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	01/29/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to document nursing care in an accurate, concise manner when:1. Wound treatments were not documented for one of two residents (Resident 36); and,2. Skin observations were documented as being performed for one of two residents (Resident 60) with a condom catheter (a non-invasive device for males that looks like a condom, fits over the penis, and has a tube to drain urine into a collection bag), when no condom catheter was present, when reviewed for documentation.These failures had the potential for Resident 36 and Resident 60's clinical record to be incomplete and inaccurate. Findings:1. Resident 36 was admitted to the facility on [DATE], with diagnoses which included hepatic encephalopathy (a decline in brain function occurring in patients with advanced liver disease), per the facility's Face Sheet.Resident 36's clinical record was reviewed 1/27/26. According to the Physician's order dated 1/3/26:a. Cleanse right leg wound, apply Silvadene (a prescription topical cream used to prevent and treat infections), cover with pad and secure with Kerlix (a woven gauze) every day.b. Cleanse right heel, apply betadine, wrap with dry kerlix every day.c. Cleanse right ischium (hip bone), apply barrier cream every day.d. Cleanse left posterior heel, apply Santyl (a prescription topical ointment used to debride (remove) dead, damaged tissue from chronic wounds) and apply alginate (a medicate cream that promotes healing). Cover with dry dressing and kerlix wrap, every day.e. Cleanse right and left leg, apply Silvadene and cover with pad, secure with kerlix wrap, every day.f. Cleanse left plantar heel (inner heel) and apply Silvadene. Cover with pad and secure with kerlix wrap, every day.g. Cleanse right buttocks, apply hydrogel (a medicated cream that promotes healing). Cover with dry dressing, every day.h. Cleanse left heel, apply Santyl and alginate. Cover with foam dressing and change daily.A review of Resident 36's Treatment Administration Record (TAR), indicated no wound treatments were performed on 1/15/26.A review of Resident 36's Nursing Progress notes, indicated Resident 36 remained in the facility on 1/15/26.A review of the nursing schedule, dated 1/15/26, indicated the Infection Control Nurse (ICN) was the acting treatment nurse during the day shift (7 A.M.to 3:30 P.M.). An interview and record review was conducted with the ICN on 1/27/26 at 4:18 P.M. The ICN stated she filled- in for the treatment nurse 1/15/26, after the treatment nurse called in sick. The ICN reviewed Resident 36's TAR and stated she performed the wound treatments on 1/15/26, but did not them. The ICN stated she knows she performed all the wound treatments, because it took so long and she specifically recalls doing the treatments. The ICN stated by not documenting wound treatment, the reader would not know if the physician's order was followed. The ICN stated it was important to document all wound treatments, so everyone knows they were done. 2. Resident 60 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar) type II (non-insulin dependent) with foot ulcer (wound), per the facility's Face Sheet. An interview was conducted with Resident 60 on 1/26/26 at 8:52 A.M., as he laid in bed. Resident 60 stated They took away my condom catheter and now I'm wet all the time, and the urine irritates my skin. Resident 60 could not recall if the condom catheter was removed at the hospital or when he arrived at the facility. Resident 60 asked if he could get a condom catheter again, because it really helped keep him dry and pain free. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 60's clinical record was reviewed on 1/28/26. According to the physician's order, dated 1/23/26, monitor skin surrounding condom catheter for skin integrity or any skin breakdown, every shift.According to Resident 60's TAR dated 1/23/26 through 1/28/26, the skin surrounding the condom catheter was checked 14 out of 14 times as being performed and skin intact.A wound treatment observation of Resident 60 was conducted on 1/28/26 at 2:04 P.M. with Licensed Nurse 1 (LN 1). During the wound treatment, Resident 60 was observed not having a condom catheter, and LN 1 did not inspect the skin surrounding his penis for irritation.An interview and record review was conducted with LN 1 on 2/28/26 at 2:35 P.M., after Resident 60's wound treatment. LN 1 confirmed it was her signature that signed off Resident 60's skin inspection around the condom for the past three days. LN 1 stated she never realized Resident 60 was supposed to have a condom catheter and she never actually performed a skin inspection. LN 1 stated she missed it completely. LN 1 stated the harm of not having a condom catheter as ordered by the physician, would be skin irritation and possibly moist skin associated damage. LN 1 stated by documenting a skin inspection, which was not actually done, was considered inaccurate documentation and false.An interview and record review was conducted with the ICN on 1/28/26 2:37 P.M., of Resident 60's TAR. The ICN reviewed Resident 60's admission assessment and stated the resident did not have a condom catheter on admission. The ICN stated she expected the admission nurse to capture the order for a catheter condom or to contact the physician when she did not see one. The ICN stated the condom catheter should have been captured to prevent pain and a decline in skin integrity. The ICN stated the nurses should not have been documenting the skin and condom catheter were intact, if they never checked it. An interview was conducted with the Director of Nursing (DON) on 1/29/26 at 1:01 P.M. The DON stated he expected resident medical records to be complete, accurate, and concise. The DON stated if wound treatments were not completed and condom catheters were not checked; the reader would not know what treatment was really being provided.According to the facility's policy, titled Charting and Documentation, undated, The resident's clinical record is a concise account of treatment, care, response to care, signs and symptoms and progress of the resident's condition.

