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	09/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to replace a damaged low air loss mattress (LAL-mattress used to protect a residents' skin) for one of 27 sampled residents (168).This failure had the potential for Resident 168 to lose sleep during the night and put his skin integrity at risk.Findings:Review of admission Record for Resident 168 indicated he was admitted on [DATE] for diagnoses which included: Congested Heart Failure (a chronic condition where the heart muscle becomes weakened and cannot pump blood effectively), Myocardial Infarction (a condition where blood flow to the heart muscle is blocked, leading to damage or death of heart tissue), and muscle weakness.Review of Minimum Data Set (MDS-a standardized, comprehensive assessment for nursing homes) Section C-Cognitive Patterns indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition (thinking processes).Review of MDS Section GG, Functional Abilities- indicated Resident 168 needed supervision or touching assistance when rolling left to right, sitting to lying, lying to sitting on the side of the bed, and chair to bed transfer.Review of MDS Section M-Skin Conditions- indicated Resident 168 had no pressure ulcers (areas of damaged skin and tissue caused by sustained pressure) at the time of admission.Review of physician order dated 9/23/25 at 11:26 A.M., indicated Tx [treatment]: LOW AIR LOSS MATTRESS (LAL) FOR MAINTENANCE OF SKIN INTEGRITY, every shift.Review of Care Plan Report dated 9/6/2025 indicated Has actual skin impairment r/t [related to] Skin Assessment upon admission: -Non blanchable redness to coccyx [tailbone] and bilateral heels.TX: LN [Licensed Nurse] TO MONITOR PLACEMENT AND PROPER FUNCTIONING OF LAL MATTRESS TX: LAL MATTRESS SETTINGS ACCORDING TO RESIDENTS WEIGHT AND/OR COMFORT LEVEL.TX:LOW AIR LOSS MATTRESS (LAL) FOR MAINTENANCE OF SKIN INTEGRITY.On 9/23/2025 at11:46 A.M., an interview with Resident 168 and observation of room [ROOM NUMBER] B was conducted. Resident 168 was alert and oriented, sitting bedside in his wheelchair. Resident 168 looked sleepy. Resident 168 stated Yesterday, the staff took the pump off the [LAL] mattress, without removing mattress topper. I asked them to change it last night, but they stated they could not, and I had to sleep on the mattress topper all night without the pump, but the people who changed the beds came in this morning and changed the bed in 60 seconds. Why couldn't they have gotten me a new bed or put me somewhere else I could sleep? Resident 168's LAL was observed to be connected to a pump and appeared functional at the time of the interview.On 9/26/2025 at 9:08 A.M., an interview with the Director of Maintenance (DOM) was conducted. The DOM stated that if staff had problems with LAL mattress during the day shift, staff can call him for immediate problems. The DOM stated at night there is a janitor who stays until midnight. The DOM stated during the day the vendors will put newly ordered mattresses on the bed. The DOM stated if there is a problem with mattress during off-shift hours, the night shift staff should have changed the mattress for the resident. The DOM stated the importance of changing broken mattresses for residents as soon as possible is for resident comfort and protecting the resident's skin.On 9/26/2025 at 9:18 A.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1stated she was Resident 168's CNA on the morning of 9/24/25. CNA 1 stated Resident 168 complained about his mattress that morning, that it was uncomfortable and deflated. CNA 1 stated the LAL seemed (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
	555425	A. Building B. Wing	09/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	underinflated, thin, and uncomfortable looking. CNA 1 stated that Resident 168 complained of not getting a good night's sleep that night. CNA 1 stated the expectation was to report malfunctioning or uncomfortable beds to his nurses, and to try to get new mattress for Resident 168. CNA 1 stated the importance of getting Resident 168's bed repaired or replaced was to make him comfortable, so he could get a good night's sleep and protect his skin.On 9/26/2025 at 9:27 A.M., an interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated that the CNA 1 made her aware that Resident 168's mattress was malfunctioning, and he was not comfortable during the night shift. LN 2 stated she called maintenance immediately, and they came to change the mattress that morning. LN 2 stated that she was unaware that the mattress had been malfunctioning that night, and that Resident 168 was uncomfortable. LN 2 stated the expectation was that the night shift staff should have changed the mattress themselves or given the resident a comfortable alternative to sleep on. LN 2 stated the importance of fixing Resident 168's broken LAL, was to have a comfortable place to sleep and to protect his skin integrity.On 9/26/2025 at 9:40 A.M., an interview with Registered Nurse Supervisor (RNS) 3 for Unit 2 was conducted. RNS 3 stated if the LAL was having problems during the day, she would call maintenance immediately. RNS 3 stated that if she had problems with LAL during the night, she would ask her manager what to do, and in the meantime provide the resident with a comfortable alternative, a recliner or other type of chair. RNS 3 stated the expectation was to change a broken LAL as soon as possible, to accommodate resident's needs to sleep comfortably and protect their skin integrity. On 9/26/2025 at 10:10 A.M., an interview was conducted with the Interim Director of Nursing, (IDON). The IDON stated the expectation for a broken LAL mattress would be to change mattress as soon as possible (ASAP) for pressure relief and comfort. The IDON stated the importance of fixing a broken LAL ASAP, was to accommodate the resident so he could sleep comfortably and prevent pressure ulcers.Review of facility policy titled Physical Environment, dated 3/2025, indicated that .the facility must provide a safe, functional, sanitary, and comfortable environment for residents.Resident rooms must be designed and equipped for adequate nursing care, comfort .Review of facility policy titled Residents Rights, Accommodation of Needs dated 4/2025, indicated It is the policy of this facility to provide accommodation of reasonable needs to residents while in the facility.Staff will Review resident's preference and accommodate their needs.If the request of need cannot be met another intervention will be in place to ensure resident is comfortable.Examples of Accommodation of Needs.Comfortable bed/mattress.

