STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555246	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista View Post Acute	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)
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** Based on interview and record review, the facility failed to ensure respect and dignity was provided to one of three sampled residents (Resident 2) when a certified nursing assistant (CNA) opened resident's drawer without permission and said inappropriate words towards Resident 2. This failure had the potential to make residents feel disrespected and may have resulted in diminished quality of life and lower self-esteem. Findings: Resident 2 was admitted on [DATE], with diagnoses which included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and bipolar disorder (a mental health condition that causes extreme mood swings), per the facility's admission Record. A review of Resident 2's minimum data set (MDS- an assessment tool), dated 4/16/25, indicated, her brief interview for mental status (BIMS - test the resident's cognition status) was 15 (13- 15 meant intact cognition). On 5/28/25 at 12:31 P.M., an interview was conducted with the Director of Social Services (DSS). The DSS stated a text message was received from Licensed Nurse (LN) 4 regarding the incident with Resident 2. The DSS stated on 5/19/25, an interview with Resident 2 was conducted. Resident 2 told DSS that CNA 2 went to Resident 2's room looking for diapers, opened her (resident) drawer without asking permission. Resident 2 stated while she was reporting the incident to LN 4 in the nursing station, CNA 2 told Resident 2 Shut the f** up. The DSS stated Resident 2 was upset with the incident but later calmed down. On 5/28/25 at 1:43 P.M., an interview was conducted with Resident 2. Resident 2 stated on 5/19/25 around 5 A.M., she was awake in her bed and was in her phone when CNA 2 came inside the room. CNA 2 opened her drawers looking for diapers without asking permission. Resident 2 stated she asked CNA 2 to stop rummaging her drawers, but CNA 2 responded You don't own these diapers. Resident 2 stated she went to the nursing station and reported to LN 4 regarding the incident with CNA 2. Resident 2 stated, while she was talking to LN 4, CNA 2 screamed at her and told her to shut the f** up. On 5/28/25 at 2:14 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated staff were trained on resident rights and different kinds of abuse, and who to report abuse at least annually. The DSD stated staff should treat residents with respect and dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 7:34 A.M., a telephone interview was conducted with Licensed Nurse (LN) 4. LN 4 stated she worked on the date of the incident. LN 4 stated Resident 2 was alert and oriented, and able to make her needs known. LN 4 stated she was coming out in one of the rooms in front of the nursing station when she saw Resident 2 and CNA 2 in front of the nursing station and heard CNA 2 saying shut the f** up . Resident 2 told LN 4 that CNA 2 went inside her room and started opening her drawers looking for diapers without asking her permission and followed me in the nursing station and said the word shut the f** up. LN 4 stated CNA 2 was not assigned to Resident 2 on the date of the incident. LN 4 stated CNA 2 should have gone to the supply room for diaper instead of going through the resident's supply in resident's room. LN 4 further stated CNA 2 should have not said those inappropriate words to the resident at any time. On 6/10/25 at 4:03 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation for her staff was to respect residents' privacy and treated with dignity. Staff should asked permission from the resident when opening their personal belongings and not to use vulgar words. A review of the facility's policy and procedures (P & P) titled, Resident Rights, dated 12/19/22, indicated . the resident has the right to a dignified existence, self -determination, and communication .4. Respect and Dignity . the resident has the right to be treated with respect and dignity .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify and confirmed bed hold notice to the resident's family representative upon transfer to an acute care facility (hospital) for one of three sampled residents (Resident 1). This failure resulted in Resident 1' s family representative confusion related to bed hold payment. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a common lung disease causing restricted airflow and breathing problems), per the facility's admission Record. A review of Resident 1's Bed Hold Notification Informed Consent Form was conducted. There was no indication of Resident 1's family representative was notified and confirmed the bed hold when Resident 1 was transferred to an acute hospital. On 5/28/25 at 1 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated nursing staff, or social services would follow up with the family representative to offer bed hold when a resident was transferred to an acute care facility. On 6/9/25 at 9:32 A.M., a telephone interview was conducted with the Business Office Manager (BOM). The BOM stated nursing staff would contact the family to notify and confirmed bed hold when a resident transferred to an acute care facility. The BOM stated residents were not placed on bed hold right away. The nursing staff would notify and confirm with the family representative that they would like a bed hold. On 6/9/25 at 9:55 A.M., a telephone interview was conducted with the DON. The DON stated the nurse would contact the family representative to confirm and verify the bed hold. The DON stated nursing staff should have documented the notification and confirmation from the family representative. On 6/9/25 at 5 P.M., a telephone interview was conducted with Licensed Nurse (LN) 1. LN 1 stated when Resident 1 was transferred to an acute care facility on 1/22/25, he did not verify and confirmed the bed hold with the family representative. LN 1 stated family should be notified and verified bed hold with the resident or family representative and documented in the form. On 6/10/25 at 7:27 A.M., a telephone interview was conducted with LN 2. LN 2 stated she did not follow up with Resident 1's family representative to offer and confirmed bed hold when Resident 1 was transferred to an acute care facility on 1/22/25. LN 2 stated when the family confirmed the bed hold, it should have been documented in the bed hold form and or progress note. On 6/10/25 at 3:53 P.M., a telephone interview was conducted with the Social Service Director (SSD). The SSD stated nursing was responsible for contacting and following up with the resident and or family representative to offer bed hold when a resident was transferred out to an acute care facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 4:19 P.M., an interview was conducted with the DON. The DON stated Resident 1's Bed Hold Informed Consent Form did not have any documentation related to the notification, confirmation of transfer and bed hold provision. The DON stated the nursing staff should have completed and documented in the form and in the progress notes when Resident 1 was transferred out to an acute care facility. A review of the facility's policy and procedures (P&P), titled Bed Hold Notice, dated 12/19/22, indicated . at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and /or the resident representative a written notice which specifies the duration the bed hold policy .2. In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed hold policies .