STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056330	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review the facility failed to notify the attending physician and resident representative on four of five residents (Resident 2, 3, 5 and 7) reviewed for changes in condition when: 1. Resident 2 ' s representative was not notified of a wound deterioration. 2. Resident 3 ' s attending physician was not notified of a significant weight loss. 3. Resident 5 ' s attending physician was not notified of a significant weight loss. 4. Resident 7 ' s representative was not notified of a wound deterioration. These failures had the potential for a delay in care in treatment. In addition, the residents ' representatives were not aware of the change in condition. 1. Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (an impairment of brain function, such as memory loss and judgment) and muscle weakness according to the facility ' s Admission Record. During an interview on 9/9/24 at 8:48 A.M. with Resident 2 ' s granddaughter, the granddaughter stated Resident 2 was admitted to the facility with a bruise on the tailbone which worsened to a stage four wound (bedsore extended to muscle, tendon, or bone) and the family was not notified. During a review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/9/24, section GG0170 A through E indicated Resident 2 was dependent with rolling in bed, sit to lying, lying to sitting on side of bed, sit to stand and transfers. During observation on 9/9/24 at 9:41 A.M., Resident 2 was in bed with an air mattress and oxygen via nasal cannula (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen). Resident spoke only Spanish. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2 ' s care plans was conducted. Resident 2 ' s skin care plan initiated on 7/2/24 indicated, .at risk for skin breakdown related to activity intolerance, Braden Risk (a measurement of a resident ' s risk of developing pressure ulcers, or sores) score, Cardiovascular disease .impaired ADL (activities of daily living) ability .Assist to turn and reposition as indicated/tolerated, check skin during daily care provisions . On 9/9/24 at 9:35 A.M. the treatment nurse (TN) was observed entering Resident 2 ' s room. The TN stated she will be providing treatment to Resident 2 ' s pressure ulcer (bedsore) on the sacro-coccyx (the triangular shaped bone at the base of the back area and tailbone) area. The TN was observed during treatment of Resident 2 ' s pressure ulcer. Resident 2 ' s sacro-coccyx area was observed with a large (size of a golf ball), deep pressure ulcer with medium amount of tan/yellow drainage inside the pressure ulcer, yellow tissue and with foul odor. Resident 2 stated, Oww, as the treatment nurse cleaned the pressure ulcer. An interview and joint record review on 9/9/24 at 10:17 A.M. was conducted with the treatment nurse. The TN was not able to find Resident 2 ' s initial skin assessment in the resident ' s electronic medical record (EMR). The TN reviewed Resident 2 ' s progress notes (PN) dated 7/16/24 and stated Resident 2 developed stage two (some of the outer surface or the deeper layer of the skin is damaged) pressure ulcers on Resident 2 ' s medial (middle) buttocks. The TN stated the family was not notified. During a follow up unannounced visit at the facility on 9/23/24 licensed nurse (LN) 1 was interviewed at 10:30 A.M. LN 1 stated resident change in condition was documented in the e-INTERACT (Interventions to Reduce Acute Care Transfers- an electronic communication form about changes in resident status) change in condition form. LN 1 stated the resident ' s physician and family should be notified of any resident change in condition. On 9/23/24 at 12:24 P.M., the assistant director of nursing (ADON) was interviewed. A concurrent record review of Resident 2 ' s progress notes was conducted with the ADON. The progress notes dated 8/15/24 at 3:44 P.M. indicated, .Sacro coccyx stage 4 pressure injury, deteriorating. Measuring 3 cm [centimeter] x 2 cm x 2.5 cm, undermining [a pocket on wound ' s edges] 9-4 o'clock @ 3.5 cm, 70% granulation [process of wound healing] and 30% slough [dead tissue] with large amount of serosanguinous [bloody] drainage). The ADON stated the son was Resident 2 ' s responsible party and was not notified of the wound deterioration. The ADON stated it was important to notify the responsible party to be aware of Resident 2 ' s regression or progress. During an interview on 10/2/24 at 10:49 A.M. with the Director of Nurses (DON), the DON stated it was her expectation for licensed nurses to update the family and the physician for any resident change in condition. DON stated the family and the physician needed to be aware of the change and to discuss the plan of care. 2. Resident 3 was admitted to the facility on [DATE] with diagnoses including protein-calorie malnutrition (reduced nutrients in the body) according to the facility ' s Admission Record. During an observation on 9/9/24 at 10:15 A.M., Resident 3 was in bed watching TV. Resident 3 stated she was told she had lost weight. Resident 3 stated her weight loss was due to stomach pain when eating and had decreased meal intake. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 9/23/24 at 10:30 A.M. was conducted with licensed nurse (LN) 1. LN 1 stated for residents with weight loss, the attending physician and dietician will be notified, and the e-INTERACT (Interventions to Reduce Acute Care Transfers- an electronic communication form about changes in resident status) change in condition and progress notes will be completed. LN 1 stated the resident ' s physician should be notified of any resident change in condition. During an interview and concurrent record review on 9/23/24 at 12:06 P.M. with the ADON, the ADON reviewed Resident 3 ' s weight record. The ADON stated Resident 3 ' s weighed 205 lbs.(pounds) on 8/1/24 and 187 lbs. on 9/3/24. The ADON stated the attending physician was notified of significant weight changes. The ADON reviewed the nutrition care plan dated 9/5/24 for Resident 3 which indicated a weight loss of 18 lbs. in one month. The ADON then reviewed progress notes for Resident 3 and stated there was no physician notification regarding the weight loss. During an interview on 10/2/24 at 10:49 A.M. with the Director of Nurses (DON), the DON stated it was her expectation for licensed nurses to update the family and the physician for any resident change in condition. DON stated the family and the physician needed to be aware of the change and discuss the plan of care. 3. Resident 5 was admitted to the facility on [DATE] with diagnoses including encounter for attention to gastrostomy (feeding tube) and quadriplegia (loss of ability to move both arms and legs) according to the facility ' s Admission Record. During an observation on 9/23/24 at 9:16 A.M., Resident 5 was in bed with his eyes closed. A tube feeding pump was observed on a pole next to Resident 5 ' s bed and it was turned off. An interview on 9/23/24 at 10:30 A.M. was conducted with licensed nurse (LN) 1. LN 1 stated for residents with weight loss, the attending physician and dietician will be notified, and the e-INTERACT (Interventions to Reduce Acute Care Transfers- an electronic communication form about changes in resident status) change in condition and progress notes will be completed. LN 1 stated the resident ' s physician should be notified of any resident change in condition. During an interview and concurrent record review on 9/23/24 at 12:18 P.M. with the ADON, the ADON reviewed Resident 5 ' s weight record. The ADON stated Resident 5 ' s weights indicated: 139 lbs. on 8/5/24, 133 lbs. on 8/12/24, 136 lbs. on 8/19/24, 135 lbs. on 8/30/24 and 129 lbs. on 9/4/24. The ADON further reviewed progress notes for Resident 5 and stated the attending physician was not informed of the ten-pound weight loss in one month. An interview on 10/2/24 at 10:54 A.M. with the Registered Dietician (RD) was conducted. The RD stated a list of residents who triggered for undesirable weight change was provided to the nursing staff during the skin and weight meetings on Thursdays. The RD stated nursing staff would complete the e-INTERACT change in condition and notify the attending physician for weight changes. 4. Resident 7 was admitted to the facility on [DATE] with diagnoses including unspecified protein-calorie malnutrition (reduced nutrients in the body) and left femur (thigh bone) fracture according to the facility ' s Admission Record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/824 for Resident 7 indicated a cognitive (thinking, reasoning, or remembering) score of 12, indicating moderate cognitive impairment. During an observation on 9/23/24 at 9:46 A.M., Resident 7 was in bed lying on her left side with her eyes closed. Resident 7 was observed with an air mattress in bed. An interview on 9/23/24 at 9:31 A.M. with certified nurse assistant (CNA) 1 was conducted. CNA 1 stated to prevent pressure ulcers, residents were kept clean and dry, repositioned in bed every two hours, and offered to be out of