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	09/26/2025

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 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** Based on observations, interviews, and record review the facility failed to repair two of 27 residents' (10 & 168) rooms with damaged ceiling and wall .This failure had the potential to affect Resident 10 & 168's overall mood and well-being.Findings:Review of admission Record for Resident 10 indicated he was admitted on [DATE] for diagnoses which included: Pneumonitis (inflammation of the lungs) , Parkinson's Disease (chronic disorder that affects movement, balance, and other bodily functions), and Major Depressive Disorder (mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life). Review of Minimum Data Set (MDS-a standardized, comprehensive assessment for nursing homes) Section C-Cognitive Patterns dated 8/22/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition (thinking processes).Review of admission Record for Resident 168 indicated he was admitted on [DATE] for diagnoses which included: Congested Heart Failure (a chronic condition where the heart muscle becomes weakened and cannot pump blood effectively), Myocardial Infarction (a condition where blood flow to the heart muscle is blocked, leading to damage or death of heart tissue), and muscle weakness.Review of MDS Section C-Cognitive Patterns, dated 4/10/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.On 9/23/2025 at 11:03 A.M., an interview with Resident 10 and observation of room [ROOM NUMBER] B was conducted. Resident 10 stated that A man fell through ceiling headfirst while repairing the roof. I would like them to repair and paint the roof. It's not homelike and it's been like that for a week and a half. The ceiling was observed to have a two foot by two-foot area that was repaired with plaster, but not painted, a person's handprint was observed next to the area of repair. Resident 10 stated, I have to look at that all day.On 9/23/2025 at 11:46 A.M. an interview with Resident 168 and observation of room [ROOM NUMBER] B was conducted. 220 B's wall by the right side of Resident 168's bed was observed to have a one by two-foot area with many gouges in the paint and drywall from collisions with the bed. Resident 168 stated that the wall has been like that for a while, and he didn't feel it was homelike and would like it repaired. On 9/25/2025 at 3:02 P.M., a follow up observation of 215 B's ceiling and 220 B's wall was conducted. room [ROOM NUMBER] B's ceiling damage was not repaired or painted. ˆOn 9/25/2025 at 3:19 P.M., a review of Maintenance Log for Nursing Unit 2 was conducted for the month of September. No entries for the damage to 215 B's ceiling or the damage to 220 B's wall were found. On 9/25/2025 3:21 P.M., an interview with Certified Nursing Assistant (CNA) 4 and observation of 215 B's ceiling was conducted. CNA 4 stated he thought the ceiling damage might be related to water damage on the ceiling. CNA 4 stated if he was there for initial damage, he would put in work order in the computer, call his supervisor, call maintenance, and document the needed repair in the maintenance log. CNA 4 stated the importance of reporting room damage was to maintain a homelike environment for the residents. On 9/26/2025 at 9:08 A.M., an interview with Director of Maintenance (DOM) and observation of pictures of room [ROOM NUMBER] B's ceiling and 220 B's wall was conducted. The DOM stated that the damage on wall and ceiling should have been repaired in a timely manner and were not homelike.On 9/26/2025 at 10:10 A.M. an interview with the Interim Director of Nursing (IDON) and observation of pictures of room [ROOM NUMBER] B's ceiling and 220 B's wall was conducted. The IDON stated that the damage to the wall and ceiling should have been repaired in a timely manner and were not homelike and could affect the residents' mood.Review of the facility policy titled Physical Environment, dated 3/2025, indicated that .the facility must provide a safe, functional, sanitary, and comfortable environment for residents.Resident rooms must be designed and equipped for adequate nursing care, comfort.

