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	08/26/2022

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 301) was provided privacy during wound care when the resident's privacy curtain was not closed all the way. During Resident 301's wound treatment, the resident's roommate (Resident 88) was brought back to the room by staff. This deficient practice had the potential for Resident 301's care and treatment to be observed by other persons, and for the resident to feel embarrassed and undignified. Findings: A review of Resident 301's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include a stage 3 pressure ulcer (injury to the skin that extends into the fatty tissue layer) of the sacral region (area where the lower back and tailbone meet). A review of Resident 301's Minimum Data Set Assessment (MDS, an assessment tool) dated 8/18/22, indicated the resident scored 03 on the brief interview of mental status (this meant the resident was severely cognitively impaired). A review of Resident 88's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 88's MDS dated [DATE], indicated the resident scored 13 on the brief interview of mental status (this meant the resident was cognitively intact). (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

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	08/26/2022

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/25/22 at 9:05 A.M., an observation was conducted of Resident 301's wound treatment with licensed nurse (LN) 12 and certified nursing assistant (CNA) 13 while inside the resident's room. During the wound treatment, LN 12 left Resident 301's bedside, while CNA 13 was holding the resident, and went to retrieve a bottle of alcohol-based hand sanitizer. When LN 12 returned to Resident 301's bedside, the LN did not close the resident's privacy curtain. Resident 301's privacy curtain was left open with an approximate four foot gap around the resident's bed. At 9:15 A.M., Resident 301 was turned onto his left side with his pants pulled down and his buttocks exposed, when a staff brought Resident 88 back to the room he shared with Resident 301. Resident 88 was overheard stating that he wanted to go to bed. CNA 13 asked the staff and Resident 88 to go back out of the room while Resident 301's care was being finished. LN 12 stated she had forgotten to pull the curtain closed and that privacy should have been provided to Resident 301. CNA 13 stated the resident's curtain should have been fully closed to provide privacy during care. On 8/25/22 at 9:26 A.M., an interview was conducted with Resident 88. Resident 88 stated he wanted to be provided full privacy when receiving care and treatment. Resident 88 stated a lack of privacy was undignified. On 8/26/22 at 8:13 A.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation that full privacy was provided during a resident's care and treatments. A review of the facility's admissions packet and undated document titled Resident Right's, indicated, .You have the right to be treated with respect and dignity .You have the right to personal privacy

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39111 Based on observation, interview, and record review, the facility failed to ensure resident room temperatures were kept at a comfortable and homelike level for one out of 24 sampled residents (87), five unsampled residents (1, 38, 96, 309, 312), and two confidential group residents. This deficient practice had the potential for residents to feel uncomfortable. Findings: A review of Resident 87's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 38's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 96's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 309's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 312's Admission Record indicated the resident was admitted to the facility on [DATE]. On 8/23/22 at 10 A.M., an observation and interview was conducted with Resident 309 while inside the resident's room. Resident 309 was observed shivering in bed and holding her blanket up to her chin. Resident 309 stated, It's cold in this room. On 8/23/22 at 10:39 A.M., an observation and interview was conducted with Resident 1 while in the hallway outside of the resident's room. Resident 1 was observed having staff place a blanket over his legs while he sat in his wheelchair. Resident 1 stated he did not like to complain, but that the temperature in his room ran a little cold for him. On 8/23/22 at 10:53 A.M., an observation and interview was conducted with Resident 38 while inside the resident's room. Resident 38 was lying in bed with her blankets pulled up to her chest. The top blanket was a thick, personal blanket. The resident was also wearing a heavy jacket while lying in bed. Resident 38 stated that she was usually always cold in her room. On 8/23/22 at 11:40 A.M. an interview was conducted with Resident 87 while inside the resident's room. Resident 87 stated the temperature in her room was uncomfortable at night during the first couple of days after admission to the facility. (continued on next page)

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	555425	A. Building B. Wing	08/26/2022

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/23/22 at 3 P.M., an interview was conducted with Resident 96 while inside the resident's room. Resident 96 stated, It's so cold in this room all the time. Need extra blanket. On 8/24/22 at 10:03 A.M., a confidential resident group meeting was conducted. Two out of 15 confidential group residents stated their rooms were too cold. On 8/25/22 at 9:30 A.M., an interview was conducted with Resident 312 while inside the resident's room. Resident 312 stated, This room is cold. Especially in the morning. On 8/25/22 at 8:25 A.M., a joint observation and interview was conducted with maintenance assistant (MA) 1. MA 1, using the facility's thermometer, tested the air temperature of the following rooms: Room B was 70.3 F (Fahrenheit) Room G was 69.1 F Room J was 73.6 F MA 1 stated resident room temperatures had to be maintained within a range of 71 F to 81 F. MA 1 stated rooms B and G were not warm enough. MA 1 stated everyday Monday through Friday, maintenance was required to check the temperature of one resident room on each unit in order to monitor the room temperatures. MA 1 stated directly after taking a room temperature, it had to be recorded in the log book. On 8/25/22 at 8:46 A.M., a joint interview and record review was conducted with MA 1. The corporate maintenance consultant (MC) was also present. MA 1 and the MC reviewed the Daily Temperature Logs Room-air-Temperature for August 2022. The log entries for resident room temperatures were blank on Monday, Tuesday, and Wednesday (8/22, 8/23, 8/24). The MC stated the expectation was for room temperatures to be documented immediately after taking the temperature. The MC stated when the logs were blank, the facility could not demonstrate that the room temperatures had been monitored daily Monday through Friday. On 8/26/22 at 2:57 P.M., a joint interview was conducted with the director of nursing and the facility's administrator (ADM). The ADM stated it was his expectation for room temperatures be kept within a range that was comfortable to the residents. A review of the facility's undated policy titled Environmental Condition indicated, .It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for the residents . Resident rooms . Must maintain a temperature of 71 F -81 F

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32097 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide pharmaceutical services to two non-sampled residents (Residents 1 & 2) to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of the residents. * The facility failed to ensure there was a valid physician medication order for Resident 1's morphine (controlled medication used to treat moderate to severe pain) infusion via morphine pump implanted (a surgical procedure performed to permanently implant a pump that delivers morphine to the spinal fluid to treat chronic pain) on 8/3/22. * The facility also failed to ensure Percocet (oxycodone/acetaminophen, controlled medication used to treat moderate to severe pain) tablets taken out of the Resident 1's controlled drug records (CDR) were administered to Resident 1 and documented on the medication administration record (MAR). * In addition, the facility failed to ensure Resident 2's Dulera (a combination of mometasone furoate and formoterol fumarate, used to prevent and lessen asthma symptoms) inhaler was ordered or administered as specified by the manufacturer. Dulera inhaler was ordered 1 puff inhalation every four hours as needed for asthma instead of 1 puff inhalation twice a day as specified by the manufacturer. These failures had the potential of negatively impacting the Residents well-being and had the potential for diversion (to use illegally) of controlled substance medications (a medication that can cause physical and mental dependence). Findings: 1. During an observation with LN 1 on 8/23/22 at 10:10 A.M., the medication cart on Unit 2 was inspected. Resident 1 was noted to have two different dosages of oxycodone/acetaminophen tablets for pain. a. During a concurrent interview, LN 1 stated Resident 1 also had morphine pump implanted for continuous delivery of morphine. During a concurrent record review, there was no medication order for morphine on Resident 1's medical record. LN 1 acknowledged there was no medication order for morphine on Resident 1's record. During an interview on 8/26/22 at 11:44 A.M., the Director of Nursing (DON) acknowledged there was no medication order for morphine on the facility computer system (Point Click Care) but there was a record from the outside physician who implanted the morphine pump in the chart. b. (i) Resident 1's Record review also showed medication order for Percocet 10-325 mg to give 1 tablet by mouth every 8 hours as needed for moderate pain, ordered on 8/11/22. (continued on next page)

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	555425	A. Building B. Wing	08/26/2022

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review on 8/23/22, Percocet tablets signed out of the CDR were cross checked with the doses administered to Resident 1. Review showed Percocet 10-325 mg tablets were signed out of the CDR but were not documented on the MAR on the following dates: 8/11/22 at 12:15 hours 8/12/22 at 20:40 hours. (ii) Resident 1's Record review showed medication orders for Percocet 5-325 mg: Give 1 tablet by mouth every 4 hours as needed for moderate pain, discontinued on 8/8/22. Give 2 tablets by mouth every 4 hours as needed for severe pain, discontinued on 8/8/22. Give 1 tablet by mouth every 8 hours as needed for moderate pain, ordered on 8/9/22. During record review on 8/23/22, Percocet tablets signed out of the CDR were cross checked with the doses administered to Resident 1 for July & August 2022. Review showed Percocet 5-325 mg tablets were signed out of the CDR but were not documented on the MAR on the following dates: 7/1/22 at 1215 hours, (2 tablets), 7/2/22 at 1240 hours (2 tablets), 7/3/22 at 1225 hours (2 tablets), 7/8/22 at 1230 hours (1 tablet), 7/11/22 at 2100 hours (2 tablets signed out, 1 tablet documented on MAR), 7/13/22 at 1215 hours (1 tablet), 7/15/22 at 1700 hours (2 tablets), 7/15/22 at 2100 hours (2 tablets), 7/18/22 at 2030 hours (1 tablet), 7/26/22 at 1230 hours, (2 tablets), 7/27/22 at 1230 hours, (1 tablet), 7/27/22 at 2100 hours (2 tablets signed out, 1 tablet documented on MAR), (continued on next page)

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	555425	A. Building B. Wing	08/26/2022

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/31/22 at 1200 hours (1 tablet), 8/5/22 at 2100 hours (2 tablets), 8/8/22 at 1600 hours (1 tablet), 8/8/22 at 2100 hours (1 tablet), 8/9/22 at 1230 hours (1 tablet), 8/14/22 at 1215 hours (1 tablet), 8/18/22 at 1115 hours (1 tablet), 8/22/22 at 1215 hours (1 tablet). On 8/26/22 at 11:44 A.M., during an interview, the DON acknowledged Percocet tablets taken out of records but were not documented on the MAR. 2. On 8/24/22 at 9:40 A.M., during an observation on Unit 1 with LN 2, the medication cart was inspected. Dulera inhaler was observed in the medication cart for Resident 2, labeled to inhale 1 puff every 4 hours as needed for asthma. During record review on 8/24/22 at 9:50 A.M., Resident 2's medication order showed Dulera inhaler,1 puff inhale orally every 4 hours as needed for asthma ordered on 3/28/22. During a concurrent interview, the Unit 1 Clinical Director acknowledged Dulera inhaler was not a rescue inhaler and dosing should have been scheduled and not as needed. The Unit 1 Clinical Director stated their dispensing pharmacy would normally catch this type of error. Review of the facility policy & procedure (P&P) titled Physician Orders indicated No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness . Licensed staff shall place the order for all prescribed medications. Review of the facility P&P titled Medication Administration indicated it is the policy of this facility to accurately prepare and administer medications as ordered . document in residents' record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 32097 Based on interview and record review, the Consultant Pharmacist (CP) failed to report irregularities in Resident 2's Dulera inhaler (a combination of mometasone furoate and formoterol fumarate, used to prevent and lessen asthma symptoms) to the attending physician, Director of nursing and/or medical director and the facility administrator. This failure had the potential to negatively impact the resident's well-being. Findings: On 8/24/22 at 9:40 A.M., during an observation on Unit 1 with LN 2, the medication cart was inspected. Resident 2's Dulera inhaler was observed in the medication cart, labeled to inhale 1 puff every 4 hours as needed for asthma. On 8/24/22 at 9:50 A.M., during Resident 2's record review, the medication order showed Dulera inhaler, 1 puff inhale orally every 4 hours as needed for asthma ordered on 3/28/22. During an interview on 8/25/22 at 12:55 P.M., the CP stated her record showed Resident 2's Dulera inhaler order was 1 puff twice a day. The CP also stated she downloaded residents' medication orders from the facility dispensing pharmacy. Review of the facility policy & procedure (P&P) titled, Medication Regimen Review, indicated the consultant pharmacist performs a comprehensive review of each resident's medication regimen at least monthly . Medication regimen review also involves reporting of findings with recommendations for improvement . resident specific irregularities and/or clinical significant risks resulting from or associated with medications are documented and reported to the Director of Nursing, and /or prescriber as appropriate.

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	555425	A. Building B. Wing	08/26/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32097 Based on interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 3) was free from unnecessary psychotropic (is any medication that affects brain activities associated with mental processes and behavior.) medications as per the facility's policy & procedure. * The facility failed to attempt gradual dose reduction (GDR, the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.) and no clinical contra-indication was documented. * In addition, the facility failed to implement any non-pharmacological interventions (interventions not involving a medication for mental illness). Resident 3 was receiving several psychotropic including Anti-psychotic (used to manage/treat symptoms of some mental health disorders); Anti-depressant (used to relieve symptoms of depression); Anti-anxiety (used to treat anxiety and panic issues); and Hypnotic (used for the treatment of insomnia which is characterized by difficulties with falling asleep or maintaining sleep). These failures increased the potential for medication interactions, adverse reactions, and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss. Findings: Medical record review for Resident 3 was initiated on 8/25/22. Resident 3 was admitted to the facility on [DATE]. 1. Review of Resident 3's current medication orders included: Ambien (zolpidem, short term treatment for problem with falling asleep) 5 milligrams (mg) via gastrotomy tube (GT, is a surgically placed device used to give direct access to your stomach for supplemental feeding) at bedtime for inability to sleep dated 2/23/19. Risperidal (risperidone, used to manage/treat symptoms of some mental health disorders) 1 mg via GT at bedtime psychotic symptoms manifested by striking out, dated 2/9/19. Risperidone 1.5 mg via GT two times a day. Trazodone 25 mg via GT at bedtime for depression manifested by irritability dated 2/9/19. Buspirone 20 mg via GT two times a day for anxiety manifested by restlessness dated 2/9/19. Lorazepam 0.5 mg via GT two times a day for anxiety manifested by restlessness dated 2/9/19. (continued on next page)

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	555425	A. Building B. Wing	08/26/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's medical record showed GDR was not attempted for any of the psychotropics as requested by Resident 3's responsible party and there was no clinical contraindication to GDR documented. 2. Further review of Resident 3's medical record including Medication Administration Record, on 8/25/22, showed non-pharmacological behavioral interventions were not implemented. On 8/25/22 at 9:56 A.M., during an interview and concurrent medical record review for Resident 3, the Director of Nursing (DON) acknowledged GDR has not been attempted for any of the psychotropics as requested by the responsible party for the resident. Resident 3's physician and the facility Medical Director were aware. The DON also acknowledged non-pharmacological behavioral interventions were not implemented. On 8/25/22 at 12:18 P.M., during a phone interview, the facility Medical Director stated that in this Country, patients have rights to decide what medications they want and what they don't want. The responsible party for Resident 3 has requested no GDR for the psychotropics. On 8/26/22 at 8:35 A.M., attempted to interview Resident 3's primary physician and the psychiatrist, left messages at their offices but was not successful. Review of the facility's policy & procedure titled, Psychotropic Drug Use, indicated residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, to discontinue these drugs.

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	555425	A. Building B. Wing	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Knoll Specialized Care Facility	2000 Westwood Road Vista, CA 92083

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32097 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure medications were stored as per the facility's P&P and outdated medications were not available for residents' use. * Multiple expired medications observed in Unit 1 and Unit 2. * The opened Tuberculin PPD 1 ml vial (purified protein derivative, a multi-dose injectable solution used in skin test to determine if a patient has tuberculosis) was not labeled with the open date and was stored in the refrigerator in Unit 2 locked medication room. These failures had the potential to result in unsafe administration of medications to the residents and posed the risk of the test not showing an accurate result when determining if a resident had tuberculosis. Findings: 1. On 8/23/22 at 11:00 A.M., an inspection of house supply Medication Room in Unit 2 was conducted with LN 3. The following outdated medications were observed: Adult tussin expectorant (guaifenesin 200 mg/10 ml, used to clear mucus from the chest) 118 ml expired on 3/22 x 1 bottle. Famotidine 20 mg tablet (used to treat stomach ulcers, erosive heartburn or acid indigestion, and gastroesophageal reflux disease (GERD), a condition where the acid in the stomach washes back up into the esophagus) X 75 tablets expired on 6/22. During a concurrent interview, LN 3 acknowledged the expired medications. 2. On 8/23/22 at 11:15 A.M., an inspection of locked Medication Room in Unit 2 was conducted with LN 3. An opened vial of Tuberculin PPD 1 ml observed in the refrigerator was not labeled with an open date. The label on the Tuberculin PPD vial showed to discard opened product after 30 days. The pharmacy label on the PPD vial was dated 7/17/22. When asked when the PPD vial was opened, LN 3 stated she did not know since the vial did not show a date when it was opened. LN 3 stated it should have been labeled with the open date. 3. On 8/23/22 at 11:24 A.M., an inspection of Medication Cart 1 Unit 2 was conducted with LN 4. Bisacodyl 10 mg (used to treat constipation) x 6 suppositories expired on 1/22, and insulin lispro kwikpen 3 ml (used to control high blood sugar in people with diabetes) opened but not labeled with opened date were observed in the medication cart. LN 4 acknowledged the expired suppositories and the unlabeled open insulin. (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	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Knoll Specialized Care Facility	2000 Westwood Road Vista, CA 92083

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 8/24/22 at 9:40 A.M., an inspection of Medication Cart 1 in Unit 1 was conducted with LN 2. Novolog flexpen (used to control high blood sugar in people with diabetes) dated opened on 7/10/22, and Adult Tussin expectorant 118 ml x 1 expired on 3/22, were observed in the medication cart. LN 2 stated the flexpen was stored in the medication cart when opened. LN 2 acknowledged the Novolog flexpen should have been discarded after 28 days. LN 2 also verified the expired adult tussin bottle. During a concurrent interview, the Unit 1 Clinical Director acknowledged the outdated Novolog flexpen and the expired adult tussin bottle. During an interview on 8/26/22 at 11:44 A.M., the Director of Nursing (DON) acknowledged expired medications and medications opened but not labeled with opened dates. Review of the facility's Policy & Procedure titled, Medication Access, Storage and Labeling, indicated outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for the medication destruction and reordered from the pharmacy, if a current order exists.

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	08/26/2022

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Vista Knoll Specialized Care Facility	2000 Westwood Road Vista, CA 92083

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39111 Based on observation, interview, and record review, the facility failed to ensure food was served at an appetizing and palatable temperature for two of 15 confidential group residents and during a meal test tray observation. This failure had the potential for residents not to enjoy their food. Findings: On 8/24/22 at 10:03 A.M., a confidential resident group meeting was conducted. Two out of 15 confidential residents stated that their food was not palatable because the hot food was not served hot and the cold food was not served cold. On 8/25/22 at 11:30 A.M. an observation was conducted in the facility's kitchen of the lunch time food service. At 12:33 P.M., the food was observed being placed on resident trays for Unit 2. At 1:31 P.M., the last food cart was brought to Unit 2. On 8/25/22 at 1:36 P.M., the last tray on the food cart on Unit 2 was tested . The director of dietetic services (DDS) 2, using the facility's thermometer, tested the temperatures of the food and drink items on the test tray. The facility's registered dietitian (RD) was also present. The DDS 2 tested the food temperatures as followed: BBQ Pork- 133 F (Fahrenheit) Bread roll- 98 F Resort Fruit Dessert- 50.5 F Milk- 48.9 F The test tray was incomplete and was missing the broccoli salad and baked beans that was on the lunch menu and that had been served to the residents. The DDS stated the resort fruit dessert and milk were cold foods and should have been served below 45 F. The DDS stated the cold food was not at an acceptable temperature for delivery to the residents. The DDS stated, Cold wasn't served cold. On 8/26/22 at 8:25 A.M., a joint interview was conducted with the RD and DDS 2. The RD stated the cold food on the test tray during lunch on 8/25/22 should have been colder. The DDS 2 stated the kitchen staff had made a mistake and forgot to add the broccoli salad and baked beans to the test tray on 8/25/22. On 8/26/22 at 2:57 P.M., a joint interview was conducted with the director of nursing (DON) and the facility's administrator (ADM). The ADM and DON stated they expected the residents' food to be served at temperatures deemed palatable by the residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Meal Service dated 2018, indicated, .The goal is to serve cold food cold and hot food hot .Recommend Temp at Delivery to Resident . Fruit or Cold Dessert =50 F .Milk/Cold Beverage =45 F

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31919 Based on observation, interview and record review, the facility failed to ensure that 1 of 2 sampled residents, Resident 81, received a selected lunch meal and a chosen lunch entree. This deficient practice had the potential to result in weight loss and further compromise the resident's medical status. Findings: Per the facility's Admission record, Resident 81 was admitted on [DATE] with diagnoses including surgery on the nervous system, and traumatic subdural hemorrhage (bleeding inside the skull after an injury). On 8/23/22 at 2:35 P.M., an interview was conducted with Resident 81. Resident 81 stated, I did not get my lunch yesterday. Resident 81 further stated, The CNA said she did not see a tray for me. Someone called the kitchen and came back with a sandwich and a bag of chips. Resident 81 stated, I didn't get what I wanted, instead I ate a sandwich for lunch. On 8/24/22 at 1:20 P.M., during a concurrent observation and interview with Resident 81, Resident 81 was observed lifting the lid off the plate warmer (a plastic plate with a lid used to keep food hot). The lunch plate was observed with a starch portion and a vegetable portion. There was no protein portion. On 8/24/22 at 2:58 P.M., the dietary supervisor (DS) was interviewed. The DS stated, The Activities Director (AD) hands out the Menu Selection (a menu approved by the Registered Dietician [RD]), where residents chose what they wanted for the week). DS further stated, Resident 81 crossed out oven fried chicken and wrote chicken tenders then crossed it out again. Review of the Menu Selection for the facility indicated, on 8/24/22, the entree on the lunch menu was oven fried chicken. Oven fried Chicken was crossed out and chicken tenders was written in and crossed out. Below the lunch menu were instructions .Cross off foods you do not want and write in a substitute from the list on the back. In the space provided, was written, rice, fruit and Salisbury steak. On 8/25/22 at 3 P.M., the Menu Selection was reviewed with Resident 81, Resident 81 stated, I wrote Salisbury steak on the lunch menu but it isn't what I requested. On 8/26/22 at 1:50 P.M., a concurrent interview with the RD and DS 1 was conducted. The RD stated, Resident 81 is followed daily due to weight loss and loose stool. DS 1 stated, We prepared a lunch tray for Resident 81 on 8/23/22, it was put on the cart. We don't know what happened to it.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39111 Based on observation, interview, and record review, the facility failed to ensure food was stored in accordance with food safety standards, when: - Spoiled produce was stored among non-spoiled produce. - Dented cans were stored among non-dented cans and were in circulation to be used. These deficient practices had the potential for residents to be exposed to the risk of foodborne illness. Findings: On 8/23/22 at 8:30 A.M., an observation of the facility's kitchen was conducted with the director of dietetic services (DDS) 1. The walk-in produce refrigerator was inspected. There was a large box of romaine lettuce heads. In the box, approximately five heads had large brown spots on the leaves, fuzzy gray material on the leaves, and they were secreting a slimy substance onto the other heads of lettuce that were in the box. The DDS 1 stated the whole box should have been tossed out. In the dry storage area, there was an onion that was soft and squishy and a banana that was black and slippery and leaked a gray fluid. The DDS 1 stated that spoiled produce should not have been stored with the non-spoiled produce. The DDS 1 stated all food on the shelves in the dry storage were ready for immediate use. On one of the shelves, there was a large can [brand name] sauerkraut that had a dent approximately half an inch down from the top seam that fit two fingers in the space and caused the top seam to bend down. Two large cans of [brand name] pineapple were also on the shelf. Both cans of pineapple were dented directly on the top seam of the can, and created a distortion of the seam approximately one inch in size. One large can of [brand name] pumpkin was on the shelf with a dent near the top of the can that fit approximately three fingers in the space. The DDS 1 stated the dented cans should have been removed from circulation and placed in the dented can area for return to the supplier. The DDS 1 stated dented cans had to be removed and disposed of because the dent could create a leak in the can and could cause foodborne illness. According to the U.S. Department of Agriculture Food Safety and Inspection Service's article titled, Shelf-Stable Food Safety, dated 3/24/15, .Discard deeply dented cans. A deep dent is one that you can lay your finger into. Deep dents often have sharp points. A sharp dent on either the top or side seam can damage the seam and allow bacteria to enter the can. Discard any can with a deep dent on any seam On 8/26/22 at 8:25 A.M., an interview was conducted with the DDS 2 and the facility's registered dietitian (RD). The RD stated dented cans should not have been stored in with non-dented cans. The RD stated the dented cans should have been removed from circulation and placed into the designated dented can area. The RD stated dented cans could allow bacteria to enter the can and could cause foodborne illness. The RD stated spoiled produce had to be promptly removed from the food storage area because spoilage could cause the other produce to spoil. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Storing Produce dated 2018, indicated, 1. Check boxes of fruit and vegetables for rotten, spoiled items. One rotten tomato, apple or potato in a box can cause the rest of the produce to spoil faster. Throw away all spoiled items A review of the facility's policy titled Storage of Food and Supplies, dated 2017, indicated, .Food and supplies will be stored properly and in a safe manner .15. Food in unlabeled rusty, leaking, broken containers or cans with side seam dents, rim dents or swells shall not be retained or used.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure the clinical records of 14 residents (Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, 96) in rooms A through H were stored in a safe and secure manner when the residents' clinical records were stored on a rolling bookcase in the residential hallway. This deficient practice had the potential for Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, and 96's private health information to become lost, destroyed, or accessed by unauthorized persons. Findings: A review of Resident 311's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 151's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 310's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 309's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 308's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 48's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 307's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 306's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 305's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 304's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 303's Admission Record indicated the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 302's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 81's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 96's Admission Record indicated the resident was admitted to the facility on [DATE]. On 8/23/22 at 9:30 A.M., an observation was conducted in the residential hallway for rooms A, B, C, D, E, F, G, and H. The clinical records of residents in rooms A through H were stacked on a rolling bookcase in the hallway next to a closed door. The clinical records were not locked or secured with any device and were not being monitored by an assigned staff. The clinical records were not visible from the nurses' station. Residents, visitors, and staff (clinical and non-clinical) were observed passing through the unit or going into resident rooms. On 8/24/22 at 11:09 A.M., an observation was conducted in the residential hallway for rooms A through H. The clinical records of residents in rooms A through H were stacked on a rolling bookcase in the hallway next to a closed door. The clinical records were not visible to staff in the nurses' station, were not actively monitored, and were not secured. On 8/25/22 at 10:30 A.M. an observation and record review was conducted in the residential hallway for rooms A through H. The clinical records of residents in rooms A through H were stacked on a rolling bookcase in the hallway next to a closed door. The clinical records were not visible to staff in the nurses' station, were not actively monitored, and were not secured. Residents, visitors, and staff (clinical and non-clinical) were observed passing through the unit or going into resident rooms. At 10:35 A.M., No one was observed in the residential hallway. The clinical records for Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, and 96 were reviewed. The residents' clinical records contained admission records (information that included name, date of birth, social security number, address and telephone number, insurance information, diagnoses, and emergency contact information), physician notes and hospital stay documentation, consent forms, and other private health information. On 8/25/22 at 10:36 A.M., a joint observation and interview was conducted with licensed nurse (LN) 11. LN 11 observed Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, 96's unsecured clinical records on the rolling bookcase stored in the residential hallway. LN 11 stated she would not want her medical information stored like that because anyone could have access. On 8/25/22 at 10:40 A.M., a joint observation and interview was conducted with the assistant director of nursing (ADON) 1. The ADON 1 observed Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, 96's unsecured clinical records on the rolling bookcase stored in the residential hallway. The ADON 1 stated the residents' medical records had not been stored securely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/25/22 at 10:48 A.M., a joint observation and interview was conducted with the assistant director of nursing (ADON) 2. The ADON 2 observed Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, 96's unsecured clinical records on the rolling bookcase stored in the residential hallway. The ADON 2 stated the residents' medical records had not been stored in a secure location. The ADON 2 stated the residents' clinical records should have been kept inside the nurses' station to prevent unauthorized access. On 8/25/22 at 10:51 A.M., a joint observation and interview was conducted with the medical records director (MRD). The MRD observed Residents 311, 151, 310, 309, 308, 48, 307, 306, 305, 304, 303, 302, 81, 96's unsecured clinical records on the rolling bookcase stored in the residential hallway. The MRD stated the residents' medical records were not stored securely and in a manner that limited unauthorized use. On 8/25/22 at 11 A.M., an interview was conducted with the director of nursing (DON). The DON stated the clinical records of the residents in rooms A through H had not been stored in a secure manner. The DON stated the residents' medical records should have been stored in a manner that prevented unauthorized access at all times. A review of the facility's admissions packet and undated document titled Resident Right's, indicated, .Privacy and Confidentiality. You have the right to . secure and confidential personal and medical records A review of the facility's undated policy titled, Resident-Identifiable Information, indicated, . 1. Resident records, whether medical, financial, or social in nature, will be safeguarded to protect the confidentiality of the information