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	04/17/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on observation , interview and record review, the facility failed to ensure one of ten residents (19) observed during lunch in the dining room had a meal tray at the same time as the other residents. This failure had the potential to not provide and preserve Resident 19's dignity and respect. Findings. A review of Resident 19's undated Admission Record indicated that Resident 19 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (abnormal blood sugar) with Diabetic Neuropathy (a type of nerve damage that occurs with diabetes). During a dining room lunch observation on 4/14/25 at 11:42 A.M., residents were seated in their assigned areas in the dining room. There were three tables assigned for restorative feeding program (aims to help individuals regain or maintain their ability to eat independently). The fourth table was observed with two residents seated. Licensed Nurse 11 checked the meal ticket with the trays and then handed it to the restorative aides and certified nursing assistants to give to the residents. The three tables where residents seated for RNA feeding started eating and were assisted by staff. An observation on 4/14/25 at 12:09 P.M. was conducted. Resident 19 was observed looking around in the dining room while other residents were eating their lunch. Resident 19 stated, I am hungry, but it happens at times when I would have to wait to get served my tray. Everyone had their tray and I don't, I guess it's okay, but I am hungry. Resident 19 was observed to receive her lunch tray 30 minutes after all the other residents' trays were served. An interview on 4/14/25 at 12:15 P.M., with the restorative nursing assistant (RNA) was conducted. The RNA stated every resident in the dining room should have their tray at the same time, to provide and preserve their dignity and ensure respect. An interview on 4/14/25 at 12:25 P.M., in the dining room with Licensed Nurse 13 was conducted. LN 13 stated it was inappropriate for Resident 19 to have waited for her tray while other residents have eaten or started eating. LN 13 stated I would be upset if everyone had their trays, and I didn't. LN 13 stated it was important for all the residents in the dining room to have their trays served at the same time to ensure the facility provided them the dignity and respect. (continued on next page)

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

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	04/17/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/17/25 at 10:00 A.M., with the Director of Nursing (DON) was conducted. The DON stated it was a dignity issue and that every resident in the dining room should be served their trays at the same time. The DON stated I would feel left out too if I did not get a tray. A review of the facility's policy on Resident Rights dated February 2021 , indicated, Policy statement . Employees shall treat all residents with kindness , respect and dignity. Policy Interpretation and Implementation #1. Federal and state laws guarantee certain basic rights to all residents in the facility. These rights include a. a dignified existence .

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	04/17/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to accurately code the Minimum Data Set (MDS- a nursing assessment tool) for one of seven sampled residents (Resident 134) reviewed for MDS accuracy. This deficient practice resulted in providing inaccurate information to the Federal database (information maintained by the federal government). Findings: Resident 134 was admitted to the facility with diagnoses including cystitis (inflammation of the bladder) according to the facility's Admission Record. During a review of Resident 134's MDS dated [DATE], the MDS, section O0100J1 indicated an x for dialysis (procedure done by a trained professional to remove wastes and excess fluids from the body). A review of Resident 134's physician's orders in the electronic medical record (EMR) indicated no orders for dialysis treatments. An interview and observation was conducted with Resident 134 on 4/15/25 at 8:52 A.M. Resident 134 was in bed and stated she had irritation with frequent urination. Resident 134 stated she was starting an antibiotic today (4/15/25). Resident 134 did not have a dialysis graft (a synthetic tube placed in the arm, used to connect an artery or vein used as pathway during dialysis treatments). Resident 134 stated she did not have dialysis treatments. An interview on 4/16/25 at 2:29 P.M. was conducted with licensed nurse (LN) 13. LN 13 stated she was the assigned medication nurse for Resident 134. LN 13 stated Resident 134 did not have dialysis. A concurrent record review and interview was conducted with the MDS nurse (MDSN). The MDSN reviewed Resident 134's diagnoses and MDS in the EMR. The MDSN stated the MDS was marked with an x which meant Resident 134 was on dialysis. The MDSN stated the MDS assessment dated [DATE] was coded inaccurately because Resident 134 was not on dialysis. The MDSN further stated that it was important for the MDS to be accurate because it determined the resident's plan of care and reimbursement for the facility. During an interview on 4/17/25 at 2:34 P.M. with the Director of Nursing (DON), the DON stated the MDS assessment should be accurate because it captured the resident's condition to formulate a care plan. A review of the facility's policy and procedure (P&P) titled, Accuracy of the Resident Assessment, dated December 2023 was conducted. The P&P indicated, .Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment . (continued on next page)