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	09/26/2025

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 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** The facility failed to accurately complete the Minimum Data Set (MDS-a required resident assessment in a nursing facility) for one of 27 residents reviewed for MDS accuracy. (Resident 127) This failure had the potential for Resident 127 to receive inadequate care.According to the current admission Record, Resident 127 was admitted to the facility on [DATE], with a primary diagnosis of Paranoid Schizophrenia (a serious mental health condition that affects how people think, feel and behave. It may include hallucinations - seeing or hearing things that aren't there or delusions - a strong fixed belief about things that are untrue).On 9/23/25 at 8:46 A.M. Resident 127 was observed walking in the hallway, and using his four wheel walker. In an interview, he was pleasant, denied pain and spoke clearly. He knew his name, the time and place of where he was, and his situation in the facility. Resident 127 ended the interview by asking where the nearest restroom was, and after stating he knew his room number and where it was, was directed to the restroom in his room. On 9/24/25 at 9:10 A.M. Resident 127 was interviewed in the TV room. Resident 127 denies hearing any voices currently, and stated he used to hear family members yelling at him.On 9/24/25 at 1:20 P.M. Resident 127s health records were reviewed (physician notes, geriatric psychiatry notes, nursing progress notes, MDS and the current physician orders).All quarterly and annual MDS assessments on file indicated Resident 127 had paranoid schizophrenia as an active diagnosis. Resident 127's physician orders included olanzapine (an antipsychotic medication used to control symptoms of psychosis), dated 3/1/2024, 10mg (milligram) tablet daily at bedtime for paranoid schizophrenia; olanzapine, dated 4/14/25, 5 mg tablet daily in the morning for schizophrenia; and olanzapine, dated 5/2/23, 2.5mg every six hours as needed for acute psychosis-hearing voices.The most recent geriatric psychiatry note, dated 8/11/2025, from (the physician), reflected that Resident 127s past history of major NCD (neurocognitive disorder-a decline is memory, thinking, and reasoning); psychosis not otherwise specified (a collection of symptoms that can include hallucinations and agitation, can be caused by substance abuse as well as mental illness). No diagnosis of schizophrenia is noted, nor of paranoid schizophrenia. All the geriatric psychiatry notes were reviewed, dating back to 4/1/24 with no diagnosis listed of paranoid schizophrenia.The discharge note from the San Diego VA Medical Center, dated 1/26/23 reflected diagnosis of: unspecified psychosis, [rule out] substance induced vs neurocognitive disorder. The discharge note reflected Resident 127's past medical history for multiple hospitalizations, attributed to psychosis caused by either: not taking medication, or methamphetamine use. The hospital records did not indicate a diagnosis of paranoid schizophrenia.On 9/25/25 at 2:05 PM a simultaneous record review and interview was conducted with LN 32. LN 32 stated the admitting diagnosis were discussed by the IDT (interdisciplinary team- team members with various areas of expertise who work together toward the goals of their residents). After the discussion the health diagnosis are usually entered by the MDS nurse into the resident's record. The MDS nurse that entered Resident 127s diagnosis of paranoid schizophrenia had since retired. LN 32 suggested the physician sometimes adds a diagnosis after seeing and assessing a resident over multiple visits. Record review with LN 32 of the psychiatry notes reflected only psychosis, as does the admission discharge report from VAMC SD. On 9/26/26 at 2:50 PM, the Interim Director of Nursing (IDON) was interviewed, and stated no documentation was located for resident 127's diagnosis of paranoid schizophrenia. The IDON stated the expectation was that assessments and diagnoses were entered correctly by the MDS nurse and after review by the IDT team for accuracy.

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	09/26/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to appropriately care for a resident's suprapubic catheter (SPC-a surgically inserted tube into the bladder through an incision below the belly button) for one of three residents reviewed for catheter care. (Resident 91) This deficient practice had potential for urinary tract infections (bladder infection) and dislodgement of the SPC.Findings:Resident 91 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia (BPH- enlarged prostate gland which can press on the tube that carries urine from the bladder to the outside of the body) according to the facility's admission Record. During an observation on 9/24/25 at 7:50 A.M., Resident 91 was lying in bed with a small bag next to Resident 91's right side on the bed. Resident 91 stated it was a bag that drained his urine. A review of Resident 91's physician's orders was conducted. The physician's orders indicated to change SPC as needed when plugged or dislodged once a day. During a review of Resident 91's care plan, the care plan indicated, SUPRA PUBIC FR 14 / 10 CC [catheter's size] BALLOON TO GRAVITY DRAINAGE. DX: [diagnosis] URINARY OBSTRUCTION [blockage of urine].Position catheter bag and tubing below the level of the bladder and away from entrance room door. A review of the facility's skills checklist titled, Foley/Suprapubic Catheter Care was conducted. The skills checklist indicated, Keep tubing below level of bladder. An interview on 9/25/25 at 10:13 A.M. was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 91's SPC bag should not be on top of Resident 91's bed. LN 11 stated the SPC bag should be clipped on the side of the bed and hanging to drain the urine. An interview on 9/26/25 at 2:45 P.M. was conducted with the Interim Director of Nursing (IDON). The IDON stated Resident 91's SPC bag should be hanging down at the edge of the bed to prevent urine from backing up to bladder. The facility did not provide a policy and procedure regarding care of a resident with SPC.