bed to attend activities. During an interview on 9/23/24 at 10:46 A.M. with licensed nurse (LN) 2, LN 2 stated the change in condition form will be completed if a resident had a new skin issue or if a wound deteriorated. LN 2 further stated the physician and family should be notified to be aware of the resident ' s condition and for the physician to provide orders. A review of Resident 7 ' s care plans was conducted. The skin care plan initiated on 6/28/24 for Resident 7 indicated, .Resident is at risk for skin breakdown related to activity intolerance .impaired ADL ability .Assist to turn and reposition as indicated . An interview and concurrent record review on 9/23/24 at 1:13 P.M. with the assistant director of nurses (ADON) was conducted. The ADON stated Resident 7 ' s admission skin assessment indicated a left hip surgical incision (after surgery wound). The ADON reviewed progress notes for Resident 7. The ADON stated resident developed a stage two (some of the outer surface or the deeper layer of the skin is damaged) on Resident 7 ' s coccyx (tailbone) on 7/8/24. The ADON Resident 7 ' s wound was debrided (surgical procedure to remove dead tissue) by the wound physician and the wound became a stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). The ADON stated Resident 7 ' s family was not notified of Resident 7 ' s wound condition. The ADON stated it was important to notify the resident ' s family to be aware of the resident ' s regression or progress. During an interview on 10/2/24 at 10:49 A.M. with the Director of Nurses (DON), the DON stated it was her expectation for licensed nurses to update the family and the physician for any resident change in condition. DON stated the family and the physician needed to be aware of the change and discuss the plan of care. During a review of the facility ' s policy and procedure (P&P) titled, Change in a Resident ' s Condition or Status, dated February 2021, the P&P indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of the changes in the resident ' s medical/mental condition and /or status .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility did not ensure one of three residents (Resident 2) reviewed for pressure ulcers (bedsore) received the necessary care and services to prevent worsening of the resident ' s pressure ulcer. This failure had the potential for infection and affect the resident ' s overall well-being. Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (an impairment of brain function, such as memory loss and judgment) and muscle weakness according to the facility ' s Admission Record. During a review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/9/24, section GG0170 A through E indicated Resident 2 was dependent on staff with rolling in bed, sit to lying, lying to sitting on side of bed, sit to stand and transfers. A review of Resident 2 ' s care plans was conducted. Resident 2 ' s skin care plan initiated on 7/2/24 indicated, .at risk for skin breakdown related to activity intolerance, Braden Risk score [a measurement of a resident ' s risk of developing pressure ulcers, or sores], Cardiovascular disease .impaired ADL [(activities of daily living] ability .Assist to turn and reposition as indicated/tolerated, check skin during daily care provisions . During observation on 9/9/24 at 9:41 A.M., Resident 2 was in bed with an air mattress (mattress designed to distribute the resident ' s body weight and help prevent skin breakdown) and oxygen via nasal cannula (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen). Resident spoke only Spanish. On 9/9/24 at 9:35 A.M. the treatment nurse (TN) was observed entering Resident 2 ' s room. The TN stated she will be providing treatment to Resident 2 ' s stage four (bedsore extended to muscle, tendon or bone) pressure ulcer on Resident 2 ' s sacro-coccyx (the triangular shaped bone at the base of the back area and tailbone) area. The TN was observed during treatment of Resident 2 ' s pressure ulcer. Resident 2 ' s sacro-coccyx area was observed with a large (size of a golf ball), deep pressure ulcer with medium amount of tan/yellow drainage inside the pressure ulcer, yellow tissue and with foul odor. Resident 2 stated, Oww, as the treatment nurse cleaned the pressure ulcer. An interview and joint record review on 9/9/24 at 10:17 A.M. was conducted with the TN. The TN reviewed Resident 2 ' s progress notes (PN) dated 7/15/24 and stated Resident 2 developed stage two (some of the outer surface or the deeper layer of the skin is damaged) pressure ulcers on Resident 2 ' s medial (middle) buttock, then on 7/16/24 Resident 2 had stage two pressure ulcers on the left and right medial buttocks. The TN stated she did not know Resident 2 ' s skin condition upon admission and was not able to find Resident 2 ' s initial skin assessment in the Resident 2 ' s electronic medical record (EMR). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up visit at the facility on 9/23/24 at 9:31 A.M., certified nurse assistant (CNA) 1 was interviewed. CNA 1 stated it was the facility ' s policy to prevent pressure ulcers from developing. CNA 1 stated interventions to prevent pressure ulcers were to keep residents ' skin clean, dry, reposition residents every two hours while in bed, offer residents to get up from bed and take them to activities. During an interview on 9/23/24 at 10:30 A.M. with licensed nurse (LN) 1, LN 1 stated to prevent pressure ulcers, residents should be repositioned every two hours and every one hour if a resident already had a pressure ulcer. A telephone interview was conducted on 9/27/24 at 9:39 A.M. with the Quality Assurance nurse (QA-a nurse who monitors and improves nursing practices and patient care). The QA nurse stated she reviewed the progress notes in e-INTERACT (Interventions to Reduce Acute Care Transfers- an electronic quality improvement program designed to improve identification, evaluation, and communication about changes in resident status) change in condition and the wound physician ' s progress notes for Resident 2. The QA nurse stated Resident 2 ' s records indicated: The Admission/Readmission Assessment, dated 6/4/24 Resident 2 ' s initial skin assessment on admission indicated Resident 2 had a maceration (a softening and breaking down of skin resulting from prolonged exposure to moisture) on the buttocks. The e-INTERACT Change in Condition Evaluation, dated 7/8/24 indicated Resident 2 had a stage two on the right medial buttock with light drainage. The PN for Resident 2 dated 7/9/24 indicated Resident 2 was sent out to the hospital for low oxygen level. The Admission/Readmission Assessment, dated 7/15/24 indicated Resident 2 had a stage two on the right medial buttock. The Skin/Wound note, dated 7/16/24 indicated Resident 2 had a stage two on the left and right medial buttock. The e-INTERACT Change in Condition Evaluation, dated 7/21/24 indicated an unstageable pressure (a full thickness tissue loss where the depth of the wound is hidden by a layer of eschar [scab like dead tissue] or slough [yellow/white material in wound bed, dead tissue] in the wound) ulcer on Resident 2 ' coccyx (tailbone) and with 100% necrotic (scab like dead tissue) tissue. The Skin/Wound note, dated 7/24/24 indicated Resident 2 had a deep tissue injury (DTI-a purple or maroon-colored area of intact skin or blood-filled blister due to damage of soft tissue from pressure or shear) on the Sacro coccyx (the triangular shaped bone at the base of the back extending to the tailbone). The Skin/Wound note, dated 7/31/24 indicated Resident 2 ' s pressure ulcer on the Sacro coccyx was reclassified by the physician as stage three (full thickness skin loss that extends into the subcutaneous [deepest layer of skin] tissue but does not expose muscle, tendon, or bone). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician ' s Visit Report dated 7/31/24 indicated Resident 2 ' s Sacro coccyx area had a stage four (bedsore extended to muscle, tendon, or bone) pressure ulcer. The facility ' s Skin/Wound Note dated 8/15/24 indicated Resident 2 ' s stage four pressure ulcer was deteriorating, with undermining (a pocket on wound ' s edges), slough (yellow/white material in wound bed, dead tissue) and serosanguinous (bloody) drainage. The facility ' s Skin/Wound Note, 8/28/24 indicated Resident 2 was seen by the wound physician and ordered negative- pressure wound therapy (NWPT-treatment using a device that pulls fluid and bacteria from a wound) for Resident 2 ' pressure ulcer. During an interview on 9/27/24 at 9:49 A.M. the QA nurse acknowledged that Resident 2 ' s skin condition had deteriorated while Resident 2 was in the facility. An interview was conducted on 10/2/24 at 10:49 A.M. with the Director of Nursing (DON). The DON acknowledged that Resident 2 developed a pressure ulcer at the facility and the pressure ulcer had deteriorated. A review of the facility ' s undated policy and procedure(P&P) titled, Pressure Injuries/Skin Breakdown-Clinical Protocol was conducted. The P&P did not provide guidance to staff regarding pressure ulcer prevention and maintenance.