

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/09/2025
NAME OF PROVIDER OR SUPPLIER  Reo Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to provide services according to standards of clinical practice when it did not report and document a change of condition in a timely manner for one of eight sampled residents. This failure had the potential to delay interventions and treatments which could have affected Resident 1's health outcomes. Findings: Review of admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included: Acute Embolism and Thrombosis of femoral vein bilateral (thrombosis is the formation of a clot in a vessel, and an embolism occurs when part of that clot breaks off and travels to block another vessel), Acute Kidney Failure (the sudden loss of kidney function), Obstructive and Reflux Uropathy (a blockage in the urinary tract that stops or slows urine flow, causing urine to back up and potentially damage the kidneys, leading to symptoms like pain, swelling, frequent urination, and difficulty urinating), Hydronephrosis (the swelling of one or both kidneys due to urine backing up), Retention of urine (the inability to completely empty the bladder). Review of History and Physical examination dated 9/22/25 indicated . The patient is A&amp;OX3[alert and oriented to person, place, time] . Patient has capacity . Review of Physical Therapy Progress note date 11/19/2025 at 12:30 P.M., indicated Pt received in supine in bed, both dtrs [daughters] present. Pt noted with increase pallor(paleness), lethargy, and clammy skin. Pt declines therapy d/t [due to] reports of severe abdominal pain 8/10. RLQ [right lower quadrant of abdomen] noted to be stiff and possibly distended. Med nurse and charge nurse made aware. On 12/9/25 at 2:35 P.M., a concurrent interview with Licensed Nurse 1(LN 1) and record review of Resident 1's Electronic Medical Record ( EMR) was conducted. Review of Resident 1's EMR indicated that Physical Therapy Note was written at 11/19/2025 at 12:30 P.M. indicating Resident 1's change of condition. LN 1 stated that the PT note indicated that Med nurse and charge nurse made aware. so they should have put a change in condition (CIC) note as well at that time. LN 1 stated the first nursing note about Resident 1's change of condition was at 3:12 P.M. LN 1 stated the expectation for a resident's change of condition is to notify the resident's attending physician (MD) or nurse practitioner (NP), notify Responsible Party(RP), get orders from the MD or NP, and document in a timely manner with a CIC note. LN 1 stated that the resident's nurse should have written a CIC note to communicate what the change was and what was done to intervene. On 12/9/25 at 2:50 P.M., a concurrent interview with LN 2, the charge nurse on unit on 11/19/25, and record review of Resident 1's EMR was conducted. LN 2 stated because the facility was in an Covid outbreak, the protocol for any symptoms was first to test for COVID. LN 2 stated at the time of incident, Resident 1 tested negative for COVID, and had stable vital signs (VS), but was complaining of abdominal pain and confusion, as written in her nurse's note. LN 2 stated she texted the NP initially when she first saw Resident 1 about 12:30 P.M. LN 2 stated that she did not chart when she initially texted NP. LN 2 stated that she texted the NP, two more times (times not remembered or documented) and after she did not respond, and then she called NP directly. LN 2 stated the expectation was to document that she notified NP each time, and that NP did not respond. LN 2 stated the importance of timely notification, response, and documentation was to provide the right intervention for Resident 1 in timely manner. LN 2 stated she asked the medication nurse (LN 3) to check on Resident 1 throughout the incident. LN 2 stated that she was not sure why there was no progress note from LN 3 about Resident 1's CIC in the EMR . Review of Infection Preventionist's (IP) CIC note written on 11/19/25 at 3:12 P.M., indicated, Resident's daughter reported that patient has increased confusion. Rehab staff also reported that patient was c/o [complained of] RLQ abdominal pain during therapy. Upon assessment, patient was alert but confused. RLQ noted with mild tenderness when palpated (touched). No guarding [of the abdomen] observed. Abdomen also slightly distended. BP 127/81. Pulse of 107. Date and time of clinician notification 11/19/25 at 15:00(3 P.M.). Date and time of family/resident representative notification 15:00. On 12/10/25 at 8:09 A.M., a phone interview was conducted with LN 3. LN 3 stated that she initially saw Resident 1 when she gave him his medication in the morning around 8:30 A.M. LN 3 stated that at 12 P.M. on 11/19/25, Resident 1 was complaining of RLQ abdominal pain. LN 3 stated that she only spoke to the daughter when the therapist came to talk to her about Resident 1's change of condition. LN 3 stated that resident's daughter was dealing mainly with the nurse, LN 2. LN 3 stated that she assessed resident, did vital signs, assessed resident's abdomen, assessed the resident's urinary catheter, and mental status. LN 3 stated that Resident 1 was confused and had dark yellow urine in foley catheter. LN 3 stated that he had no fever, but they were suspecting a possible UTI. LN 3 stated that she texted the NP at about</p>		