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	09/26/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's (MD) orders for tube feeding (TF- uses a flexible tube to deliver liquid food, water, and medicine directly into the stomach) for one of six Residents (Resident 107) reviewed with enteral (refers to any method of feeding that uses the stomach to deliver nutrition and calories) nutrition.As a result, Resident 107 did not receive the full enteral feeding as ordered by the MD with a potential risk for malnutrition.Findings:A review of Resident 107's admission Record indicated Resident 107 was admitted to the facility on [DATE] with diagnoses which included history of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing).A record review of Resident 107's MDS (Minimum data set: nursing facility assessment tool) dated 6/20/25 indicated that Resident 107 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On 9/23/2025 at 8:44 A.M., an observation and attempted interview was conducted with Resident 107, in Resident 107's room. Resident 107 was lying in bed wearing a facility gown and was unable to carry on conversation with random mumbling sounds and smiling without teeth. Resident 107's TF was turned off. On 9/24/2025 at 9:05 AM an observation was conducted with Resident 107, in Resident 107's room. Resident 107's was lying in bed with his TF turned on and running at 65 ml (milliliters)/ (per) hr (hour).On 9/24/2025 at 9:17 A.M., a record review was conducted on Resident 107's clinical chart. Resident 107's TF MD orders included: .two times a day for Dysphagia [difficulty swallowing] CONTINUOUS GT [Gastrointestinal tube-an enteral nutrition route through the stomach] FEEDING OF: [Name of enteral feeding brand] 1.5 AT 65 ML/HR X 20 HR TO PROVIDE 1300 CC [ml]/1950 CALORIES IN 24 HOURS VIA ENTERAL FEEDING PUMP. TURN PUMP ON AT 2 PM AND PUMP OFF AT 10 AM OR UNTIL DESIRED VOLUME IS REACHED.On 9/24/2025 at 9:23 A.M., an observation and interview was conducted with Licensed Nurse (LN) 21, in Resident 107's room. Resident 107 was lying in bed with the TF turned on. LN 21 stated Resident 107's TF total volume fed total (24 H) infused was 1119 ml.On 9/25/2025 at 8:41 A.M., an observation was conducted of Resident 107, at the nursing station (unit 1). Resident 107 was sitting on his wheelchair holding a plush carrot on his L (left) hand. Resident 107's TF was running at 65 ml/hr with a total feed of 1142 ml (24 hour total).On 9/25/2025 at 2:09 P.M., an observation, interview and record review was conducted with LN 21, in Resident 107's room. LN 21 stated Resident 107 should be receiving 1300ml of TF per day. LN 21 demonstrated how to read the total TF delivered with 72 hours with a total of 3665 ml delivered within 72 hours (9/23/25-9/25/25). LN 21 stated 1300ml per day within 72 hours (9/23/25-9/25/25) would total 3,900 ml. LN 21 stated on 9/23/25 Resident 107's TF was not administered timely therefore Resident 107 was short (235 ml) of TF nutrition delivered. LN 21 stated that Resident 107's TF should have been turned on per MD order and MD notified regarding a late administration of Resident 107's TF and make adjustments as necessary per MD instructions and/or recommendations. LN 21 stated it's important to follow MD orders for Resident 107 because Resident 107 relies dependently with TF to be adequate with Resident 107's nutritional needs. LN 21 stated it was important that Resident 107's nutritional intake to be administered as ordered to prevent weakness, confusion, weight loss and further decline. On 9/26/2025 at 1:29 P.M., a record review was conducted on Resident 107's weights, that included: - 3/2/2025, the resident weighed 183 lbs (pounds). On 9/1/2025, the resident weighed 176 lbs which was a -3.83% Loss (6 months).- 7/06/2025, the resident weighed 181 lbs. On 09/01/2025, the resident weighed 176 lbs which was a -2.76% Loss (3 months).- 8/4/2025, the resident weighed 179 lbs. On 09/01/2025, the resident weighed 176 lbs which was a -1.68% Loss (1 month). On 9/26/2025 at 12:47 P.M., an interview with the Interim Director of Nursing (IDON) was conducted. The IDON stated her expectations for Resident (continued on next page)

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	09/26/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	107 was for LNs to follow MD orders if running late, to clarify TF administration totals and notify MD to make adjustments as needed so that Resident 107 received the adequate nutritional TF as ordered. The IDON stated Resident 107 relies on TF and was at risk for weight loss and malnutrition from not getting the adequate caloric recommendations. Per the IDON the facility did not have a policy and procedure specific to Tube Feeding and policy and procedure that addressed TF would be titled, Physician Order.A review of the facility's policy and procedure Physician Order revised 5/2025, did not indicate TF instructions regarding concerns of administration and when to contact MD.

