STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555928	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Skilled Nursing Facility	9825 Glen Center Drive San Diego, CA 92131

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure related to notification of the physician when one of three residents (Resident 1) who had a foley catheter (a thin flexible tube inserted through the urethra(the duct by which urine is conveyed out of the body) into the bladder to drain and collect urine) had episodes of low urine output on different shifts. This failure had the potential to affect Resident 1's health condition. Findings.A review of the facility's admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included Nondisplaced Fracture of the Sacrum (a break in the base of the spine) and Neuromuscular Dysfunction of the Bladder (issues with bladder control and function). On 11/24/25 at 11:45 A.M., an interview and record review with Licensed Nurse (LN)1 was conducted. LN 1 stated Resident 1 had a foley catheter for Neurogenic Bladder (condition in which a person lacks bladder control). LN1 stated Resident 1's intake and output should be recorded every shift to ensure bladder function. LN 1 also stated the physician should be notified if Resident 1 was not eating or drinking enough. LN 1 stated there was an MD order on admission on [DATE] to discontinue the foley catheter, but FM 1 requested to have the foley catheter removed the next day on 9/15/25. On 11/24/25 at 1:58 P.M., an interview with Family Member (FM)1 was conducted. FM 1 stated Resident 1 called her and complained of pain and requested for a suppository. FM 1 stated she knew something was wrong with Resident 1. FM 1 stated she visited Resident 1 on 9/15/25, and noticed Resident 1 did not have a foley catheter. FM 1 stated she requested the licensed nurses for the resident to have a foley catheter inserted due to Resident 1's history of bladder problem. FM1 stated the facility did not document Resident 1's voiding and did not perform a bladder scan (a non-invasive procedure that measures the volume of urine in the bladder) in the facility. FM 1 stated the licensed nurse called the MD and got an order to place the foley catheter back on 9/15/25 when FM 1 got the call from Resident 1. A review of Resident 1's Order Summary Report dated 9/14/25 indicated, foley catheter (Fr #18) to bedside drainage bag for (Urinary Retention). Monitor urine output while on foley catheter every shift. A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/19/25, indicated a BIMS (brief interview for mental status) score of 15 which meant Resident 1's cognition (thought process) was intact. A record review of Resident 1's Medication Administration Record (MAR), dated September 2025, indicated the following output:A.M. shift: September 15 - no output was recorded September 16 - 60 milliliters (ml- unit of volume) September 17 -250 ml September 18 - 600 ml September 19 -200 ml September 20 - 200 ml September 21- 550 ml September 22 -375 ml September 23 - marked NA (not applicable) September 24 - mark with an x September 25 - 100 ml P. M. shift: September 15- no output was recorded. September 16 - 350 ml September 17- 800 ml September 18- 400 ml September 19 - 400 ml September 20 - 300 ml September 21 - 750 ml September 22 -750 ml September 23 - 1150 ml September 24 -550 ml Night shift : September 15- no output was recorded. September 16- 400 ml September 17 - 450 ml September 18 - 400 ml September 19 - 350 ml September 20 - 200 ml September 21 - 40 ml September 22 -150 ml September 23 - 200 ml September 24 - 100 ml On 11/25/25 at 4:53 P.M., an interview with Resident 1's physician (Medical Doctor) was conducted. The MD stated it was important for him to be notified of Resident 1's intake and output and documented, for him to check Resident 1's renal function and evaluate Resident 1's whole clinical picture. The MD stated an output with low numbers or less than 250 ml required his notification. The MD stated it was important to notify him about Resident 1's intake and output even without a written order. The MD stated, he expected the nurses to update him of any changes of all his residents' condition including Resident 1. On 12/1/25 at 8:55 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated MD notification was always important for changes in condition and that includes placing parameters when to notify resident's physician when needed on the clinical record. A review of the facility's policy titled, change of condition guidelines dated 4/9/2025 indicated, our facility shall promptly notify the resident, his or her attending physician .1e. a need to alter the resident's medical treatment significantly. 2b impacts more than one area of the resident's health status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the written care plan related to documenting intake and output for one of three residents (Resident 1) who had a foley catheter and passing low amount of urine. This failure had the potential to cause serious complications and could harm Resident 1's health. Findings.A review of the facility's admission Record indicated, Resident 1 was admitted on [DATE] with diagnosed which included Nondisplaced Fracture of the Sacrum (a break in the base of the spine) and Neuromuscular Dysfunction of the Bladder(issues with bladder control and function). On 11/24/25 at 11:45 A.M, an interview and record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated a care plan for Resident 1's foley catheter use was in place. LN1 stated during the Certified Nursing Assistants (CNA) shift, the CNA emptied Resident 1's urinary bag, recorded the output, and inform the charge nurses of the total urine output at the end of their shift. A review of Resident 1's care plan, initiated on 9/15/25 titled, foley catheter was conducted. One of the care plan interventions indicated, Observe and document intake and output as per the facility policy. On 11/24/25 at 4:20 P.M., an interview with CNA 1 was conducted. CNA 1 stated after Resident 1's urinary bag was emptied, the urine output was being recorded and would inform the charge nurse of the total urine output at the end of their shift. On 11/25/25 at 1:04 P.M., an interview with the Director of Nursing (DON) and request of the documents was conducted. The DON stated she had no access on Resident 1's clinical record and the facility could not provide the intake and urine output record for Resident 1. The DON stated it was passed the 30-day period from the time Resident 1 was admitted and discharged . There was no evidence or documentation provided that Resident 1's intake and urine output was being monitored. A review of the facility's policy titled, Nursing Services-Care plan dated November 21, 2025, indicated. Overview: the facility shall implement each patient's care plan according to patients, needs . On 12/1/25 at 8:55 A.M., a follow up interview with the DON was conducted. The DON stated, a care plan was important to know the plan of care for Resident 1 and follow the interventions listed.

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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 interview and record review, the facility failed to monitor and identify episodes of low urine output and communicated to the physician for one of three residents (Resident 1). This failure had the potential to cause worsening symptoms for Resident 1.Findings.A review of the facility's admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included nondisplaced fracture of the sacrum (a break in the base of the spine) and neuromuscular dysfunction of the bladder(issues with bladder control and function). On 11/24/25 at 11:45 A.M., an interview and record review with Licensed Nurse (LN)1 was conducted. LN 1 stated Resident 1 had a foley catheter (a flexible tube inserted through the urethra into the bladder to drain and collect urine) for Neurogenic Bladder. LN1 stated Resident 1's intake and output should be recorded every shift to ensure bladder function. A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/19/25, indicated a BIMS (brief interview for mental status) score of 15 which meant Resident 1's cognition (thought process) was intact. A review of Resident 1's MDS section H, dated 9/19/25 indicated, 0100 - Appliance - indwelling catheter. A review of Resident 1's Order Summary Report, dated 9/15/25 indicated, monitor urine output while on foley catheter every shift. On 11/24/25 at 1:58 P.M., an interview with Family Member (FM)1 was conducted. FM 1 stated when she visited Resident 1 on 9/15/25, Resident 1 did not have a foley catheter. FM 1 stated she requested the licensed nurses for the resident to have a foley catheter inserted due to Resident 1's history of bladder issues. FM1 stated the facility did not document Resident 1's voiding and did not perform a bladder scan (a non-invasive procedure that measures the volume of urine in the bladder) in the facility. The facility licensed nurse inserted the foley catheter back after the MD was notified. On 11/24/25 at 4:20 P.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated we emptied Resident 1's urinary bag, record urine output, and inform the charge nurse of the total urine output at the end of the shift. A record review of Resident 1's Medication Administration Record (MAR) dated September 2025 indicated the following record of output:A. M. shift: September 15 - no output was recorded. September 16 - 60 milliliters (ml-measure of volume) September 17 -250 ml September 18 - 600 ml September 19 -200 ml September 20 - 200 ml September 21- 550 ml September 22 -375 ml September 23 - mark with NA September 24 - mark with an x September 25 - 100 ml P.M. shift: September 15- no output was recorded September 16 -350 ml September 17- 800 ml September 18- 400 ml September 19 - 400 ml September 20 - 300 ml September 21 - 750 ml September 22 -750 ml September 23 - 1150 ml September 24 -550 ml Night shift: September 15- no output was recorded. September 16- 400 ml September 17 - 450 ml September 18 - 400 ml September 19 - 350 ml September 20 - 200 ml September 21 - 40 ml September 22 -150 ml September 23 - 200 ml September 24 - 100 ml On 11/25/25 at 1:04 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the facility could not provide the intake record of Resident 1. The DON stated she could not access the record since it had passed the 30-day period since Resident 1 was admitted and discharged . On 12/1/25 at 8:55 A. M., an interview with the DON was conducted. The DON stated it was important to document an accurate intake and output to monitor Resident 1's overall health condition. The DON could not provide Resident 1's intake record up to this time of writing. A review of the facility's policy titled ,Bowel and Bladder Management Process, dated 4/9/25 did not provide clear guidance.