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	04/17/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023 was conducted. Chapter 1.2 page seven of the User's Manual indicated the Resident Assessment Instrument (RAI) consisted of the MDS. The User's Manual chapter 1.2, page eight indicated, . The RAI process has multiple regulatory requirement .Federal regulations .require that (1) the assessment accurately reflects the resident's status . Furthermore chapter 5.5, page 668 of the User's Manual indicated, . the MDS must be accurate as of the ARD [Assessment Reference Date] .

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	04/17/2025

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** 48270 Based on observation, interview, and record review, the facility failed to ensure services to meet professional standards for two of 32 sampled residents when: 1. Resident 123's midline catheter (tube inserted in the upper arm with the tip located just below the armpit to allow access to the bloodstream for medications, fluids, blood draws, and other treatments) dressing was not changed and monitored. 2. The facility failed to provide a nutritional supplement in accordance with the resident's physician's orders. (Resident 2) This failure had the potential for complications related to intravenous (IV - method of delivering fluids, medications, or nutrients directly into the bloodstream through a vein) therapy and the potential for not meeting Resident 2's nutritional needs. Findings: 1. Per the facility's admission record, Resident 123 was admitted on [DATE] with diagnoses that included pneumonia (lung infection). A review of Resident 123's physician's orders indicated, on 4/13/25 an order was made for IV-dressing change .upon admission and to change midline dressing every night shift every seven days. On 4/14/25 at 10:45 A.M., an observation and interview were conducted with Resident 123 in his room. Resident 123 had an IV line on the right upper arm. Resident 123 stated a nurse changed the dressing yesterday and could not recall if the nurse measured his arm or the IV catheter. On 4/15/25 at 10:09 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 1. A review of the IV line dressing change documentation dated 4/13/25 in the IV Medication Administration Record (MAR) for Resident 123, measurements of arm circumference and catheter length were not done. LN 1 stated the importance of measuring arm circumference and the catheter length for a midline catheter was to ensure proper placement and prevent complications. On 4/17/25 at 10:51 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that measuring arm circumference and the catheter length for a midline catheter during the dressing change was a standard of practice and should have been done. DON stated the importance of the measuring is to make sure it is functional. A review of the facility's policy titled Peripheral and Midline IV Dressing Changes, dated March 2022, indicated .8. For midline catheters, measure arm circumference . 46235 (continued on next page)

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	04/17/2025

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	2. Resident 2 was readmitted to the facility on [DATE] with diagnoses including dysphagia (difficulty in swallowing) following cerebral infarction (disrupted blood flow to the brain) according to the facility's Admission Record. On 4/14/25 9:52 A.M. Resident 2 was observed in her bed watching TV. During interview Resident 2 did not respond verbally but nodded that she was okay. Resident 2 did not respond to further questions. During a review of Resident 2's physician's orders in the electronic medical record (EMR), the physician's orders indicated, .RNA dining program daily at lunch .Boost VHC [Very high calorie nutritional supplement] with meal for supplement . During the dining observation on 4/14/25 at 11:42 A.M. Resident 2 was observed being assisted with her meal by the Restorative Nurse Assistant (RNA- a CNA who work alongside rehab staff to provide exercises for residents with limited mobility) 1. The meal tray included a small glass of thickened milk, small glass of thickened water, a small glass of thickened juice, three small cups of puree food, a plate of puree food and a bowl of soup. RNA 1 stated Resident 2 required encouragement to eat and has had weight loss. There was no Boost on resident's tray. On 4/15/25 at 8:41 A.M. Licensed Nurse (LN) 12 was observed encouraging Resident 2 to eat breakfast in Resident 2's room. A concurrent observation of Resident 2's meal tray was conducted. The meal tray included thickened milk, thickened water and thickened juice. There was no Boost with Resident 2's meal. On 4/15/25 at 11:50 A.M. Resident 2 was observed in the dining room. RNA 1 named the beverages served for Resident 2. RNA 1 stated the beverages were: thickened milk, thickened juice and thickened water. There was no Boost served with Resident 2's meal. During an observation on 4/16/25 at 7:53 A.M. Resident 2 was in her room for breakfast. Certified Nurse Assistant (CNA) 13 was assisting Resident 2 to eat. CNA 13 stated Resident 2 had three beverages on the meal tray. CNA 13 stated a thickened juice, water and milk were served with Resident 2's meal. There was no Boost served with the meal. An interview on 4/16/25 at 2:07 P.M. was conducted with Licensed Nurse (LN) 13. LN 13 reviewed the physician's orders for Resident 2. LN 13 stated there was an order for Boost VHC with meals for supplement. LN 13 stated the CNAs were responsible for getting the Boost from the LNs which was kept in the medication cart. LN 13 further stated it was important for Resident 2 to receive the Boost to help with her nutrition. During an interview on 4/16/25 at 2:45 P.M. with the Registered Dietician (RD), the RD stated she expected staff to provide Boost to Resident 2. The RD stated she was not aware that Resident 2 was not receiving the Boost. The RD stated Boost was an intervention to address Resident 2's weight loss and it was specific to be given with meals in case Resident 2 did not eat the food that was served. An interview with the Director of Nursing (DON) on 4/17/25 at 2:34 P.M. was conducted. The DON stated staff should follow physician's order to provide resident's needs. (continued on next page)