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	09/26/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of one resident reviewed for intravenous (IV- medications administered directly into a vein) antibiotic therapy was provided care according to professional standards when: 1. Resident 129's IV antibiotic was administered three hours late. 2. Resident 129's peripherally inserted central catheter (PICC- a peripherally inserted central catheter that provides access to the large vein carrying blood to the heart to administer medication for long-term use) was not measured according to physician's orders. This failure could potentially delay healing, increase the risk of infection and delay the identification of catheter-related complications for Resident 129.Findings: 1. Resident 129 was admitted to the facility on [DATE] with diagnoses including acute osteomyelitis (an infection of the bone), right ankle and foot according to the facility's admission Record. During an observation and interview on 9/23/25 at 9:01 A.M., Resident 129 was sitting up in bed with an IV line on the right upper arm. Resident 129 stated he received IV antibiotics because of a bad infection on his right foot. Resident 129 stated last Saturday on 9/20/25, the night nurse did not administer the 6 AM dose. Resident 129 stated the morning shift nurse administered the medication at 10 AM which was very late. The Minimum Data Set (MDS- a clinical assessment tool) dated 9/10/25 for Resident 129 listed a cognitive (thinking, reasoning, or remembering) score of 15, indicating cognition was intact. A review of Resident 129's physician's orders titled, Order Summary Report was conducted. The physician's orders indicated, Cefepime HCL [an antibiotic] Intravenous Solution.2 GM [gram- a unit of measurement] .every 8 hours for.OSTEOMYELITIS until 10/14/25. An interview and concurrent record review on 9/25/25 at 10:40 A.M. was conducted with Licensed Nurse (LN) 13. LN 13 stated she was assigned to administer Resident 129's IV antibiotic. LN 13 reviewed the IV medication administration record (MAR) in the electronic medical record (EMR). LN 13 showed her two initials for 6 AM and 12 PM dose of Cefepime on 9/21/25. LN 13 stated Resident 129 told her he did not receive the 6 A.M. dose of the IV antibiotic. LN 13 stated on 9/21/25, she administered Resident 129's 6 A.M. dose at 2 P.M. which was considered a late dose. LN 13 stated medications that were missed or late should be documented and the physician should be notified. LN 13 stated there was no documentation regarding the late administration of the IV antibiotic and the physician was not notified. LN 13 further stated if an IV medication was missed, the resident may have delayed healing and the infection might worsen. The facility did not provide a policy and procedure regarding PICC line care. 2. During an interview and concurrent record review on 9/25/25 at 10:40 A.M. with LN 13, LN 13 stated Resident 129 had a PICC line. LN 13 reviewed the physician's orders for Resident 129 in the EMR. LN 13 stated there was a physician's order to MEASURE EXTERNAL CATHETER LENGTH UPON ADMISSION, AND WITH EACH DRESSING CHANGE every day shift every Sun [Sunday]. LN 13 stated she changed Resident 129's dressing on the PICC line but did not measure the length of the catheter as ordered. LN 13 stated there was also no measurement documented on admission. LN 13 further stated it was important to measure the catheter length to ensure that the catheter was intact and prevent pulmonary embolism (when a blood clot travels to the lungs blocking blood flow). An interview on 9/26/25 at 2:45 P.M. was conducted with the Interim Director of Nursing (IDON). The IDON stated she expected the nursing staff to follow physician's orders for medication administration and PICC line care to prevent complications. A review of the facility's undated policy and procedure (P&P) titled, Policy / Procedure - Nursing Clinical.Subject: Physician Orders was conducted. The P&P indicated, It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs.PICC line care and maintenance as ordered.

