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	05/01/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52585 Based on observation, interview, and facility policy review, the facility failed to maintain the blinds in 5 resident rooms (Rooms 107, 112, 130, 131, and 138) of 30 resident rooms on the first floor of the facility in good condition. Findings included: A facility policy titled, Safe and Homelike Environment, dated 12/19/2022, indicated, 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. During an observation on 05/01/2025 at 9:08 AM, room [ROOM NUMBER], located on the first floor, had horizontal window blinds in place with 22 missing blind slats (individual horizontal or vertical strips of material that made up the structure of the blind). The missing window slats created an open area that measured approximately four and one half feet by eight inches that potentially exposed residents to public view. During an observation on 05/01/2025 at 8:59 AM, room [ROOM NUMBER] had vertical blinds with 13 missing slats. During an observation on 05/01/2025 at 8:58 AM, room [ROOM NUMBER] had horizontal blinds that covered a sliding glass door with a view into a center courtyard, and two slats were missing from the blinds. During an observation on 05/01/2025 at 8:57 AM, room [ROOM NUMBER] had horizontal blinds that covered a sliding glass door with a view into a center courtyard. One slat was missing from the blinds, and one slat was noted lying on the floor. During an observation on 05/01/2025 at 9:28 AM, room [ROOM NUMBER] had vertical blinds that covered a sliding door, and the blinds were missing six slats which caused a gap of approximately one foot by seven feet. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 05/01/2025 at 9:45 AM, Certified Nursing Assistant (CNA) #3 stated if something were broken in a resident's room she would report it in the maintenance log, and she demonstrated where the maintenance log was located at the nurses' station. CNA #3 confirmed by way of observation the broken blinds in room [ROOM NUMBER] and stated she had not noticed the broken blinds before. CNA #3 entered room [ROOM NUMBER] and stated she had not noticed the two slats missing, and stated it should be reported. CNA #3 entered room [ROOM NUMBER] and stated she had been aware of the broken blinds for more than a few weeks but had not reported it. During a concurrent observation and interview on 05/01/2025 at 10:03 AM, Registered Nurse (RN) #4 stated if there was a broken but not harmful item in a resident's room she would put it in the logbook. RN #4 stated she had not reported anything recently, and she had not seen anything broken. RN #4 revealed missing blinds was something she would report to the maintenance department. RN #4 entered room [ROOM NUMBER] and stated she observed 13 missing blind slats. RN #4 entered room [ROOM NUMBER] and stated there was two missing blind slats. RN #4 entered room [ROOM NUMBER] and stated she counted six missing blind slats, and that was something she would report immediately. During a concurrent observation and interview on 05/01/2025 at 10:27 AM, the Maintenance Director stated that when a staff member observed broken items in a resident's room the staff member was expected to log the item in the maintenance book. The Maintenance Director stated he had not received a maintenance request within the last couple of weeks to repair blinds. The Maintenance Director entered room [ROOM NUMBER] and stated the 13 missing blind slats was a concern because it allowed more heat to come into the room, and the apartment building behind the facility was about 200 feet away with a clear line of sight into the room. The Maintenance Director entered room [ROOM NUMBER] and noted the two missing blind slats. The Maintenance Director entered room [ROOM NUMBER] and noted one slat on the ground. The Maintenance Director stated the six blind slats missing in room [ROOM NUMBER] needed to be repaired. During an interview on 05/01/2025 at 12:15 PM, the Director of Nursing (DON) stated that when a clinical staff member identified a maintenance issue, the staff typically called the Maintenance Director and the leadership team if the issue was an emergency. The DON stated the clinical staff sent out a text message when something was found broken. The DON stated if the staff member was a nursing assistant they told the nursing supervisor, and the supervisor would notify the team. The DON stated there was a maintenance log to document when an issue was identified. The DON stated maintenance was expected to follow-up on the concerns in the maintenance book. During an interview on 05/01/2025 at 12:44 PM, the Administrator stated staff should place a maintenance issue on the maintenance log, which was checked by the Maintenance Director. The Administrator stated after the repair was made he checked the log against the repair to verify completion. The Administrator stated if something was broken it needed to be fixed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 52203 Based on interview, record review, and facility policy review, the facility failed to refer a resident to the appropriate state-designated authority for a level II preadmission screening and resident review (PASARR) when the resident was diagnosed with a new mental illness diagnosis for 1 (Resident #104) of 2 sampled residents reviewed for PASARR. Findings included: A facility policy titled, Resident Assessment - Coordination with PASARR Program, revised 12/18/2023, revealed, This facility coordinates assessments with the preadmission screening and resident review program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy specified, 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. An Admission Record revealed the facility admitted Resident #104 on 02/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction. The Admission Record indicated the resident received a diagnosis of depression on 09/26/2024 and bipolar disorder on 11/26/2024. A quarterly Minimum Data Base (MDS), with an Assessment Reference Date (ARD) of 03/25/2025, revealed Resident #104 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had active diagnoses that included depression and bipolar disorder. Resident #104's Care Plan Report included a focus area initiated 05/07/2024, that indicated the resident used an antidepressant medication related to a diagnosis of depression. Resident #104's medical record revealed no evidence to indicate a level II PASARR was resubmitted after the resident was diagnosed with depression on 09/26/2024 or bipolar disorder on 11/26/2024. During an interview on 05/01/2025 at 9:00 AM, the Assistant Director of Nursing (ADON) stated she was one of the facility leadership staff who was responsible for PASARRs. The ADON stated that when a new mental illness diagnosis was added to a resident's record, a PASARR was completed and submitted to the state. The ADON stated the Social Services Director (SSD) and the Director of Health Information also had access to the system, and any one of them could submit a PASARR. Per the ADON, Resident #104 had a diagnosis of bipolar disorder, and a new PASARR should have been submitted. During an interview on 05/01/2025 at 9:32 AM, the SSD stated that when a new mental illness diagnosis was added to a resident record, a PASARR should be completed. According to the SSD, the ADON was responsible for submitting PASARRs. The SSD reviewed Resident #104's diagnoses list and stated she expected a PASARR to be resubmitted when the resident's bipolar disorder diagnosis was added. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 11:43 AM, the Director of Nursing (DON) stated if another PASARR was required, the ADON submitted the screening. The DON stated a new mental illness diagnosis required a PASARR to be resubmitted. During an interview on 05/01/2025 at 11:26 AM, the Administrator stated the facility followed state and federal regulations. The Administrator stated he expected PASARR screenings to be submitted following the addition of a new mental illness diagnosis. The Administrator stated the ADON took the lead on the PASARR process; however, he tried to get several people involved so that alternate staff were always available to address PASARR concerns.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 42192 Based on interview, record review, and facility policy review, the facility failed to resubmit a level I preadmission screening and resident review (PASARR) to the appropriate state-designated authority for 1 (Resident #81) of 2 sampled residents reviewed for PASARR. Findings included: A facility policy titled, Resident Assessment - Coordination with PASARR Program, revised 12/18/2023, revealed, This facility coordinates assessments with the preadmission screening and resident review program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. An Admission Record indicated the facility readmitted Resident #81 on 12/16/2024. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder, anxiety disorder, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/28/2025, revealed Resident #81 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was moderately impaired in cognitive skills for daily decision making. The MDS revealed Resident #81 had active diagnoses to include anxiety disorder, depression, and schizophrenia. Resident #81's Care Plan Report included a focus areas initiated 02/23/2022, that indicated the resident used anti-anxiety medications related to a diagnosis of anxiety disorder. The Care Plan Report also included a focus area initiated 09/27/2023, that indicated the resident used antidepressant medication related to a diagnosis of depression. The Care Plan Report included a focus area initiated 02/11/2025, that indicated the resident had a diagnosis of schizophrenia, including symptoms such as delusions, hallucinations, disorganized speech, disorganized behavior, and negative behaviors. A letter from the California Department of Health Care Services dated 12/27/2024, revealed a level II mental health evaluation was required for Resident #81 due to the resident's serious mental illness. A letter from the California Department of Health Care Services dated 12/27/2024, revealed a level II evaluation was unable to be completed for Resident #81's serious mental illness due to the facility staff being unresponsive on two or more separate communication attempts within 48 hours. Per the letter, the facility must resubmit a new Level I Screening. During an interview on 05/01/2025 at 8:56 AM, the Assistant Director of Nursing (ADON) stated she was in charge of the PASARR program and had access to the PASARR portal. The ADON stated she had not seen the notice from the state about not being able to reach the facility. According to the ADON, Resident #81's PASARR should have been resubmitted when the facility received the notice. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2025 at 11:43 AM, the Director of Nursing (DON) stated the ADON oversaw the PASARR screenings in the facility. Per the DON, if a level I PASARR was positive and the facility could not be reached for further information, she expected the screening to be resubmitted. The DON stated Resident #81's PASARR should have been resubmitted for evaluation and recommendations from the state office. During an interview on 05/01/2025 at 11:25 AM, the Administrator stated that he expected the facility to follow the state and federal requirements for reviewing and submitting PASARR screenings. He stated that if a resident had a positive level I, he expected a letter of determination to be in the resident's record and a follow up completed. According to the Administrator, the ADON was the lead for PASARRs, and multiple facility nurses had access as well. The Administrator stated Resident #81's PASARR should have been resubmitted to the PASARR office when the letter was received indicating communication could not be made with the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 52224 Based on interview, document review, and facility policy review, the facility failed to post the actual hours worked by staff directly responsible for resident care for 12 of 12 shifts reviewed. This deficient practice had the potential to affect all residents who currently resided in the facility. Findings included: A facility policy titled, Nurse Staffing Posting Information, dated 03/10/2025, indicated, It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides. The facility Nurse Staff Projection, documents dated 04/25/2025, 04/27/2025, 04/28/2025, and 04/29/2025, revealed the documents did not indicate the actual hours worked for all three shifts each day for the staff directly responsible for resident care. During an interview on 05/01/2025 at 8:54 AM. the Scheduler stated he had been the staffing coordinator for the past two years and was responsible for the posting of nurse staffing data. The Scheduler stated he tried to maintain the nurse staffing records but sometimes forgot to print or post them. During an interview on 05/01/2025 at 9:49 AM, the Director of Staff Development (DSD) stated she worked closely with the Scheduler to provide oversight. The DSD stated she did not update the nurse staffing data sheets on 04/25/2025, 04/27/2025, 04/28/2025, or 04/29/2025 to show the actual hours worked by the staff. The DSD stated she expected 100 percent compliance with the data for nurse staffing postings. During an interview on 05/01/2025 at 10:48 AM, the Director of Nursing stated she expected the nurse staffing data to be adjusted as needed for call outs, have the appropriate disciplines included in the count, and to be correct. During an interview on 05/01/2025 at 11:02 AM, the Administrator stated the nurse staffing postings should be accurate. The Administrator stated that staff should be able to go back and adjust staffing data based on staffing changes.