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	03/18/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure licensed nurse (LN) 1 administered medications according to acceptable clinical standards of practice for two of three residents (Resident 1 and 2) when: LN 1 documented another LN's medication administration for Resident 1's Cefepime (antibiotic, medication to treat infection). LN 1 administered Resident 2's Vancomycin (antibiotic) at the wrong time (four hours after the prescribed time).This deficient practice had the potential to cause medication errors and ineffective treatment.Findings:1. A review of Resident 1's admission Record indicated the resident was admitted on [DATE] with diagnoses to include unspecified osteomyelitis (a serious infection of the bone) and chronic ulcer of the left foot.A review of Resident 1's Order Summary Report, dated 3/1/26 to 3/16/26, indicated, Pharmacy.Cefepime HCl Intravenous Solution Reconstituted (Cefepime HCl) Use 2 gram intravenously every 8 hours for infection .Order Date 03/07/26.End Date 04/18/26.A review of Resident 1's Administration Record: *PACS-IV ADMINISTRATION RECORD, dated March 2026, indicated on 3/17/26, LN 1 administered the scheduled 7 A.M. IV Cefepime dose at 10:34 A.M.A review of Resident 1's care plan for Antibiotic Therapy, revised 3/6/26, .is on Antibiotic Therapy r/t infection. osteomyelitis. Administer medication as ordered. 2. A review of Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses to include sepsis (infection of the blood) and unspecified valve endocarditis (infection of the heart).A review of Resident 2's Order Summary Report, dated 3/1/26 to 3/16/26, indicated Vancomycin HCl Intravenous Solution (Vancomycin HCl) Use 900 mg intravenously every 12 hours for MRSA Bacteremia [sepsis] until 03/22/2026 23:59 . Start 03/10/26 2 0800.A review of Resident 2's Administration Record: *PACS-IV ADMINISTRATION RECORD, dated March 2026, indicated on 3/11/26, LN 1 administered the scheduled 8 A.M. Vancomycin IV dose at 12 P.M.A review of Resident 2's care plan for Antibiotic Therapy, revised 3/14/26, .is on Antibiotic Therapy r/t [related to] MRSA bacteremia upon admission. ***SEPSIS DUE TO METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS [MRSA]. Administer medication as ordered.On 3/18/26 at 11:40 A.M., a concurrent interview and record review was conducted with LN 1. LN 1 stated he was a registered nurse (RN, by scope of practice could administer IV medications). LN 1 stated the medication administration process included checking for the right patient, the right medication, and following the physician orders. LN 1 stated medications had to be given an hour before and an hour after the scheduled administration time. LN 1 stated the physician would have to be notified if the LN was unable to give medications on time. LN 1 reviewed Resident 1's *PACS-IV ADMINISTRATION RECORD for 3/17/26. LN 1 acknowledged his documentation on the Cefepime dose at 7 A.M. LN 1 stated he documented the 7 A.M. dose at 10:34 A.M. LN 1 stated he did not actually administer the IV antibiotic at 7 A.M. LN 1 stated he received report from the night shift RN that Resident 1's medication had been given at 7 A.M. LN 1 stated he documented the administration at 10:34 A.M. when he noticed the missing documentation from the night shift RN. LN 1 stated he should not have done what he did. LN 1 stated he did not follow the standard of practice.LN 1 then reviewed Resident 2's *PACS-IV ADMINISTRATION RECORD for 3/11/26. LN 1 acknowledged Resident 2 had a Vancomycin IV dose scheduled at 8 A.M. LN 1 stated he administered and documented the administration at 12 P.M., which (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was four hours later than the prescribed time. LN 1 stated Resident 2 had a doctor's appointment and was not in the facility to receive the IV medication. LN 1 reviewed Resident 2's appointment information in the appointment binder. The information indicated Resident 2 was picked up by transportation on 3/11/26 at 9 A.M. for a noon appointment. LN 1 stated Resident 2 came back to the facility from her doctor's appointment at noon. LN 1 stated he did not notify the physician regarding Resident 2's missed 8 A.M. Vancomycin dose. LN 1 stated he did not document a change of condition regarding the missed dose. LN 1 acknowledged that he should have obtained further orders from the physician to administer the resident's Vancomycin late. LN 1 further stated he could have administered Resident 2's Vancomycin prior to the resident leaving for the appointment.On 3/18/26 at 2:35 P.M., an interview was conducted with LN 2. LN 2 stated she, Never signed [documented] on other's (LN's) medication administration. That's a big no-no. LN 2 stated documenting another LN's medication administration was wrong and was not following the standard of practice. LN 2 stated she reviewed her assigned residents' appointment schedules at the start of her shift. LN 2 stated all staff had access to residents' appointment information in the appointment binder. LN 2 stated she would notify the physician if a medication administration was missed due to the resident being out for an appointment.On 3/18/26 at 3:37 P.M., an interview was conducted with the director of nursing (DON). The nurse consultant (NC) was also present. The DON stated medications should be given in a timely manner including that of residents with outside appointments. The DON stated it was her expectation for LNs to plan ahead when residents had appointments. The DON stated Resident 2's delayed IV Vancomycin dose could have been given at 7 A.M. an hour earlier than the scheduled administration time at 8 A.M. The DON stated the physician should have been notified of the four hour IV Vancomycin medication administration delay. The DON stated a change of condition documentation should have been done. The DON stated it was not acceptable for LN 1 to document another LN's medication administration. The DON stated LN 1 should have known better. The DON stated what LN 1 did was not acceptable and was not the facility's standard of practice. The NC stated she agreed with the DON. The NC stated the facility did not have a document for nursing standards of practice. The NC stated it was expected that LNs follow facility policies.A review of the facility's policy titled Administering Medications dated 2001 indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame .5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record.g. the signature and title of the person administering the drug.

