed upon return to the facility for .any unusual redness or swelling. 2. Post dialysis .access care as ordered .Documentation: Documentation related to .post-dialysis care will be placed in the clinical record and include .assessment of renal dialysis access site .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on observation, interview and record review, the facility failed to provide services for substance use disorder (a disease that affects a person's inability to control the use of a legal or illegal drug or medicine) and nicotine dependency (a state of physical or psychological habit) to one resident, Resident 151. As a result, Resident 151 had the potential to experience cravings. Findings: Resident 151 was admitted to the facility on [DATE] with diagnoses that included psychoactive substance use (an impaired ability to control substance-taking behavior). On 10/7/24 a record review was conducted. The Facility Assessment 2024 indicated the facility could provide services for residents with Mental health: active or current substance use disorder. The skilled nursing referral intake summary form dated 9/18/24 indicated Resident 151 had a current history of substance use disorder and cigarette use. The document indicated Resident 151 was receiving a nicotine patch prior to admission to the facility. The facility history and physical written by Medical Doctor (MD) 1 dated 9/20/24 did not indicate a history of nicotine use or substance use disorder. Resident 151's physician's orders, dated 9/20/24, indicated psychiatry and psychology to evaluate and treat. On 10/8/24 at 3:30 P.M. an interview was conducted with Resident 151 and the Social Services Director (SSD). Resident 151 stated, No one has offered nicotine gum or patches. I can't get the smokes. The SSD stated the resident had used substances prior to admission to the facility. The SSD stated, I didn't offer him any resources for Narcotics Anonymous (a support group for people who are recovering from substance use disorder) while in the facility. There have been no psychology or psychiatry visits. I haven't offered anything since he has been here. I have not had a conversation with him to see if he's having cravings. On 10/9/24 at 3:26 P.M. an interview and concurrent record review were conducted with the Director of Nursing (DON). The DON stated the doctor's history and physical did not include nicotine or substance use. Per the DON, the doctor should have reviewed the hospital paperwork so that the facility could treat his current problems. The DON stated the facility should have asked the patient if he still used substances or smoked and there was no admission smoking assessment for Resident 151. The DON stated the facility had not provided interventions to address nicotine use or substance use disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the job description for Social Services Manager, dated 11/30/21 and signed by the SSD indicated, The primary purpose of your job position is to . assure that the medically related emotional and social needs of the resident are met/ maintained on an individual basis .Refer resident/families to appropriate social service agencies when the facility does not provide the services or needs of the resident. A review of the facility policy titled Behavioral Health Services revised 12/2023 indicated, It is the policy of this facility to provide residents with necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being .which includes the prevention and treatment of mental and substance use disorders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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	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** 38512 Based on observation, interview and record review, the facility failed to ensure a medication was given as ordered by the physician for one of 14 sampled residents (Resident 106). This failure had the potential to affect the health and well-being of Resident 106. Findings: Resident 106 was admitted to the facility on [DATE] with diagnoses to include knee replacement surgery, per the facility's Admission Record. On 10/7/24 at 8:53 A.M., a concurrent observation and interview was conducted with Resident 106. Resident 106 was sitting on the bed, with her legs extended out in front of her. Two white patches were located on each side of her left knee. The patches were approximately five inches by four inches in size, and did not have any writing on them. Resident 106 stated the patches were for pain, as she had surgery about two weeks ago. Resident 106 stated she did not have another medication for pain, but the patches worked to control her pain, especially when the nurse first applied them each day. Per Resident 106, the pain patches were from the previous day in the morning, and she had not received new patches yet that day. Resident 106 stated she usually removed the patches each morning when the nurse came in to place new patches on her knee. On 10/9/24 at 10:25 A.M., a concurrent interview and observation of wound care was conducted with Resident 106 and Licensed Nurse (LN) 12. LN 12 removed the bandage on Resident 106's left knee, exposing one pain patch with no date or time written on it. Resident 106 stated the pain patch had been applied the previous day after Physical Therapy, at approximately 10:30 A.M. LN 12 removed the pain patch, and stated the LN from the previous evening shift should have removed the patch. On 10/10/24, a record review was conducted. A physician's order, dated 9/25/24, indicated Resident 106 was to have a Lidocaine External Patch 4% (a pain patch applied to skin) applied to the left leg once a day for pain, with the patch to be applied at 9 A.M., then removed at 9 P.M. Manufacturer's instructions on the Lidocaine patch packaging indicated the patch was to be applied, .up to 12 hours within a 24 hour period . On 10/10/24 at 8:05 A.M., an interview was conducted with LN 12. LN 12 stated the pain patch should have been removed 12 hours after being applied, as the manufacturer recommended. LN 12 stated the pain patch had cardiac (heart) effects, so writing the date and time applied was important, as was removing them as scheduled. LN 12 stated she had removed the patch during wound care on 10/9/24, approximately 12 hours late. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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	On 10/10/24 at 10:55 A.M., an interview was conducted with the Director of Nursing (DON). Per the DON, the Lidocaine patches were to be applied per physician's orders and manufacturer's recommendations. The DON stated LNs were supposed to write the date and time the patches were applied, and not doing so could cause the patient to not receive adequate medication or cause complications to their medical care. On 10/10/24 at 4:30 P.M., an interview was conducted with LN 11. LN 11 stated she had been assigned to Resident 106 several previous shifts, including evenings (approximately 3-11 P.M.) for the last two days. LN 11 stated it was her responsibility to remove the Lidocaine patches during her shift, around 9 P.M. LN 11 stated she must have forgotten to do so. Per LN 11, failing to remove the Lidocaine patches could cause the medication to be less effective. Per an undated facility policy, titled Medication Administration and Storage, It is the policy of this facility to accurately prepare, administer and document medications .2. Review and verify MD orders . Per an undated facility policy, titled Six Rights of Medication Administration, It is the policy of this facility to ensure that the six rights of medication administration are followed in order to ensure safety and accuracy of administration .2. Right Time - Medications are administered within prescribed time frames .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38512 Based on observation, interview and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's mediation error rate was 7.14%. Two medication errors were observed, a total of 28 opportunities, during the medication administration process for two of three randomly observed residents (Residents 1, 31, and 104). As a result, the facility could not ensure medications were correctly administered to all residents. Findings: 1. On 10/9/24 at 8:17 A.M., a concurrent observation of medication administration, record review and interview with Licensed Nurse (LN) 13 was conducted. LN 13 prepared medications for Resident 31. LN 13 mixed Effer-K (a potassium supplement) with five ounces of water. The package instructions indicated to mix the Effer-K with 2-3 ounces of water. When prompted, LN 13 discarded the incorrectly mixed medication and remade the medication. LN 13 stated she should have followed the instructions on the packaging. Per LN 13, mixing the medication with the wrong amount of water could cause the medication to be less effective. On 10/9/24 at 5:12 P.M., a concurrent interview and record review was conducted with LN 13. LN 13 stated different brands of each medication could be in the medication cart, so it was important to follow the manufacturers instructions on the packaging. 2. On 10/9/24 at 8:46 A.M., LN 13 prepared and administered medication for Resident 104. LN 13 counted 10 medications, with a total of 11 capsules and tablets provided to Resident 104. On 10/9/24 at 3 P.M., a record review was conducted. Resident 104 had a physician's order for a multivitamin to be administered at 9 A.M., for a total of 12 tablets which should have been administered. On 10/9/24 at 5:12 P.M., a concurrent interview and record review was conducted with LN 13. LN 13 stated it was important to follow the physician's orders as the resident may need each medication for a medical condition. On 10/10/24 at 10:46 A.M., an interview was conducted with the Director of Nursing (DON). Per the DON, it was the facility's standard to follow the package instructions on all medications. The DON stated not mixing the medication correctly might affect the way the medication worked. The DON also stated the nurses should strictly follow the physician's orders, ensuring all medications were administered. Per an undated facility policy, titled Medication Administration and Storage, It is the policy of this facility to accurately prepare, administer and document medications . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per an undated facility policy, titled Six Rights of Medication Administration, It is the policy of this facility to ensure that the six rights of medication administration are followed in order to ensure safety and accuracy of administration .3. Right Medication .4. Right Dose .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on observation, interview and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen for food storage methods, according to standards of practice and facility policy when: 1. Multiple food items were not dated correctly. 