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	04/17/2025

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	During a review of the facility's policy and procedure (P&P) titled, Physician's Orders, dated June 2013, the P&P indicated, .Physician's orders must be given, managed and carried out in accordance with applicable laws and regulations .

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	04/17/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48270 Based on observation, interview and record review, the facility failed to monitor and reassess a change in condition (significant worsening of a resident's physical or mental health) for one sampled resident (303). This failure had the potential for complications related to Resident 303's health. Findings: Per the facility admission record, Resident 303 was admitted on [DATE] with diagnoses that included chronic kidney disease stage 3 (condition where the kidneys gradually lose their ability to filter waste products from the blood, leading to a buildup of toxins and other substances in the body). Per the facility progress notes, on 4/12/25 at 3:36 P.M., a potassium level of 5.6 (normal levels 3.5 and 5.5) was reported to the physician. The physician ordered to insert a peripheral intravenous (IV) catheter (a small, thin, flexible tube inserted into a vein to deliver fluids, medications, or blood products directly into the bloodstream). The IV was inserted into Resident 303's back of left hand. Per the facility progress notes, on 4/13/25 at 9:14 P.M., Resident 303's IV infiltrated (when the tip of the catheter slips out of the vein and some of the fluid leaks out into the tissues under the skin) which caused swelling and pain. On 4/14/25, at 8:35 A.M., an observation and interview were conducted with Resident 303 in her room. Resident 303 stated she had an IV in her left hand, but it made her left hand and arm swollen with pain last night. When Resident 303 held up both of her hands and arms together, the left hand and arm were visibly swollen compared to her right hand and arm. Resident 303 stated that the nurses have not helped her with the swelling. On 4/15/25 at 10:09 A.M., a concurrent interview and record review was conducted with a licensed nurse (LN 1). LN 1 reviewed Resident 303's medical record and stated there were no documentation for monitoring or reassessing Resident 303's swollen left hand and arm. LN 1 stated it is their process to monitor and reassess the resident's change in conditions every shift for 72 hours. LN 1 stated that the importance of monitoring and reassessing a change in condition is to ensure the resident's health is improving and that there are no complications related to the change. On 4/17/25 at 10:51 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that for all change in conditions, it is her expectation that nursing are to monitor, reassess and document the identified change in condition every shift. A review of the facility policy titled Change in a Resident's Condition or Status, dated February 2021. indicated that .8. The nurse will record in the resident's medical record information relative to changes in the resident's medical .condition or status.