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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 review the facility failed to ensure a resident was informed of the right to a bed hold when transferred to the hospital.As a result, one (56) of three discharged residents was not informed of the right to a 7 day bed hold.Findings:On 1/29/26 Resident 56's clinical record was reviewed. Resident 56 was admitted to the facility on [DATE] with diagnoses which included malignant carcinoma (a type of cancer) according to the facility face sheet. Resident 56's Brief Interview for Mental Status score (a mental assessment tool) dated 10/21/25 was 12 (which indicated some memory issues, but not severely impaired).A Change in Condition Evaluation indicated Resident 56 was transferred to the hospital on [DATE]. A nursing progress note dated 10/28/25 indicated, .Writer called (the hospital) and was notified that resident is being admitted . The Discharge Minimum Data Set (standardized health status assessment tool) dated 10/28/25 indicated, Return anticipated. There was no facility document to indicate Resident 56 was informed of the right to a bed hold. On 1/29/2026 at 9:25 A.M., the Admissions Coordinator (AC) was interviewed. The AC stated the facility attempted review bed hold paperwork with Resident 56 but she was always asleep or groggy so did not sign it. The AC stated it should have been documented that the resident knew about the bed hold.On 1/29/2026 at 9:29 A.M. the Social Services Director (SSD) was interviewed. SSD stated residents should have been told about the bed hold to ensure they know the bed will be held for them. The SSD stated the resident's bed is held for 7 days after transfer to the hospital.On 1/29/26 at 1P.M., the Director of Nursing was interviewed. DON stated all residents sent to the hospital should be given a bed hold. The DON stated it should have been communicated to Resident 56 that her bed would be held for 7 days. The DON acknowledged if Resident 56 was not able to review it at the facility, the documentation should have been sent to her at the hospital.According to the facility admission packet, If you must be transferred to an acute hospital.we will notify you or your representative that we are willing to hold your bed.According to the undated facility policy Bed Hold, Procedure: 1. The resident or the resident's representative shall be informed in writing of their right to exercise the bed hold provision in the event of a transfer from the facility to a general acute care hospital.Each notice shall include: the duration of the State bed-hold policy and/or of the facility policy that the resident's bed will be held for the duration of 7 days, during which time the resident is permitted to return and resume residence in the facility.In the event of an emergency transfer, the second notice will be provided within 24 hours.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the physician's plan of care when a condom catheter (a non-invasive device for males that looks like a condom, fits over the penis, and has a tube to drain urine into a collection bag), was not applied for one of two residents (Resident 60), reviewed for plan of care.This failure had the potential for Resident 60 to experience increased pain and a decline in skin integrity.Findings:Resident 60 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar) type II (non-insulin dependent) with foot ulcer (wound), per the facility's Face Sheet. An interview was conducted with Resident 60 on 1/26/26 at 8:52 A.M., as he laid in bed. Resident 60 stated, They took away my condom catheter and now I'm wet all the time, and the urine irritates my skin. Resident 60 could not recall if the condom catheter was removed at the hospital or when he arrived at the facility. Resident 60 asked if he could get the condom catheter back again, because it really helped keep him dry and pain free. Resident 60's clinical record was reviewed on 1/28/26. According to the physician's order, dated 1/23/26, monitor skin surrounding condom catheter for skin integrity or any skin breakdown, every shift.According to Resident 60's TAR dated 1/23/26 through 1/28/26, the skin surrounding the condom catheter was checked, for 14 out of 14 times opportunities as being performed and