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	09/26/2025

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two residents (Resident 7) reviewed for Trauma Informed Care (TIC - an intervention and organization approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health), received care and services in accordance with professional standards when Resident 7's PTSD (Post-traumatic stress disorder - a disorder that may occur in people who have experienced or witnessed a traumatic event) was not identified and addressed by the healthcare providers. This failure resulted in the facility's inability to identify Resident 7's possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to past traumatic experiences).Findings: Resident 7 was admitted to the facility on [DATE] with diagnoses including PTSD according to the facility's admission Record. An interview on 9/24/25 at 2:21 P.M. was conducted with Resident 7. Resident 7 stated he was a veteran with PTSD due to an explosion which burned his body, and he was thrown in the ocean. Resident 7 stated smell and at times talking about the experiences were his triggers. Resident 7 stated he kept the light and television on because of nightmares. A review of Resident 7's care plan for PTSD conducted. The care plan indicated, At Risk for Re-traumatization r/t [related to] history of trauma Post-Traumatic Stress Disorder [PTSD] due to his time in the military.Resident can be triggered by loud noises.Resident triggers are nightmares, and at times yelling, and loud noises D/T [due to] HX [history] OF PTSD. During an interview on 9/25/25 at 8:52 A.M. with Certified Nurse Assistant (CNA) 11, CNA 11 stated she was unsure what PTSD meant. CNA 11 further stated she was not sure which residents had the diagnosis of PTSD. During an interview on 9/25/25 at 9:15 A.M. with CNA 12, CNA 12 stated PTSD meant that a resident had something stressful from past experiences, especially if the resident was in the military. CNA 12 stated he was not aware of any residents with PTSD. An interview on 9/25/25 at 10:20 A.M. was conducted with Licensed Nurse (LN) 11. LN 11 stated something could trigger past trauma for residents with PTSD. LN 11 stated it was important to know the triggers because they were part of the resident's plan of care. An interview on 9/26/25 at 9:36 A.M. was conducted with the Interim Director of Nursing (IDON). The IDON stated all staff should know which residents had the diagnosis of PTSD. The IDON further stated it was important for staff to know to properly treat and manage the resident's behavior. During a review of the facility's undated policy and procedure (P&P) titled, PTSD Disorder Management, the P&P indicated, It is the policy of this facility to identify a resident with history of trauma.All staff will maintain a safe environment and avoid unnecessary actions that may cause re-traumatization.

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	09/26/2025

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 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** Based on observation, interview, and record review, the facility failed to ensure that residents receiving antipsychotic (medication for mood, behavior, or thinking) medications had an appropriate diagnosis and monitored for side effects (SE) as recommended by the pharmacist for two of five residents (Resident 127 and Resident 16) sampled .These deficient practices placed both residents (Resident 127 and Resident 16) at risk for inappropriate treatment with psychotropic medication and undetected adverse (serious life-threatening SE) drug reactions, which could lead to dizziness, fainting, falls, or other serious complications. 1.According to the current admission Record, Resident 127 was admitted to the facility on [DATE], with a primary diagnosis of Paranoid Schizophrenia (a serious mental health condition that affects how people think, feel and behave. It may include hallucinations - seeing or hearing things that aren't there or delusions - a strong fixed belief about things that are untrue). On 9/24/25 at 1:20 P.M. Resident 127s health records were reviewed (physician notes, geriatric psychiatry notes, Minimum Data Sheet (MDS [a required assessment of a resident]) the current physician orders, nursing progress notes, and the medication administration orders for the months of August and September 2025. The quarterly and annual MDS assessments on file all documented resident 127 had paranoid schizophrenia as an active diagnosis. The most recent geriatric psychiatry note, dated 8/11/2025, indicated Resident 127s had a past history of major NCD (neurocognitive disorder-a decline is memory, thinking, and reasoning); psychosis not otherwise specified (a collection of symptoms that can include hallucinations and agitation, can be caused by substance abuse as well as mental illness). All the geriatric psychiatry notes were reviewed, dating back to 4/1/24 with no listed diagnosis of paranoid schizophrenia. Resident 127's discharge note from the San Diego VA Medical Center, dated 1/26/23 reflected a diagnosis of: psychosis, [rule out] substance induced vs neurocognitive disorder. The discharge note indicated Resident 127's past medical history was positive for multiple hospitalizations, which were attributed to psychosis caused by either: not taking medication, or methamphetamine use. There was no diagnosis of paranoid schizophrenia in the hospital record. Resident 127's medical record included three orders for olanzapine, an antipsychotic medication (a medication affecting mood, behavior, or thinking) The first order, dated 5/2/23, was for Olanzapine take 2.5 mg (milligram) every 6 hours as needed (PRN) for psychosis (hearing voices). The second order, dated 3/1/24, was for olanzapine, take10 mg at bedtime daily for schizophrenia. The third order, dated 4/14/25, was for Olanzapine 5 mg tablet once daily in the morning for paranoid schizophrenia. The side effects for Olanzapine included: restlessness and tremor, lower blood pressure when standing (orthostatic hypotension). The medication olanzapine is FDA approved for schizophrenia and bipolar (mental illness characterized by extreme mood swings) disorder. Additional physician orders are for nursing staff to monitor and record episodes of agitation, constipation, dry mouth, tremors, orthostatic hypotension (a drop in blood pressure when standing up -can cause dizziness, lightheadedness) and akathisia (inability to sit still). (continued on next page)