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	04/17/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review, the facility failed to prevent a stage four (bedsore extended to muscle, tendon or bone) pressure injury from developing after admission for one of three residents (Resident 15) reviewed for pressure injuries. This failure had the potential to affect Resident 15's quality of life. Findings: Resident 15 was admitted to the facility on [DATE] with diagnoses including fracture of shaft left femur (long, central part of thigh bone) according to the facility's Admission Records. During an observation on 4/14/25 at 9:09 A.M. Resident 15 was in bed with an air mattress and overbed trapeze. Resident 15 stated he was on air mattress due to a bedsore on his buttock. Resident 15 was pointing towards his buttocks area. A review of admission records for Resident 15 titled, 01. NURSING-ADMISSION/READMISSION EVALUATION/ASSESSMENT, dated 11/20/24 was conducted. The admission record indicated no pressure injuries. During an interview on 4/15/25 at 7:45 A.M. with Resident 15, Resident 15 stated he was admitted to the facility due to a left leg surgery, but he laid in one position and developed a pressure sore on his buttock. A review of Resident 15's BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK, dated 11/20/24 indicated a score of 15 .AT RISK . A review of the skin care plan dated 11/20/24 for Resident 15 was conducted. The skin care plan indicated, . at risk for skin breakdown .assist to turn and reposition as indicated . An interview was conducted on 4/16/25 at 8:58 A.M. with Certified Nurse Assistant (CNA) 12. CNA 12 stated Resident 15 had a bedsore on his buttock due to being up on the wheelchair too long. CNA 12 stated Resident 15 required assistance with repositioning. CNA 12 stated to prevent bedsores, residents should be changed frequently, reposition every two hours and as needed. During an interview on 4/16/25 at 9:11 A.M. with CNA 13, CNA 13 stated residents needed to be repositioned every two hours and checked frequently to prevent developing pressure ulcers. (continued on next page)

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	04/17/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent record review and interview on 4/16/25 at 10:03 A.M. was conducted with the Treatment Nurse (TN). The TN stated Resident 15 had a stage four pressure ulcer on the sacrum (the triangular shaped bone at the base of the back). The TN showed photos of Resident 15's pressure ulcer. The photo dated 12/10/24 indicated 2.28cm (centimeter) by 1.95 cm, with 80% eschar (black dead tissue) and unstageable (a type of bed sore where the base is covered by dead or yellowish tissue) on the right iliac crest (top of the hip bone). Care plans for Resident 15 were reviewed with the TN. The TN stated the care plans for Resident 15 indicated Resident 15 developed a popped blister on 12/6/24, re-classified as Deep Tissue Injury (DTI-a purple or maroon area of intact skin or blood-filled blister due to damage of soft tissue from pressure or shear) on 12/10/24, re-classified by the wound physician as unstageable (a full thickness tissue loss where the depth of the wound is hidden by a layer of eschar or slough in the wound) on 12/11/24, then re-classified as a stage four on 1/17/25 as the pressure ulcer progressed. The TN stated shearing might have caused Resident 15's pressure ulcer. The TN further stated Resident 15 had developed a blood blister on the coccyx (tailbone) and another DTI on the right buttock as of 4/15/25. During a review of the physician's progress note for Resident 15 dated 12/11/24, the progress note indicated, .Consulted for managing wounds .Patient was > [greater than] 5 hrs [hours] in the wheelchair. advised [sic] to keep sitting in the wheelchair within 1-2 hrs max . An interview on 4/17/25 at 2:34 P.M. was conducted with the Director of Nursing (DON). The DON stated she expected staff to identify residents' comorbidities and be proactive in preventing skin issues. A review was conducted of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, dated April 2020. The P&P indicated, .Reposition all residents with or at risk of pressure injuries on an individualized schedule .Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines .

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	04/17/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status by not providing a nutritional supplement for one of four residents (Resident 2) reviewed for nutrition and with a significant weight loss. This failure had the potential to result in Resident 2's unplanned weight loss which could lead to further decline in weight and overall health condition. Findings: Resident 2 was readmitted to the facility on [DATE] with diagnoses including dysphagia (difficulty in swallowing) following cerebral infarction (disrupted blood flow to the brain) according to the facility's Admission Record). On 4/14/25 9:52 A.M. Resident 2 was observed in her bed watching TV. During interview Resident 2 did not respond verbally but nodded that she was okay. Resident 2 did not respond to further questions. During a review of Resident 2's physician's orders in the electronic medical record (EMR), the physician's orders indicated, .RNA dining program daily at lunch .Boost VHC [Very high calorie nutritional supplement] with meal for supplement . During the dining observation on 4/14/25 at 11:42 A.M. Resident 2 was observed being assisted with her meal by the Restorative Nurse Assistant (RNA- a CNA who work alongside rehab staff to provide exercises for residents with limited mobility) 1. The meal tray included a small glass of thickened milk, small glass of thickened water, a small glass of thickened juice, three small cups of puree food, a plate of puree food and a bowl of soup. RNA 1 stated Resident 2 requires encouragement to eat and has had weight loss. There was no Boost on resident's tray. On 4/15/25 at 8:41 A.M. Licensed Nurse (LN) 12 was observed encouraging Resident 2 to eat breakfast in Resident 2's room. A concurrent observation of Resident 2's meal tray was conducted. The meal tray included thickened milk, thickened water and thickened juice. There was no Boost with Resident 2's meal. On 4/15/25 at 11:50 A.M. Resident 2 was observed in the dining room. RNA 1 named the beverages served for Resident 2's. RNA 1 stated the beverages were: thickened milk, thickened juice and thickened water. There was no Boost served with Resident 2's meal. During an observation on 4/16/25 at 7:53 A.M. Resident 2 was in her room for breakfast. Certified Nurse Assistant (CNA) 13 was assisting Resident 2 to eat. CNA 13 stated Resident 2 had three beverages on the meal tray. CNA 13 stated a thickened juice, water and milk were served with Resident 2's meal. There was no Boost served with the meal. (continued on next page)

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	04/17/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent record review and interview on 4/16/25 at 2:07 P.M. was conducted with Licensed Nurse (LN) 13. LN 13 reviewed the physician's orders for Resident 2. LN 13 stated there was an order for Boost VHC with meals for supplement. LN 13 stated the CNAs was responsible for getting the Boost from the LNs which was kept in the medication cart and Resident 2 did not receive the Boost. LN 3 reviewed Resident 2's weight record. LN 3 stated Resident 2's weight on 3/7/25 was 103 lb. (pounds) and 91 lb. on 4/9/25. LN 3 stated Resident 2 had significant weight loss. LN 13 further stated it was important for Resident 2 to receive the Boost to help with her nutrition. A review of the Registered Dietician's (RD) progress note for Resident 2 dated 4/10/25 was conducted. The progress notes indicated, .- [minus]12# [pounds] x 1 mo [month] 11.6% .underweight status .wt [weight] below goal . A review of Resident 2's weight record in the EMR indicated: 1/4/25 110 lb. 2/3/25 106 lb. 3/1/25 100 lb. 3/7/25 103 lb. 3/17/25 98 lb. 4/3/25 97 lb. 4/9/25 91 lb. During an interview on 4/16/25 at 2:45 P.M. with the Registered Dietician (RD), the RD stated she expected staff to provide Boost to Resident 2. The RD stated she was not aware that Resident 2 was not receiving the Boost. The RD stated Boost was an intervention to address Resident 2's weight loss and it was specific to be given with meals in case Resident 2 did not eat the food that was served. An interview with the Director of Nursing (DON) on 4/17/25 at 2:34 P.M. was conducted. The DON stated staff should follow physician's order to provide resident's needs. The DON further stated if Boost was ordered due to weight loss, staff should provide it to the resident. During a review of the facility's policy and procedure (P&P) titled, Nutritional Assessment, dated October 2017, the P&P indicated, .The nutritional assessment will be conducted .and shall identify at least .an estimate of calorie, protein, nutrient and fluid needs .The multidisciplinary team [team members with various areas of expertise working together towards the goals of the residents] shall identify .Inadequate availability of food or fluids-lack of access to the amount of food or fluids that the resident requires to maintain sufficient nutrition and hydration . During a review of the facility's policy and procedure (P&P) titled, Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, dated September 2012, the P&P indicated, .The nursing staff will monitor and document .dietary intake of residents .Treatment decisions should consider all pertinent evidence and relevant issues .The physician will authorize appropriate interventions .