2. The ice machine was observed to have black residue inside the ice bin and the water filter for the ice machine was 45 days past the due date to be changed. These failures had the potential for food contamination, which could result in food borne illnesses for all residents who consume food from the kitchen. The census was 42. Findings: 1. An initial kitchen tour with [NAME] (CK) 1 was conducted on [DATE] at 7:45 A.M. An open box of corn starch and an open box of rice cereal were not transferred to sealed containers and labeled with a use by date. An open bottle of imitation vanilla flavoring was not labeled with a use by date. Boxes of fountain juices were labeled with numbers 921 and 105 without indication of what the numbers meant. Bags of toasted oats cereal were labeled [DATE] without indication of what the date referred to. CK 1 stated the toasted oats cereal should have an R for received next to the date. CK 1 stated opened food items should be marked with OP to indicate an opened date and BY to indicate a used by date. On [DATE] at 11:55 A.M. an interview was conducted with the Certified Dietary Manager (CDM) who stated food items should be marked with the received date designated with the letter R, the opened date designated with the letters OP and the use by date designated with the letters BY. The Registered Dietitian (RD) stated, The contractor dates the boxes of drinks as received date. Staff should mark them with the open date. The vanilla should have been marked with the opened date and the use by date. The cereals should have been transferred to a container with a lid and labeled with the opened date and the use by date. On [DATE] a record review was conducted. Per an undated facility training document, titled Food and Nutrition Skills Check - Labeling and Dating of Foods indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures .The Use By date will be the absolute date in which the food must be consumed or discarded by the facility. Food delivered to the facility needs to be marked with a delivery or received date. The individual preparing/handling food shall be responsible for date marking at the time of processing and/or storage Food should be dated once opened with the date by which foods shall be consumed or discarded - Use By date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per a facility policy, dated 2023 and titled Labeling and Dating of Foods, Policy: All food items in the store room, refrigerator, and freezer need to be labeled and dated based on established procedures .Definitions: . DD = Delivery, or received date; OD = Open Date .UB = Use By Date Food delivered to facility needs to be marked with a delivery or received date The individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage 2. During an initial kitchen tour on [DATE] at 7:45 A.M., an observation of the ice machine was conducted with [NAME] (CK) 1. The interior of the machine had black residue along the top seam directly above the ice. Condensation from the area dripped directly onto the ice cubes below. CK 1 stated, That's mold. Patients might get sick. A concurrent record review of the ice machine cleaning log was conducted. CK 1 stated, The last time the ice machine was cleaned by the contractor was [DATE]. The last time it was cleaned by our maintenance was [DATE]. A filter between the water inlet at the wall and the connecting hose to the ice machine was dated [DATE]. On [DATE] at 11:55 A.M. an interview was conducted with the CDM, the RD and the Maintenance Director (MaintD). The MaintD stated, I service the machine monthly. Every time I clean and wipe there's something black that I find. The filter should be changed once per year. It was last changed on [DATE], it's late by one and a half months. The CDM stated he did not know about the filter. The RD stated, I was not aware of the expired filter. The substance in the ice machine is probably mold and the maintenance director should have made someone aware so we could find the root cause of the issue. The risk is food borne illness. On [DATE] at 9:25 A.M. an interview was conducted with the Contracted Technician (CT) for the ice machine. The CT stated a technician was responsible to check the filter to see if it was due to be changed. Per the CT, if the filter had been changed it was possible the ice machine would not have developed mold, as the filter had antimicrobial properties. On [DATE] a record review was conducted. A review of the contractor Service Work Order and Invoice dated [DATE] did not include change of the filter in the description of work done. A review of the Instruction Manual for Hoshizaki KM-520MAJ-E ice machine indicated Maintenance Schedule: .More frequent maintenance may be required depending on water quality, the appliance's environment, and local sanitation regulations Monthly: external water filters. A review of the facility policy titled Sanitation dated 2023 indicated, The FNS (Food Nutrition Services) Director is responsible for instructing employees in the fundamentals of sanitation in food service and for training employees to use appropriate techniques The Maintenance Department will assist Food and Nutrition Services as necessary in maintaining equipment .Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to implement infection control procedures when: 1. Continuous Positive Airway Pressure (CPAP- a device that delivers oxygen) machine mask and tubing were not stored in a sanitary manner. 