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	09/26/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The electronic medication administration records for August 2025 and September 2025 were also reviewed. The nurses began checking + positive, for akathisia / inability to sit still for Resident 127 on the night shift of August 23, and then every shift after, up to and including 9/25/25, the last date documented. The nursing progress notes for Resident 127 from 8/24/25 to 9/25/25 were reviewed. There was no nursing progress note located to indicate Resident 127's physician or psychiatrist was informed of the new symptom of akathisia. On 9/23/25 at 8:46 A.M. Resident 127 was observed walking in the hallway, and used his four wheel walker. On 9/24/25 at 9:10 A.M., Resident 127 was interviewed in the TV room, and observed to be in the same clothing as on 9/23/25. Resident 127 was observed frequently moving from sitting to standing and did not remain sitting for more than a minute or two. Resident 127 stated he has to move and can't seem to be still. Resident 127 did not fidget when seated, but both hands were trembling, the right hand more than the left hand. Resident127 also stated he had not always felt the need to move so much. Resident 127 said the feeling started in about the last 3 months , and he had not reported this symptom to anyone. On 9/25/25 at 10:05 AM an interview and joint record review was conducted with Licensed Nurse (LN) 23 about Resident 127's positive record of akathisia movements each shift since mid-August. LN 23 stated the new symptom was brought up in a recent weekly review and discussed with the psychiatrist who discontinued Resident 127s antidepressant. LN 23 reviewed Resident 127's physician orders and acknowledged that akathisia was listed as a side effect. As of 9/26/26 at 3:30 P.M., no documentation was located to confirm the physician or the psychiatrist had been notified of Resident 127s akathisia. On 9/26/26 at 2:50 PM, the Interim Director of Nursing (IDON) was interviewed, and stated no documentation was located for resident 127's diagnosis of paranoid schizophrenia. The IDON stated the expectation was that assessments and diagnoses were entered correctly by the MDS nurse, after review by the IDT team for accuracy. The IDON also stated it was important to have the correct indication or diagnosis for each medication prescribed. The IDON also acknowledged no documentation was located that the physician was notified of Resident 127's possible side effect of akathisia / restlessness due to the antipsychotic medication, and the expectation was the physician would be notified. A new plan may be started to decrease or eliminate the side effects. Findings: 2. A review of Resident 16's admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses which included history of Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of Resident 16's MDS (Minimum data set: nursing facility assessment tool) dated 8/7/25 indicated that Resident 16 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. (continued on next page)

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	09/26/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/2025 at 8:47 A.M., a record review was conducted on Resident 16's Medication Record Reconciliation (MRR), Medication Administration Record (MAR) and physicians orders, as indicated, - MRR indicated: Resident 16's MRR for July 31, 2025 indicated, .This resident [Resident 16] is receiving Trazodone [serotonin antagonist and reuptake inhibitors [[NAME]]-increases the amount of serotonin available in the brain used for depression]/Serotonin Reuptake Blocker [SSRI- increases the levels of the neurotransmitter [chemical messenger] serotonin in the brain, which helps to regulate mood], both for depression. Please note, that coadministration of Trazodone and Serotonin Reuptake Blockers [Sertaraline] may lead to the development of serotonin syndrome. Recommendation In order to prevent an interaction between Trazodone and Serotonin Reuptake Blockers [Sertaraline], or where interaction is suspected, stop one or both drugs. Serotonin syndrome symptoms include he [sic] following: Agitation, shakiness, diaphoresis, hyperreflexia [overactive reflex response], and resting tremors, difficulty concentrating, and intermittent myoclonus [uncontrollable muscle jerk, twitch, or spasm] of extremities) .Physician/Prescriber response box x other with noted will obs [observe]. Signed by MD on 8/4/25. - MAR indicated no serotonin syndrome symptoms were being observed and/or monitored for the month of July 2025 thru September 2025. - Physicians orders indicated: .traZODone HCl Oral Tablet 50 MG [milligram] (Trazodone HCl) Give 1 tablet by mouth at bedtime for Depression. .Sertraline HCl Oral Tablet (Sertraline HCl)Give 75 mg by mouth one time a day for DEPRESSION. On 9/26/2025 at 9:36 A.M., an observation was conducted on Resident 16, outside of Unit 1's outdoor patio. Resident 16 was sitting on his wheelchair, mumbling to self and was unable to carry on a conversation displaying hand tremors, jerking legs and spontaneously wanting to stand up out of wheelchair. On 9/26/2025 at 9:38 A.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 22, next to Resident 16. CNA 22 stated that Resident 16 likes to get up by himself but was a fall risk due to past fall incidents. CNA 22 further stated that the tremors on Resident 16 was normal for him. Resident 16 jerked his legs again started to push self towards the table in front of him and was making grunting agitated sounds. CNA 22 stated Resident 16 did get agitated as demonstrated with pushing self towards the table with grunting agitated sounds. On 9/26/2025 at 9:41 A.M., an observation and interview was conducted with CNA 23, next to Resident 16. CNA 23 stated Resident 16 is a fall risk (while spontaneously jerking legs and trying to stand up again in wheelchair) and here and there he gets agitated. On 9/26/2025 at 9:44 A.M., an observation and interview was conducted with Licensed Nurse (LN) 22, outside of Unit 1's outdoor patio. LN 22 stated Resident 16's tremors are not new. LN 22 stated Resident 16 was on medications for depression (Trazodone and Sertraline). LN 22 stated both medications increased or blocked Serotonin levels in the brain to treat depression and can contribute to serotonin syndrome if using both medications. LN 22 stated serotonin syndrome symptoms (continued on next page)