skin intact. A wound treatment observation of Resident 60 was conducted on 1/28/26 at 2:04 P.M. with Licensed Nurse 1 (LN 1). During the wound treatment, Resident 60 was observed without a condom catheter, and LN 1 did not inspect the skin surrounding his penis for skin irritation.An interview and record review was conducted with LN 1 on 2/28/26 at 2:35 P.M., after Resident 60's wound treatment. LN 1 confirmed it was her signature that signed off Resident 60's skin inspection around the condom for the past three days. LN 1 stated she never realized Resident 60 was supposed to have a condom catheter and she never actually performed a skin inspection. LN 1 stated she missed the physician's order completely. LN 1 stated the harm of not having a condom catheter as ordered by the physician, would be skin irritation and possibly moist skin associated damage. LN 1 stated by documenting something she was not doing, was considered inaccurate and false.An interview and record review was conducted with the ICN on 1/28/26 2:37 P.M., of Resident 60's TAR. The ICN reviewed Resident 60's admission assessment and stated the resident did not have a condom catheter on admission. The ICN stated she expected the admission nurse to capture the order for a catheter condom or to contact the physician when she did not see observed a condom catheter. The ICN stated the condom catheter should have been captured in order to prevent pain and a decline in skin integrity. The ICN stated the nurses should not have been documenting the skin and condom catheter were intact, if they never checked it. An interview was conducted with the Director of Nursing (DON) on 1/29/26 at 1:01 P.M. The DON stated he expected staff to be aware of the physician's orders and to contact the physician if clarification was needed. According to the facility's policy, titled Physician Orders, dated June 2024, .3. admission orders are reviewed with the physician on admission based on the discharge instructions from the discharging facility and are transcribed accordingly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review ,the facility failed to ensure safe infection control practices were followed when a urinary catheter bag (a flexible tube inserted in order to drain urine from the bladder into an external collection bag), and its tubing was in contact with the floor for one of two residents (Resident 5) when reviewed for catheter care.This failure had the potential for Resident 5 to sustain a urinary tract infection from bacteria on the floor. Findings:Resident 5 was admitted to the facility on [DATE] with diagnoses which included need for personal assistance, per the facility's [NAME] Sheet.An observation was conducted of Resident 5 during initial tour on 1/26/26 at 9:30 A.M. Resident 5 was asleep in bed with a urinary collection bag clipped to the left side of the bedframe. The catheter collection bag and the tubing were both in contact with the floor. An observation and interview was conducted with certified nursing assistant 1 (CNA 1), of Resident 5 on 1/26/26 at 9:39 A.M. CNA 1 observed Resident 5's urinary collection bag and stated, the bag and tubing are in contact with the floor. CNA 1 stated the catheter on the floor was an infection control issue, and the resident was at risk for infection. Resident 5's medical record was reviewed on 1/26/26. According to the physician's order, dated 8/15/25, indwelling catheter to gravity drainage for diagnoses of urinary retention (the inability to empty the bladder on your own). An interview was conducted with the Infection Control Nurse (ICN) on 1/27/26 at 10:36 A.M. The ICN stated urinary collection bags and their tubing should never be in contact with the floor because bacteria could travel up the tubing into the resident, resulting in an infection.An interview was conducted with the Director of Nursing (DON) on 1/29/26 at 1:01 P.M. The DON stated urinary collection bags should never be on contact with the floor, because the floor contains bacteria and the resident could be at risk of an infection. According to the facility's policy, titled Infection Prevention and Control Program, undated, .The infection prevention and control program is comprehensive in that it addresses detection, prevention, and control of infections among residents.