

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Vista View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 304 N. Melrose Dr Vista, CA 92083	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471</p> <p>Based on interview and record review, the facility failed to ensure the licensed nurses (LN) had specific competencies and training related to Central Venous Catheter site (CVC- a soft plastic tube inserted into a vein to provide vascular access for hemodialysis [a treatment that filters waste and excess fluid from the blood of people whose kidneys were not functioning properly] for 5 of 7 licensed nurses (LN).</p> <p>This failure had the potential to result in inaccurate assessment and delayed care and treatment of a resident with a CVC line.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease (ESRD- kidney failure) per the Admission Record.</p> <p>On 8/22/24 at 4:30 P.M., an interview was conducted with LN 3. LN 3 stated that to assess the CVC site, LNs had to examine the site and document the signs and symptoms of infection and the condition of the dressing. LN 3 further stated there would be no bruit [a whooshing sound] that happens when the blood flows to the body and trill [vibration over the blood vessel]. LN 3 stated the bruit and trill would be heard and felt for residents with AVF (arteriovascular fistula- a surgical connection between an artery and a vein).</p> <p>A review of Resident 1's Dialysis Communication Form was conducted. Under the Dialysis Center Information section, dated 7/24/24 through 8/7/24, Resident 1 had a CVC line in the left chest that the dialysis center used during dialysis treatment.</p> <p>On 7/24/24, 7/29/24, and 8/3/24, under the post-dialysis information [assessment performed by the facility], LN 1 documented the presence of bruit and trill.</p> <p>On 7/26/24, under the post-dialysis information section, LN 6 documented the catheter was patent (no obstruction), and bruit and trill were present. LN 6 was a licensed vocational nurse (LVN).</p> <p>On 7/31/24, under the post-dialysis information section, LN 4 documented the presence of bruit and trill.</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/5/24, under the post-dialysis information section, LN 6 documented the presence of bruit and trill.</p> <p>On 8/7/24, under the post-dialysis information section, LN 5 documented the presence of bruit and trill.</p> <p>On 8/22/24 at 3:16 P.M., an interview was conducted with LN 1. LN 1 stated she had cared for Resident 1 and did not have proper training for CVC for hemodialysis.</p> <p>On 8/22/24 at 4 P.M., an interview was conducted with LN 2. LN 2 stated there was no formal training about the CVC for hemodialysis. Per LN 2, It was verbal instructions during endorsement (report).</p> <p>On 8/28/24 at 4:30 P.M., an interview was conducted with LN 4. LN 4 stated he did not have formal training for CVC for hemodialysis.</p> <p>On 8/29/24 at 12:30 P.M., an interview was conducted with LN 5. LN 5 stated he had formal training in CVC assessment. However, on 8/7/24, many things were happening, and human error occurred. LN 5 further stated he documented check marks on the bruit and trill (dialysis communication form) without assessing the site, and should not have.</p> <p>On 8/29/24 at 1:15 P.M., an interview was conducted with LN 6. LN 6 stated she watched many videos upon hire and could not recall if one was about CVC assessment and care. LN 6 stated she should not have documented that the catheter was patent because it was beyond her scope (as a LVN) to check the CVC line's patency, and she was not allowed to touch the CVC. LN 6 further stated she assumed the line was patent because Resident 1 returned from hemodialysis.</p> <p>On 9/3/24 at 4:40 P.M., an interview was conducted with the Director of Nursing (DON). The DON acknowledged the LNs should have competencies and training (for CVC), and stated assessment for the CVC site should have been monitored for bleeding, signs and symptoms of infection, and if the dressing was intact.</p> <p>The facility could not provide a policy and procedure for CVC care, training, and skills checks for the CVC line.</p>