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	04/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure staff provided necessary supervision (1:1 supervision to monitor continuously and not left unattended) according to the care plan to prevent falls for one of six sampled residents (Resident 1) who had a known history of falls, impaired safety awareness, and an identified need for ongoing staff presence to prevent unsafe self-transfers and falls. As a result, Resident 1 fell in her room, sustained bruises to the forehead, facial swelling, and bruising on arms associated with pain. Resident 1 was subsequently transferred to the hospital for medical evaluation and treatment. Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Cerebral Infarction (when a blood clot or blockage stops blood from reaching a part of the brain) affecting right dominant (stronger) side and unsteadiness of feet.A record review of Resident 1's Minimum Data Set (MDS- nursing facility assessment tool) dated 3/24/26 indicated, Resident 1 was rarely or never understood with moderate cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits with poor decisions and supervision required.A record review of Resident 1's quarterly fall assessment, dated 3/2/26 indicated, Resident 1 was a high fall risk with a score of 22.A review of the Nurse Practitioner Assessment Notes dated 12/2025 (12/2, 12/11, 12/22, 12/29), 1/2026 (1/5, 1/12, 1/15, 1/19, 1/26), 2/2026 (2/2, 2/5, 2/26), 3/2026 (3/2 and 3/3/26), included a description of .Patient remains high risk.Cont [continue] fall precautions and sitter .sitter at bedside. On 4/7/26 at 2:28 P.M., an interview and joint review of Resident 1's electronic record was conducted with Licensed Nurse (LN) 3. LN 3 stated Resident 1 had a history of falls and required assistance due to weakness, and a forward-leaning posture. LN 3 stated Resident 1 frequently attempted to get out of bed and toilet independently, particularly between 4 A.M., and 6 A.M., placing Resident 1 at high risk for falls. LN 3 stated staff reported monitoring every 30 minutes; however, record review did not identify documentation confirming consistent 30-minute safety checks were implemented. LN 3 also stated the first fall incident occurred on the 3/3/26 NOC (night) shift, when the assigned Certified Nursing Assistant (CNA) assisted Resident 1 with toileting. LN 3 stated Resident 1 became unbalanced and was assisted to the floor. LN 3 stated Resident 1 required 1:1 supervision; however, the facility had discontinued consistent 1:1 supervision (approximately 5/21/25 to 3/3/26). LN 3 stated on 3/24/26 during the morning shift it was reported to her that Resident 1 experienced an unwitnessed fall inside her room. LN 3 stated Resident 1 sustained bruises to the forehead and facial swelling and was subsequently admitted to the hospital. Furthermore, LN 3 confirmed the need for continuous 1:1 supervision to ensure staff consistently implemented individualized fall interventions; however, the facility had discontinued this intervention. LN 3 stated Resident 1 should have remained on 1:1 supervision which required staff to keep Resident 1 within direct view at all times due to high fall risk and not leave unattended. On 4/7/26 3:06 P.M., an observation, interview, and record review were conducted with Certified Nursing Assistant (CNA) 1, at the North Side nursing station. CNA 1 demonstrated use of the electronic charting (e-chart) system to review Resident 1's fall risk status (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 0689 Level of Harm - Actual harm Residents Affected - Few	and care plan interventions. CNA 1 stated Resident 1 had a history of falls, dementia (a progressive state of decline in mental abilities), and impulsive behavior, and frequently attempted to get up independently without assistance, particularly when attempting to toilet. CNA 1 stated Resident 1 had previously been on 1:1 supervision due to high fall risk; however, the 1:1 supervision was discontinued. CNA 1 stated Resident 1 was at high risk for injury due to poor safety awareness, attempts to self-transfer, and behaviors such as leaning forward and attempting to get out of bed without assistance. CNA 1 stated Resident 1 was sent to the hospital after sustaining a fall during the morning shift (approximately 7 A.M.) and acknowledged Resident 1 had multiple risk factors requiring close supervision. On 4/7/26 3:20 P.M., an interview was conducted with CNA 