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	04/17/2025

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 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** 50175 Based on observation, interview, and record review, the facility failed to ensure a medication was given as ordered by a physician for one of three residents (Resident 107) observed for medication administration. This failure had the potential for Resident 107's medical needs to be unmet. Findings: Resident 107 was admitted to the facility on [DATE] with diagnoses including diabetes (high blood sugar), according to the Admission Record. Licensed Nurse (LN) 31 was observed preparing and administering medications to Resident 107 on Wednesday, 4/16/25, at 7:55 A.M. Resident 107 was given the following medications: benazepril (a blood pressure medication), empagliflozin (a diabetes medication), apixaban (a blood thinner), gabapentin (a medication to treat nerve pain), arginine (a supplement), ascorbic acid (a vitamin), aspirin (a blood thinner), ferrous sulfate (an iron supplement), multivitamin, and insulin glargine (a diabetes medication). A review of Resident 107's medical record was conducted on 4/16/25. A review of Resident 107's physician's orders included dulaglutide injection (a diabetes medication) every Wednesday. Resident 107 did not receive dulaglutide during the medication administration observation. An interview was conducted with LN 31 on 4/16/25 at 10:10 A.M. LN 31 stated she did not notice that dulaglutide was due because it was on the last part of the medication administration record (a record including a resident's medication orders). LN 31 stated she had not given the medication yet. LN 31 stated dulaglutide was due at 9:00 A.M. A follow-up interview was conducted with LN 31 on 4/16/25 at 10:44 A.M. LN 31 stated dulaglutide was not available when it was due, and the medication needed to be ordered from the pharmacy. An interview with the Director of Nursing (DON) was conducted on 4/17/25 at 10:11 A.M. DON stated medications needed to be available when it was due. DON stated medication nurses were responsible for making sure the medication was available, especially if it was due only once a week. DON stated it was important to give medications on time and to follow physician's orders. A review of the facility's policy titled Administering Medications, revised April 2019, indicated .Medications are administered in accordance with prescriber orders, including any required time frame .Medications are administered within one (1) hour of their prescribed time .

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	04/17/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review the facility failed to ensure one of 8 residents (41) reviewed for psychotropics (drugs that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) had the proper indication for the use of an anti-anxiety medication (a drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness and muscle tightness that may occur as a reaction to stress). This failure resulted in Resident 41's continued use of an antipsychotic medication without proper indication and possible exposure to the medication's side effects. Findings: A review of Resident 41's undated Admission Record indicated that Resident 41 was admitted to the facility on [DATE] with diagnoses that included Anxiety Disorder (feelings of worry, nervousness and fear) and Major Depressive Disorder (persistent feelings of sadness and loss of interest in activities). An interview on 4/16/25 at 8:52 A.M., with Resident 41 was conducted. Resident 41 was seen lying in bed, watching TV in her room. Resident 41 stated she had been taking xanax (medication to treat anxiety) for years for her anxiety. Resident 41 stated she gets panic attacks and would feel her heart beating fast and somehow, she felt like she had to be somewhere but does not know where. Resident 41 stated the facility was giving the medication as needed before, but she had requested it to be administered on a routine basis. Resident 41 stated it usually takes two hours for the medication to work on her before she calmed down or else she is trouble. A review of Resident 41's minimum data set (MDS- a federally mandated assessment tool) dated 3/17/25 indicated Resident 41 had a brief interview for mental status (BIMS) of 15 which meant Resident 41's cognition (thought process) was intact. An interview on 4/16/25 at 8:50 A.M., with certified nursing assistant (CNA) 24 was conducted. CNA 24 stated when Resident 41 started talking about her family issues, Resident 41 gets anxious, and Resident 41 would tell CNA 24 she felt her heart beating fast. An interview on 4/16/25 at 9:10 A.M., with Licensed Nurse (LN) 21 was conducted. LN 21 stated Resident 41 would exhibit anxiety manifested by Resident 41's refusal of care. An interview on 4/17/25 at 8:05 A.M., with LN 22 was conducted. LN 22 stated Resident 41 did not have any episodes of feeling of impending danger, she was alert and oriented enough to let staff know. LN 22 stated the behavior monitoring was not accurate for the use of xanax. LN 22 stated feeling of impending danger was not the same as panic attacks. LN 22 stated it was important to get the right behavior monitoring for the efficacy of the medication and to provide Resident 41's physician adequate information regarding Resident 41's progress. A record review of Resident 41's Physician's orders dated 3/2/25 indicated Alprazolam tablet 0.5 mg, give 1 tablet by mouth every 8 hours for anxiety, as exhibited by: feeling of impending danger. (continued on next page)

