STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555425	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Knoll Specialized Care Facility	2000 Westwood Road 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to timely complete the Minimum Data Set (MDS-a federally mandated clinical assessment tool) for one of three residents (Resident 3), reviewed for Resident Assessment, as required by Federal regulation S483.20(f)(3). This failure had the potential for a delay in care planning of Resident 3's ongoing clinical problems.Findings: Resident 3 was readmitted to the facility on [DATE] according to the facility's admission Record. A review of Resident 3's hospital history and physical, dated 4/28/26, prior to 5/1/26 admission to the facility, indicated a diagnosis of right femoral neck (flat bone connecting the ball of the hip bone to the thigh bone) fracture from a mechanical fall and dementia. An interview and joint record review on 6/2/26 at 10:30 A.M. with the Minimum Data Set Coordinator (MDSC-a Registered Nurse who completed the federally mandated clinical assessment tool [MDS] used to evaluate a resident's physical, psychological, and psychosocial needs). The MDSC reviewed the progress notes (PN) for Resident 3 in the EMR. MDSC stated the PN dated 5/5/26 at 4:42 P.M indicated at approximately 3:30 P.M., a report was received that Resident 3 was on the floor in prone position by the door with significant blood on the floor. The PN further indicated that Resident 3 had a skin tear on her nose and bleeding from that and inside of her nose, and a physician was notified with an order for Resident 3 to be transferred to the emergency room. Resident 3 returned to the facility on 5/8/26. A review of Resident 3's MDS in the Electronic Medical Record (EMR) was conducted on 6/2/26 at 11:20 A.M. The EMR indicated an admission MDS with an Assessment Reference Date (ARD) of 5/15/26 was in progress. A phone interview on 6/9/26 st 3:08 P.M. with the MDSC was conducted. The MDSC stated she reviewed Resident 3's MDS in the EMR. The MDSC stated the EMR indicated and entry MDS was completed on 5/8/26 and an admission MDS with an Assessment Reference Date (ARD-the specific endpoint of the clinical observation period to capture a resident's health status) of 5/15/26 was completed on 6/6/26 and transmitted to Centers for Medicare & Medicaid Services (CMS-government agency overseeing nursing health facilities) on 6/7/26. The MDSC stated the MDS was completed late. The MDSC stated MDS assessments should be completed and transmitted on time per Medicare regulations, for billing and for accuracy of assessments. The MDSC further stated the purpose of the MDS was also for Interdisciplinary Team (IDT-team members with various areas of expertise who work together toward the goals of their residents) collaboration on the specific care and needs of each resident. An interview was conducted with the Director of Nursing on 6/11/26 at 10:56 A.M. The DON stated residents' MDSs should be submitted timely for the database to have information regarding the resident and for payment purposes. A review of the validation report for Resident 3's admission MDS was reviewed. The validation report indicated, Assessment Completed Late: For this admission assessment.Z0500B [completion date] is more than 13 days after A1600 [entry date].Z0500B [assessment completion date] is more than 14 days after A2300 [assessment reference date] .V0200B2 [CAA-Care Area Assessment/care planning] is more than 13 days after A1600 [entry date. During a review of the facility's policy and procedure titled, Policy / Procedure - Resident Assessment Instrument, dated 10/1/25 indicated, The Long-Term Care Facility Resident (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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Instrument 3.0 User's Manual Version 1.20.1 October 2025 will be the source of guidance for the RAI [Resident Assessment Instrument- instructions for completing the MDS] Process. A review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2025 was conducted. Chapter 5 of the RAI indicated, For the admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600) . Care Area Assessment [CAA] Completion Date [V0200B2] must be no later than 13 day after the Entry Date.Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements.Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date.

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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 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 interview and record review the facility failed to ensure one (Resident 3) of three residents who required total assistance with activities of daily living (ADL bathing or showering, dressing, getting in and out of bed or a chair, walking, toileting and eating) was free from injury when: 1.There was no documented evidence of fall preventive measures verbalized by facility staff, 2.The at risk for fall care plan was not person centered, 3.admission Record for Resident 3 had an inaccurate diagnosis listed. As a result of this deficient practice, Resident 3 got out of bed unassisted, fell and sustained a nasal fracture and was sent out to the hospital. Findings: On 6/2/26 at 9:30 A.M., an unannounced onsite visit at the facility was conducted related to a report regarding Resident 3's fall with injury. Resident 3 was readmitted to the facility on [DATE] according to the facility's admission Record. A review of Resident 3's hospital history and physical, dated 4/28/26, prior to 5/1/26 admission to the facility, indicated a diagnosis of right femoral neck (flat bone connecting the ball of the hip bone to the thigh bone) fracture from a mechanical fall and dementia. 