2, at the North side nursing station. CNA 2 stated Resident 1 had a history of falls (two falls in March 2026 on 3/3 and 3/24) and required 1:1 supervision due to impulsive behavior and a tendency to lean forward during transfers, particularly when using the bathroom. CNA 2 stated that Resident 1 did not consistently use the call light, would attempt to get up independently, and required close monitoring due to poor safety awareness and difficulty with redirection. CNA 2 stated that safety interventions were in place, including a yellow identification band for fall risk, a lowered bed, and floor mats; however, 1:1 supervision had been discontinued approximately one month prior to fall. On 4/7/26 at 4:07 P.M., an interview was conducted with CNA 4. CNA 4 stated that Resident 1 previously had 1:1 supervision due to high fall risk and impulsive behavior; however, approximately four weeks prior, staff were instructed by the nursing managers to discontinue the 1:1 sitter and provide general supervision instead. CNA 4 stated that Resident 1 was impulsive, attempted to get up independently, did not consistently use the call light, and demonstrated poor safety awareness related to her dementia. CNA 4 stated that Resident 1 frequently attempted to perform tasks, such as going to the bathroom or handling personal items without assistance, increasing her risk for falls. CNA 4 further stated that Resident 1 was safer when a sitter was present because staff could provide immediate intervention and physically remain with Resident 1 to prevent unsafe transfers. CNA 4 stated that supervision was more challenging during PM (evening) and NOC (night) shifts when there were fewer activities to keep the residents occupied. On 4/7/26 at 4:17 P.M., an interview and record review was conducted with LN 2, at the South Side nursing charting room. LN 2 stated Resident 1 had falls on 3/3/26 (assisted fall in bathroom with nursing staff) during the NOC shift and again on 3/24/26 (unwitnessed with bruising to face and arms) during shift change. LN 2 stated Resident 1 previously received 1:1 supervision due to high fall risk, which was discontinued following a change in administration. LN 2 stated that Resident 1 had dementia, poor safety awareness, and impulsive behavior, and does not consistently use the call light, resulting in attempts to stand and transfer independently. LN 2 stated that Resident 1's agitation, combativeness with staff, and impulsiveness increased the likelihood of falls without continuous supervision indicating both falls in March 2026 occurred after the 1:1 supervision was removed. LN 2 stated Resident 1 received continuous monitoring due to high fall risk and impaired safety awareness. LN 2 stated the fall on 3/24/26 could have been prevented if 1:1 supervision had remained in place, as close monitoring had previously been effective in preventing falls and reducing risk of serious injuries. On 4/8/26 at 8:53 A.M., an interview was conducted with CNA 3, assigned CNA for Resident 1 on 3/24/26. CNA 3 stated Resident 1 had a history of falls, impulsive behavior, and required assistance with toileting and transfers. CNA 3 stated Resident 1 typically woke around 6:30 A.M., required staff assistance to use the toilet, and was at high risk for attempting to stand or transfer independently without using the call light. CNA 3 stated Resident 1 previously had 1:1 supervision during the NOC (night) shift, with staff either assigned as a dedicated sitter or rotating every 30 minutes to ensure continuous monitoring. CNA 3 stated the 1:1 supervision had been discontinued prior to the fall incident. CNA 3 stated that on the morning of 3/24/26 at approximately 6:30 A.M., she assisted Resident 1 into the wheelchair for breakfast and positioned a bedside table in front of Resident 1, then left Resident 1 unsupervised to use the bathroom. However, despite requiring 1:1 supervision, Resident 1 attempted to get up independently, resulting in an (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	unwitnessed fall. CNA 3 stated Resident 1 attempted to get up without assistance on the morning of the fall (3/24/26) and was found in her room on the floor, facing down near the left side of the bed (the side of bed that was not against the wall). CNA 3 stated Resident 1 sustained swelling to the face but remained alert. CNA 3 stated Resident 1 demonstrated poor safety awareness due to cognitive impairment, impulsiveness, and an inability to