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	04/17/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 41's care plan dated 3/18/22 indicated Requires use of xanax for anxiety as evidenced by (AEB): feeling of impending danger. An interview on 4/17/25 at 10:00 A.M., with the Director of Nursing (DON) was conducted. The DON stated it was important to identify the exact behavior to give the proper intervention, and the facility does the gradual dose reduction (GDR) to ensure the medication worked. A review of the facility's policy on Psychotropic Medication Use dated February 2025, indicated Policy Interpretation and Implementation .#3 .c. adequate monitoring for efficacy and adverse consequences. Adequate Indications for Psychotropic Medication Use .#1.Adequate indication for use refers to the identified , documented clinical rationale for administering medication that is based on .a. an assessment of the resident's condition .

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	04/17/2025

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 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** 46235 Based on record review and interview, the facility did not maintain a complete Physician Orders for Life Sustaining Treatment (POLST- a medical form used to communicate a resident's wishes during a life-threatening emergency) for eight of 32 residents reviewed for complete and accurate medical records. (Residents 2,15, 45, 57, 58, 59, 245, 111) This failure did not provide an accurate representation of the care provided and had the potential to cause confusion amongst care providers. Findings: 1. Resident 2 was readmitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction ((disrupted blood flow to the brain) according to the facility's Admission Record. 2. Resident 15 was admitted to the facility on [DATE] with diagnoses including fracture of shaft left femur (long, central part of thigh bone) according to the facility's Admission Records. 3. Resident 45 was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation (an irregular, rapid heartbeat causing poor blood flow) according to the facility's Admission Records. 4. Resident 57 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction according to the facility's Admission Record. 5. Resident 58 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease (heart problems that develop due to long term high blood pressure) with heart failure according to the facility's Admission Record. A concurrent record review and interview was conducted on [DATE] at 8:12 A.M. with Licensed Nurse (LN) 11. LN 11 reviewed POLST forms in the electronic medical records (EMR) for Resident 2, 15, 45, 57 and 58 at the nurse's station. LN 11 stated POLST forms for Residents 2, 15, 45, 57 and 58 were all incomplete in section D of the form pertaining to information regarding advance directives (a legal document with a person's wishes for medical care when unable to communicate them). The Social Service Director (SSD) was at the nurse's station and stated nurses were responsible for completing the POLST form including section D regarding advance directives. LN 11 stated the admission nurse completed the form during admission of a resident. LN 11 stated she had worked as an admission nurse and have not completed or followed up with section D of the POLST. LN 11 stated it was important to complete section D the advance directive part of the POLST to help determine if a resident can make decisions regarding care. An interview was conducted with the Director of Nursing (DON) on [DATE] at 1:45 P.M. The DON stated POLST for residents should be complete for continuity of care and for staff to be well informed. (continued on next page)

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	04/17/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policies and procedures (P&P) titled, Charting and Documentation, dated [DATE] indicated, .The medical record should facilitate communication between the interdisciplinary team [IDT- team members with various areas of expertise who work together toward the goals of their residents] regarding the resident's condition and response to care .Documentation in the medical record will be objective .complete, and accurate . 47466 Findings. 6. A review of Resident 59's undated Admission Record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses that include cancer of the left ear and chronic obstructive pulmonary disease (a chronic lung disease that caused difficulty in breathing). A review of Resident 59's Physician Orders for Life Sustaining Treatment (POLST-a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can and cannot be done at the end of life) dated [DATE] indicated Resident 51 was A. attempt Resuscitation CPR), B. selective treatment C. trial period of artificial means nutrition, including feeding tubes and D. was left blank regarding Advanced Directives, as signed by Resident 59. A review of Resident 59's minimum data set (MDS- a federally mandated assessment tool) dated ,d+[DATE] indicated Resident 59's brief interview for mental status (BIMS) score was 15, which meant Resident 59's cognition (thought process) was intact. 7. A review of Resident 245's undated Admission Record indicated Resident 245 was admitted to the facility on [DATE] with diagnoses that include Hypertension (elevated blood pressure) and Dementia (a progressive state of decline in mental abilities). A review of Resident 245's POLST dated [DATE] indicated Resident 245 was A. attempt CPR, selective treatment C. Trial period of artificial means of nutrition, including feeding tubes D. was left blank regarding Advanced Directives , as signed by Resident 245's family member (FM), Resident 245's daughter. A review of Resident 245's minimum data set (MDS) dated [DATE] , indicated Resident 245's BIMS score was 09 which meant Resident 245's cognition (thought process) was moderately impaired. A review of Resident 245's MDS dated [DATE] indicated Resident BIMS score was 09 which meant Resident 245's cognition (thought process) moderately impaired. A review of the facility's policies and procedures (P&P) titled, Charting and Documentation, dated [DATE] indicated, .The medical record should facilitate communication between the interdisciplinary team [IDT- team members with various areas of expertise who work together toward the goals of their residents] regarding the resident's condition and response to care .Documentation in the medical record will be objective .complete, and accurate . 50175 (continued on next page)