2a. Enhanced Barrier Precautions (EBP- infection control procedures to lessen the risk of cross-contamination) were not implemented for three rooms and, 2b. Visitors were not educated regarding the need for hand hygiene. This failure had the potential for the spread of infection to other residents in the facility. Findings: 1. According to the Admission Record, Resident 28 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea (a condition in which breathing is interrupted during sleep). During a record review conducted on 10/7/24, the Minimum Data Set (MDS, an assessment tool) for Resident 28 indicated a Brief Interview for Mental Status (BIMS assessment tool) of 15 indicating intact cognition. On 10/7/24 at 8:59 A.M., a concurrent observation and interview was conducted with Resident 28. Resident 28's CPAP machine was observed on the resident's night stand. The CPAP mask, which would come in contact with the resident's face, was observed dangling from the night stand, uncovered and approximately an inch of an empty urinal. On 10/8/24 at 4:18 P.M., an interview was conducted with Resident 28. Resident 28 stated the CPAP machine was his personal one brought from home. Resident 28 stated I don't clean it here .nobody does. On 10/8/24 at 4:20 P.M. an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 28's CPAP mask should be stored in a plastic bag. LN 2 stated if the mask was on the floor, .it can get dirty .it should be contained for infection control . On 10/10/24 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was his expectation for staff to clean CPAP machines after each use, and to store the mask in a plastic container. The DON stated, It is important to clean it every night to avoid growing microorganisms. It's wet, you don't want to inhale it. Respiratory infection can happen . A review of the facility's undated policy titled Care and Storage of Nebulizer/CPAP Equipment indicated, It is the policy of this facility to clean the .equipment after use . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. On 10/7/24 at 8 A.M., an observation was conducted. Three residents were identified with indwelling devices, such as a feeding tube and a catheter. Of the three, none had signage outside the door indicating EBP or isolation supplies. During an interview on 10/8/24 at 8:59 A.M. with LN 1, LN 1 stated residents with indwelling devices should be on EBP, .because of potential risk for infection to the patient. On 10/9/24 at 10:41 A.M., an interview was conducted with the Infection Preventionist (IP). The IP stated residents with devices should be on EBP, per Centers for Disease Control (CDC) guidelines. The IP stated residents on EBP should have a sign posted outside the room to indicate the precaution. The IP stated there should be a supply of Personal Protective Equipment (PPE-gowns, gloves, masks) available near residents' rooms. On 10/10/24 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was the responsibility of the IP to ensure residents who required EBP were placed on EBP precautions. The DON stated .EBP is important for patient safety, to prevent the patient from getting infection and to protect everyone else . 2b. Resident 16 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (irreversible kidney damage) and dependence on dialysis, per the facility's Admission Record. On 10/10/24 at 8:12 A.M., an observation of Resident 16's room was conducted. An orange sign was posted outside the room, indicating Resident 16 was in EBP, and, .EVERYONE MUST: Clean their hands, including before entering and when leaving the room . LN 13 was preparing medications outside of the room, and Certified Nursing Assistant (CNA) 11 was inside the room. On 10/10/24 at 8:15 A.M., an observation was conducted. Two visitors entered Resident 16's room without reading the sign or performing hand hygiene. On 10/10/24 at 8:16 A.M., an interview was conducted with LN 13. LN 13 stated Resident 16 was in EBP due to an indwelling device, which placed her at higher risk for infection. LN 13 stated she had not seen the visitors enter the room, but she should have stopped them and provided education regarding the need for hand hygiene. LN 13 stated it was important to educate visitors as it was intended to protect the resident from infection, but she had not done so. On 10/10/24 at 8:18 A.M., an interview was conducted with CNA 11. CNA 11 stated Resident 16 was in EBP due to her indwelling device. CNA 11 stated it was everyone's responsibility to educate visitors and staff regarding the importance of performing hand hygiene before entering the room. CNA 11 stated she had not informed the visitors to do so. CNA 11 stated not performing hand hygiene could cause the resident to get sick from infections. On 10/10/24 at 11:36 A.M., an interview was conducted with the DON. Per the DON, all staff should follow the instructions on the signs, and visitors must be educated to follow the facility guidelines. The DON stated, All staff is responsible for educating about this. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled IPCP Standard and Transmission Based Precautions indicated, .It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions .EBP .is indicated .for nursing home residents with .indwelling medical devices . 49330