consistently follow instructions, which placed the resident at risk for repeated falls. CNA 3 stated it was important that Resident 1 received continuous 1:1 supervision because Resident 1 frequently attempted to get up independently and required ongoing cueing and redirection to prevent unsafe transfers. CNA 3 stated the fall could have been prevented if 1:1 Supervision had remained in place, as direct supervision allowed staff to promptly intervene and reduce the risk of serious injury such as head trauma. A review of Resident 1's fall care plan dated 5/20/25 indicated, .Actual fall. initiated on 5/20/25 indicated: .CNAs were also reminded not to leave the patient unattended and by herself in the room for safety d/t (due to) patient is a high fall risk. Additionally, a care plan dated 7/4/24, indicated: .Keep within supervised view as much as possible. A review of Resident 1's record, notes written by a Nurse Practitioner dated 3/3/26 14:39 (2:39 PM), indicated .Patient seen and examined. Notes reviewed and updates provided by staff. Patient being seen for follow up. She was noted with witnessed fall early this morning with head strike and hematoma to front of forehead. she was sent to ER for evaluation.small hematoma to forehead with central abrasion . Mentation at confused baseline. She continues to be a nigh[sic] fall risk due to impulsive behavior and confusion, needs sitter.last fall on 3/3/26 with head strike, sent to ER [emergency room]. A review of Resident 1's record written by LN 1 dated 3/24/2026 07:05 (7:05 A.M.). The note indicated the following: .before endorsement found by night cna on the floor resident had unwitnessed fall with noted right side of the face swollen and slightly reddened with c/o [complaint of] of 7/10 pain no open area noted resident as stated by night cna was face down on the right side in front of her wheelchair noted resident was up on her wheelchair before that as a preparation for breakfast resident with a license nurse translating resident was trying to reposition herself in her wheelchair and lost her balance going forward resident was [sic] help back by cna to her wheelchair called [Physician Name] made aware of fall with injury on residents right face swelling with pain md [Medical Doctor] ordered to transfer resident to [Hospital Name] for eval [sic]. On 4/8/28 at 12:07 P.M., an interview and record review was conducted with LN 1, in the Director of Nursing's (DON) office. LN 1 stated Resident 1 sustained an unwitnessed fall on 3/24/26 between approximately 7 A.M.-7:50 A.M. during shift change. LN 1 stated Resident 1 had a history of multiple falls, confusion, impulsivity and required close monitoring due to repeated falls. LN 1 stated Resident 1 was found with swelling to the right side of the face and arms after attempting to reposition and/or stand without assistance from the wheelchair. LN 1 stated CNA 3 was not present at the time of Resident 1's fall. LN 1 stated Resident 1 had previously received 1:1 supervision due to high fall risk, this had been discontinued prior to the fall. LN 1 stated the ambulance was called and Resident 1 was transported to the hospital for further evaluation due to facial injury and risk for potential head trauma (any injury to the scalp, skull, or brain caused by a blow, fall, or bump to the head). LN 1 stated it was important Resident 1 received continuous supervision (i.e. 1:1 supervision) and that staff consistently followed the fall care plan, including maintaining awareness of Resident 1's high fall risk and toileting needs, to prevent further injuries such as fractures, facial trauma, and head injury.Resident 1's hospital record was reviewed. Resident 1's hospital imaging notes titled, CT [computed tomography- painless imaging test that acts like a specialized X-ray (specialized camera that takes internal pictures of the body) machine hooked up to a computer] Maxillofacial [focusing on the bones and tissues of the face, jaw, mouth, and nose] Bones WO [without] IV [intravenous-soft flexible tube inserted to vein] Contrast [medical dye used for imaging] dated 3/24/26 9:49 A.M., indicated, .Right facial soft tissue [non-bone flexible, and connective parts of the body] swelling and 3 cm [centimeters] hematoma [severe bruise] right lateral [side] to the nose. Resident 1's Emergency Department notes titled [Hospital Name] ED [emergency department] Provider Note (continued on next page)

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