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	09/26/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included confusion, change of level of consciousness (LOC), agitation, restlessness, tremors, and muscle twitching. LN 22 stated these symptoms could contribute to accidents like falls if not monitored. LN 22 stated that Resident 16 was not being monitored for serotonin syndrome. LN 22 stated she was unable to find interventions in Resident 16's care plan that monitored serotonin syndrome. LN 22 stated it was important to monitor serotonin syndrome if the pharmacist had recommended for safety. On 9/26/2025 at 10:01 A.M., an interview and record review was conducted with LN 23, in the nursing station (Unit 1). LN 23 stated he was also the Minimum Data Set Nurse (MDSN) and was responsible for checking the monthly MRR for his unit. LN 23 stated he checked Resident 16's MRR on July 31, 2025 and stated the MD signed .will obs [observe]. LN 23 stated the MD was not at the facility on a daily basis and would come on a weekly basis. LN 23 stated Resident 16's clinical chart did not have observations data to support if serotonin syndrome was being monitored by the MD or the LNs. LN 23 stated he did not clarify with the MD as to how he wanted the LNs to monitor to gather data that supported serotonin syndrome was being observed nor did he find any MD notes to support the observation of serotonin syndrome. LN 23 stated it was important to monitor for serotonin syndrome as per the MRR recommendations for medication treatment efficiency, report side effects and address medication safety concerns with falls. LN 23 stated this could contribute to Resident 16's safety due to potential increase of falls from the concurrent anti-depressant/psychotropic medication use. On 9/26/2025 at 12:57 P.M., an interview was conducted with the Interim Director of Nursing (IDON). The IDON stated her expectations was for the LNs to clarify with the MD regarding what specific medications should be monitored and/or serotonin syndrome to be monitored exclusively. The IDON stated the drug-to-drug interactions should be discussed with the interdisciplinary (IDT) team members to include the MDS and the LN unit managers during their psychotropic meetings. The IDON stated this was a safety issue for Resident 16 because resident is taking other psychotropic medications and can interact which can contribute to high risk for falls. The Facility was unable to provide a policy and procedure for Psychotropic Medication use and/or monitoring.

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	09/26/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews the facility failed to clean up trash around the kitchen dumpsters.This failure had the potential to cause rodent and other pest infestations, which in turn could affect infection control.Findings:On 9/24/2025 at 9:08 A.M., a concurrent observation of the trash dumpsters and interview with the Dietary Manager (DM) was conducted. Three facility dumpsters were observed to be locked behind steel fencing. A pinkish-orange substance appearing to be food waste and food wrappers were observed in a two foot by two-foot area between two dumpsters. The DM stated that the expectation is that the area around the dumpsters should be clean with no food waste or debris between dumpsters. The DM stated that this could attract rodents and other pests. On 9/24/25 at 12:45 P.M., a concurrent interview with the Director of Maintenance-(DOM) and observation of pictures of dumpster area was conducted. The DOM stated after a dumpster is emptied, the maintenance workers move the dumpsters, sweep the area, and power wash the area. The DOM stated the expectation is there shouldn't be any trash around dumpsters. The DOM stated the importance was to prevent infestations with rodents or other pests. 09/26/2025 10:10 A.M., a concurrent interview with the Interim Director of Nursing (IDON) and observation of pictures of dumpster area was conducted. The IDON stated the expectation all environments should be sanitized and clean. The IDON stated the importance was to prevent infestations from rodents and other pests and for infection control.Review of the facility policy titled, Physical Environment, dated 3/2025, indicated .the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and public.Trash/dumpster receptacles must be clean and tidy by.kitchen area.