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to offer and/or provide education regarding the benefits and potential side effects of the pneumococcal (a type of bacterial lung infection) vaccine to four of ten residents (Residents 18, 71, 105, and 201) reviewed for immunizations. This failure posed the risk of the residents contracting pneumonia and its associated complications. Findings: 1. According to a review of Resident 18's Admission Record, the resident was over [AGE] years old. During a review of Resident 18's immunization record, there was no indication the resident was offered or received the pneumococcal vaccine. 2. According to a review of Resident 71's Admission Record, the resident was over [AGE] years of age. During a review of Resident 71's immunization record, there was no indication the resident was offered or received a pneumococcal vaccine. 3. According to a review of Resident 105's Admission Record, the resident was over [AGE] years old. During a review of Resident 105's immunization record, there was no indication the resident was offered or received a pneumococcal vaccine. 4. According to a review of Resident 201's Admission Record, the resident was over [AGE] years old. During a review of Resident 201's immunization record, there was no indication the resident was offered or received a pneumococcal vaccine. On 10/10/24 at 8:49 A.M. an interview was conducted with the Infection Preventionist (IP). The IP stated it was important to offer vaccines to residents aged 65 and older .to protect them, us or family members from different viruses .older people are more frail . The IP stated it was important give the pneumococcal vaccine to help residents stay healthy. On 10/10/24 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated his expectation was that staff offer the pneumococcal vaccine to eligible residents. The DON stated . [Residents] are more susceptible to pneumonia .its important to protect them . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy titled Immunizations-Resident indicated, Receipt of vaccinations is essential to the health and well-being of long-term care residents .Pneumococcal pneumonia .is a common cause of hospitalization and death. People [AGE] years or older are two to three times more likely than the younger population to get pneumococcal infections . The policy also indicated, Information related to education provided regarding the benefits and risks of (the pneumococcal vaccine) and the administration or refusal of or medical contraindications to the vaccine will be documented in the resident's medical record .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to ensure four of ten residents sampled for immunizations were offered the Covid-19 vaccine. This failure resulted in the potential for residents to be infected with or experience complications from Covid-19. Findings: According to the Admission Record, Resident 39 was admitted to the facility on [DATE]. A review of Resident 39's immunization indicated Resident 39 received the Covid-19 vaccination in 2021. There was no documentation that Resident 39 was offered, received, or declined the Covid-19 vaccine since admission. According the the Admission Record, Resident 201 was admitted to the facility on [DATE]. There was no documentation that Resident 201 was offered, received, or declined the Covid-19 vaccine since admission. According to the Admission Record, Resident 30 was admitted to the facility on [DATE]. According to the Immunization Record, Resident 30 received the Covid-19 booster shot in 2022. There was no documentation that Resident 30 was offered, received, or declined the Covid-19 vaccine since admission to the facility. According to the Admission Record, Resident 9 was admitted to the facility on [DATE]. A review of Resident 9's Immunization Record indicated Resident 9 received the Covid-19 booster shot in 2021. There was no documentation that Resident 30 was offered, received, or declined an updated Covid-19 vaccine since admission to the facility. On 10/10/24 at 8:49 A.M., a concurrent interview and record review for Residents 39, 201, 30, and 9 were conducted with the Infection Preventionist (IP). The IP stated the facility offered updated Covid-19 vaccinations to residents .every three to four months . The IP stated every resident's vaccination status (including refusals, declinations, or receipt of the Covid-19 vaccines) should be documented in the residents' electronic chart under Immunizations. The IP stated education provided to the resident regarding the Covid-19 vaccine should also be documented. On 10/10/24 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important that residents are offered the Covid-19 vaccine. The DON stated it was important to offer vaccinations .even if it doesn't prevent .Covid, it will prevent an ill effect of the disease. Plus they're older and more susceptible . The DON stated it was his expectation for residents' Covid-19 vaccination status to be updated in the Immunization Record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055505	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Vista Nursing Center	3022 45th Street San Diego, CA 92105

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy titled Vaccinations Policy indicated, It is the policy of this facility to offer and administer .Covid-19 immunizations to eligible residents .to minimize the risk of residents acquiring, transmitting, or experiencing complications from .Covid-19 by ensuring that each resident .has the opportunity to receive .the Covid-19 vaccine .Document that the resident either received .the Covid-19 immunization or did not receive the Covid-19 immunization .[in the] electronic health record/immunization tab/progress notes .