1.An interview on 6/2/26 at 10:09 A.M. was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated she had been assigned to Resident 3 in unit 2 prior to the fall incident and in unit 1 after the fall. CNA 1 stated Resident 3 was not aware of using the call light, and it was Resident 3's spouse who pushed the call light for Resident 3. CNA 1 stated Resident 3 was antsy and tried to get up from bed without assistance. CNA1 resident was dependent on staff with her ADLs. CNA 1 stated she had found Resident 3 with one leg dangling at the edge of the bed. CNA 1 stated Resident 3 had a floor mat next to the bed. CNA 1 stated all residents were at risk for falls and she checked residents frequently every two hours and kept everything within reach. CNA 1 stated the frequent checks were not documented. An interview and joint record review on 6/2/26 at 10:30 A.M. with the Minimum Data Set Coordinator (MDSC-a Registered Nurse who completed the federally mandated [rule or requirement enforced by the government] clinical assessment tool [MDS- used to evaluate a resident's physical, psychological, and psychosocial [how the mind interacts with the social environment needs] was conducted. The MDSC reviewed the progress notes (PN) for Resident 3 in the Electronic Medical Record (EMR). MDSC stated the PN dated 5/5/26 at 4:42 P.M indicated at approximately 3:30 P.M., a report was received that Resident 3 was on the floor in prone position (face down) by the door with significant blood on the floor. The PN further indicated that Resident 3 had a skin tear on her nose and bleeding from that and inside of her nose, and a physician was notified with an order for Resident 3 to be transferred to the emergency room. The MDSC stated the PN dated 5/8/26 indicated Resident 3 returned to the facility with a diagnosis of post fall with nasal bone fracture. The MDSC stated fall assessments were completed for residents on admission and after a fall incident. The MDSC reviewed fall assessments for Resident 3. The fall assessment dated [DATE] indicated a score of 17, high risk for fall according to the MDSC. An interview on 6/2/26 at 10:45 A.M. was conducted with CNA 3. CNA 3 stated she took care of Resident 3. CNA 3 stated Resident 3 was confused and was at high risk for fall due to restlessness in bed. CNA 3 stated Resident 3 rolled side to side in bed and attempted to get up from bed. CNA 3 stated Resident 3's husband arrived in the morning and left before the end of shift at 3 P.M. CNA 3 stated all residents were at risk for falls. CNA 3 stated fall prevention measures included bed in lowest position, lock the bed, frequent checks and keeping residents occupied in activities. CNA 3 stated the frequent checks were not documented. 2.An interview on 6/3/26 at 5:07 P.M. with Licensed Nurse (LN) 4 was conducted. LN 4 stated on 5/5/26 at around 3:30 P.M. during rounds, she heard a sound from Resident 3's room, sounded like a cry. LN 4 stated she went to Resident 3's room and she saw Resident 3 face down on the floor, on the right side of the bed, near the door. LN 4 stated Resident 3 was active, moved around in bed with legs on the side of the bed attempting to get up. LN 4 stated for PM shift, she instructed the assigned CNA to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	get Resident 3 up in the wheelchair to go to activities, have dinner in the dining room then back to bed around 7 P.M. LN 4 stated this intervention and Resident 3's attempt to get up from bed were not documented in Resident 3's care plan. LN 4 stated residents who were high risk for falls had their beds in the lowest position, call light within reach, personal belongings within reach and frequent visual checks. LN 4 stated visual checks was every 15 minutes but was not documented. The care plans for Resident 3 were reviewed. The At risk for fall care plan dated 5/1/26, indicated At risk for falls r/t [related to] s/p [status post] fall with R [right] femoral neck fx [fracture].Interventions.Avoid rearranging furniture.Be sure the call light is within reach and encourage to use it to call for assistance as needed.Bed in lowest position.Ensure resident is wearing appropriate footwear when ambulating.Keep needed items, water, etc, in reach.Maintain a clear pathway, free of obstacles. The care plan did not indicate Resident 3's restlessness in bed, attempting to get up unassisted and staff's various answers on interventions such as frequent visual checks and taking resident to activities. In addition, Resident 3 could not use the call light due to Resident 3's cognition (brain's ability to think, learn, and make sense of the world) according to staff interview. 3. According to Resident 3's admission Record, Resident 3 was readmitted to the facility on [DATE] with diagnoses including fracture of left pubis (bones that form the lower and front part of each side of the hip bone), unspecified fall and dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) according to the facility's admission Record. A joint record review and interview on 6/11/26 at 10 A.M. with LN 5 was conducted. LN 5 reviewed Resident 3's hospital History and Physical (H&P) in the EMR. The H&P dated 4/28/26 indicated femoral neck fracture from a mechanical fall reaching for something and advanced dementia. A joint record review and interview on 6/11/26 at 10:20 A.M. was conducted with the MDSC. The MDSC reviewed Resident 3's admission Record for 5/1/26 and stated the diagnosis of left pubis fracture was inaccurate. The MDSC stated the resident was admitted to the facility on [DATE] with a diagnosis of right femoral neck fracture, not left pubis fracture. The MDSC stated the left pubis fracture diagnosis was from Resident 3's previous admission to the facility in March 2025, also due to a fall. The MDSC stated the admission Record should be accurate for staff knowledge of Resident 3's condition. An interview on 6/11/26 at 10:48 A.M. was conducted with the Assistant Director of Nursing (ADON). The ADON stated appropriate fall prevention interventions for residents were based on resident assessment. The ADON stated each resident was different and based on assessments, interventions were developed. The ADON stated a floor mat can be a trip hazard, but she had not observed Resident 3 trying to get up from bed. The ADON stated there were no Interdisciplinary (IDT-team members with various areas of expertise who work together toward the goals of their residents) meetings for residents with history of falls to discuss appropriate fall prevention measures. The ADON stated IDT meetings were held post fall only. A review of the facility's undated policy and procedure (P&P) titled, Fall Prevention was conducted. The P&P indicated, It is the policy of this facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury. The policy did not provide guidance to staff for residents with a history of falls and to determine appropriate interventions based on the score from a fall assessment.