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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** Based on interview and record review, the facility failed to ensure intravenous (IV, a method of administering medications through the veins) antibiotics (medications to treat infection) were administered according to physician's orders for two of three residents (Resident 1 and 2) when:Licensed nurse (LN) 1 documented another LN's medication administration for Resident 1's Cefepime (antibiotic, medication to treat infection).2. LN 1 administered Resident 2's Vancomycin (antibiotic) four hours later than the prescribed time.This deficient practice had the potential for the residents' antibiotic therapy to have reduced efficacy and increased risk for antibiotic resistance.Findings:1. A review of Resident 1's admission Record indicated the resident was admitted on [DATE] with diagnoses to include unspecified osteomyelitis (a serious infection of the bone) and chronic ulcer of the left foot.A review of Resident 1's Order Summary Report, dated 3/1/26 to 3/16/26, indicated, Pharmacy.Cefepime HCl Intravenous Solution Reconstituted (Cefepime HCl) Use 2 gram intravenously every 8 hours for infection.Order Date 03/07/26.End Date 04/18/26.A review of Resident 1's Administration Record: *PACS-IV ADMINISTRATION RECORD, dated March 2026, indicated on 3/17/26, LN 1 administered the scheduled 7 A.M. IV Cefepime dose at 10:34 A.M. 2. A review of Resident 2's admission Record indicated the resident was admitted on [DATE] with diagnoses to include sepsis (infection of the blood) and unspecified valve endocarditis (infection of the heart).A review of Resident 2's Order Summary Report, dated 3/1/26 to 3/16/26, indicated, Vancomycin HCl Intravenous Solution (Vancomycin HCl) Use 900 mg intravenously every 12 hours for MRSA Bacteremia [sepsis] until 03/22/2026 23:59. Start 03/10/26 2 0800.A review of Resident 2's Administration Record: *PACS-IV ADMINISTRATION RECORD, dated March 2026, indicated, on 3/11/26, LN 1 administered the scheduled 8 A.M. Vancomycin IV dose at 12 P.M.On 3/18/26 at 11:40 A.M., a concurrent interview and record review was conducted with LN 1. LN 1 stated he was a registered nurse (RN, by scope of practice could administer IV medications). LN 1 stated the medication administration process included checking for the right patient, the right medication, and following the physician orders. LN 1 stated medications had to be given an hour before and an hour after the scheduled administration time. LN 1 stated the physician would have to be notified if the LN was unable to give medications on time. LN 1 reviewed Resident 1's *PACS-IV ADMINISTRATION RECORD for 3/17/26. LN 1 acknowledged his documentation on the Cefepime dose at 7 A.M. LN 1 stated he documented the 7 A.M. dose at 10:34 A.M. LN 1 stated he did not actually administer the IV antibiotic. LN 1 stated he received report from the night shift RN that Resident 1's medication had been given at 7 A.M. LN 1 stated he documented the administration at 10:34 A.M. when he noticed the missing documentation from the night shift RN. LN 1 stated he should not have done what he did.LN 1 then reviewed Resident 2's *PACS-IV ADMINISTRATION RECORD for 3/11/26. LN 1 acknowledged Resident 2 had a Vancomycin IV dose scheduled at 8 A.M. LN 1 stated he administered and documented the administration at 12 P.M., which was four hours later than the prescribed time. LN 1 stated Resident 2 had a doctor's appointment and was not in the facility to receive the IV medication. LN 1 reviewed Resident 2's appointment information in the appointment binder. The information indicated Resident 2 was picked up by transportation on 3/11/26 at 9 A.M. for a noon appointment. LN 1 stated Resident 2 came back to the facility from her doctor's appointment at noon. LN 1 stated he did not notify the physician regarding Resident 2's missed 8 A.M. Vancomycin dose. LN 1 stated he did not document a change of condition regarding the missed dose. LN 1 acknowledged that he should have obtained further orders from the physician to administer the resident's Vancomycin late. LN 1 further stated he could have administered Resident 2's Vancomycin prior to the resident leaving for the appointment.On 3/18/26 at 2:35 P.M., an interview was conducted with LN 2. LN 2 stated she, Never signed [documented] on other's (LN's) medication administration. That's a big no-no. LN 2 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated documenting another LN's medication administration was wrong and was not following the standard of practice. LN 2 stated she reviewed her assigned residents' appointment schedules at the start of her shift. LN 2 stated all staff had access to residents' appointment information in the appointment binder. LN 2 stated she would notify the physician if a medication administration was missed due to the resident being out for an appointment.On 3/18/26 at 3:37 P.M., an interview was conducted with the director of nursing (DON). The nurse consultant (NC) was also present. The DON stated medications should be given in a timely manner including that of residents with outside appointments. The DON stated it was her expectation for LNs to plan ahead when residents had appointments. The DON stated Resident 2's delayed IV Vancomycin dose could have been given at 7 A.M. an hour earlier than the scheduled administration time at 8 A.M. The DON stated the physician should have been notified of the four hour IV Vancomycin medication administration delay. The DON stated a change of condition documentation should have been done. The DON stated it was not acceptable for LN 1 to document another LN's medication administration. The DON stated LN 1 should have known better. The DON stated what LN 1 did was not acceptable and was not the facility's standard of practice. The NC stated she agreed with the DON.A review of the facility's policy titled Administering Medications dated 2001 indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame .5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record.g. the signature and title of the person administering the drug.