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	04/17/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Resident 111 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by an illness in the body) and age-related cognitive decline (difficulty thinking and remembering) according to the Admission Record. A concurrent interview and record review was conducted with the Director of Nursing (DON) on [DATE] at 10:16 A.M. The DON stated Resident 111's POLST Section D was blank. The DON stated a blank Section D indicated that there was no documentation that someone asked Resident 111 or the responsible party if Resident 111 had an Advance Directive. A review of the facility's policies and procedures (P&P) titled, Charting and Documentation, dated [DATE] indicated, .The medical record should facilitate communication between the interdisciplinary team [IDT- team members with various areas of expertise who work together toward the goals of their residents] regarding the resident's condition and response to care .Documentation in the medical record will be objective .complete, and accurate .

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	04/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46235 Based on observation, interview, and record review, the facility failed to ensure current infection control practices were followed when a facility employee touched the spout of beverage cartons upon opening the cartons during mealtime. This failure had the potential for cross contamination (spread of germs and bacteria) and infection. Findings: A dining room observation was conducted on 4/14/25 at 11:34 A.M. at the facility's south dining room. The dining room was observed with four round tables with numbers 1, 2, 3 and 4. The Restorative Nursing Assistants (RNA-a Certified Nurse Assistant who worked alongside rehab staff to provide exercises for residents with limited mobility) were at tables 1, 2 and 3. Table 4 had two residents who were waiting for their trays to be served. On 4/14/25 at 12:05 P.M. meal trays for the residents in table 4 were served by Licensed Nurse (LN) 11. LN 11 opened three small cartons of beverages using her bare forefinger to open the spout on the cartons. LN 11 then proceeded to feed one of the residents in table 4. An observation and interview was conducted on 4/16/25 at 12:15 P.M. with RNA 2. RNA 2 demonstrated how to open a beverage carton. RNA 2 stated after pulling the carton's opening to the sides, the corner of the carton must be squeezed, and the spout will open. RNA 2 stated if the spout will not open, pull the other end of the carton to the sides and the carton will fully open. RNA 2 stated touching the spout was an infection control issue. An observation and interview on 4/16/25 at 12:27 P.M. was conducted with LN 11. LN 11 demonstrated how to open a beverage carton. LN 11 stated after pulling the edges of the carton, the carton should be squeezed at the ends and the spout will open. LN 11 stated she did not follow this procedure and placed her finger on the spout to open it. LN 11 stated using her finger was an infection control issue. During an interview on 4/17/25 at 2:35 P.M. with the Director of Nursing (DON), the DON stated staff should not open beverage cartons by touching the spout because of infection control and spreading of germs. A review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated April 2025 was conducted. The P&P indicated, .Prevention of Infection .educating staff and ensuring that they adhere to proper techniques and procedures .communicating the importance of standard precautions . The policy did not define standard precautions to prevent the spread of infection and explain the precautions during resident care activities. (continued on next page)

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	04/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Centers for Disease Control and Prevention (CDC- the national public health agency that protects the public's health in the United States https://www.cdc.gov/infection-control/hcp/isolation-precautions/summary-recommendations.html) Summary of Recommendations, dated November 27, 2023, the recommendations indicated .Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting .