

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Arroyo Vista Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3022 45th Street San Diego, CA 92105	
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** Based on interview and record review, the facility failed to ensure one resident (Resident 1) was treated with dignity/respect when the facility denied Resident 1 re-entry following a return from being out on pass (OOP; also referred to as a day pass; physician ' s order that gives permission for a resident to leave the facility for a specified period of time). This failure had the potential to affect Resident 1 ' s physical and psychosocial well-being related to feeling betrayed and kicked out from his home. (Cross Reference F-553 and F-657) Findings: According to the facility ' s admission Record, Resident 1 was admitted to the facility on [DATE], with diagnoses which included multiple fractures of the pelvis and right ribs. An interview was conducted with Resident 1 on 4/11/25 at 10:12 A.M. Resident 1 stated that he has always been allowed to leave on a day pass to spend time with friends. Resident 1 stated that on the early morning of 3/19/25, the facility would not allow him back inside, because it was after midnight and those were their rules. Resident 1 stated he was never informed that he would be locked out after midnight. Resident 1 stated he was finally allowed back into the building three hours later, after he called the police. Resident 1 stated he felt betrayed, as if the facility was trying to kick him out, because he had no other place to go. On 4/11/25, Resident 1 ' s medical record was reviewed. According to the physician ' s order, dated 9/30/24, Resident 1 was able to go Out on Pass. According to the quarterly Minimum Data Set (a clinical assessment tool), dated 2/13/25, Resident 1 had a cognitive score of 15, indicating cognition was intact. Per the Functional Abilities section, Resident 1 was independent for activities of daily living (eating, dressing, showering), and used a manual wheelchair to move around. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the nurse ' s note dated 3/19/25 at 12:07 A.M., Licensed Nurse 2 (LN 2) documented, patient still not back from pass, Nurse Practitioner (NP) [name] aware, waiting for orders. Orders received from NP [name] that patient is now AMA (against medical advice; referring to when a patient leaves the facility against the recommendation of the physician or healthcare provider), not to allow him in the building and has to go to the emergency room. Called resident and left message through voicemail. According to the nurse ' s note dated 3/19/25 at 12:45 A.M., LN 2 documented patient came via private vehicle with a female driver. Patient was ambulating with a front wheel walker and informed about what NP [name] ordered. Patient wanted to talk to NP [name] but per NP [name], to call director of nursing (DON) per DON patient is now discharged , follow what NP [name] ordered and that patient needs to go to ER. Resident outside facility door and made aware. According to nurse ' s notes dated 3/19/25 at 2:28 A.M., Three police officers arrived and spoke to writer as well as patient. Per Officer 1, we have to let patient in due to civil matter, that there is no medical reason for patient to go to ER and that he ' s been living here for a period of time and has established residency. Officer 1 asked to speak with Administrator or DON, but no response from either one. Patient was let in back to his room and will talk to the DON or administrator in the am. According to the nurses ' s note dated 3/19/25 at 3:08 A.M., LN 2 documented Patient asked for pain meds and writer informed him that it will be clarified to DON if writer will be allowed to give his medication since he was AMA and was considered discharged .Patient then insist to have urine collected and send to lab .writer informed .no order, cannot be sent to lab. An interview was conducted with NP on 4/11/25 at 11:35 A.M. NP stated he was notified by the facility that it was after midnight and Resident 1 had not returned. NP instructed staff to consider the resident AMA and not to allow him back in. While on the phone with the facility, Resident 1 arrived and demanded to be let back in. NP instructed staff to consider Resident 1 discharged and to instruct him to go to the emergency room. NP stated he thought the OOP deadline was midnight, and that was the reason staff was instructed to deny the resident entry. NP stated since this event, he learned the deadline for AMA if leaving on OOP, was actually three days. The Administrator, DON, and Director of Staff Development were unavailable on 4/11/25 for an interview. According to the facility ' s policy titled Resident Rights and Responsibility, undated, .7. To assure that out residents, staff, and visitors are continually informed and aware of resident rights, grievance procedures, and responsibilities .		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident 1) was included in his own person-centered planning of care related to Interdisciplinary Team meetings (IDT; head of department staff meet with the resident to discuss care or concerns/issues) after an incident when the facility refused Resident 1 entry back into the facility following an Out on Pass leave (OOP; physician ' s order that allowed the resident to leave the facility; usually for the day; also referred to as a day pass). This failure resulted in Resident 1 not being informed of the facility rules or expectations when leaving on and returning from, being OOP. In addition, this failure had the potential to result in an AMA (against medical advice)-triggered discharge, which had the potential to affect Resident 1 ' s physical and psychosocial well-being. (Cross-reference F-550 and F-657) Findings: According to the facility ' s admission Record, Resident 1 was admitted to the facility on [DATE], with diagnoses which included multiple fractures of the pelvis and right ribs. An interview was conducted with Resident 1 on 4/11/25 at 10:12 A.M. Resident 1 stated that he has always been allowed to leave on a day pass to spend time with friends. Resident 1 stated that on 3/19/25, upon returning from being out on a day pass, the facility would not allow him back inside, because it was after midnight, and those were their rules. Resident 1 stated that he was never informed that he would be locked out from the facility after midnight. Resident 1 stated that his friend ' s car had broken down on the way back to the facility, which caused his delay in returning. Resident 1 stated that he was finally allowed back into the building three hours later, after he called the police. Resident 1 stated that he felt betrayed, because he had no other place to go, and felt the facility was trying to kick him out. On 4/11/25, Resident 1 ' s medical record was reviewed. According to the physician ' s order, dated 9/30/24, Resident 1 was able to go Out on Pass (OOP). According to the quarterly Minimum Data Set (a clinical assessment tool), dated 2/13/25, Resident 1 had a cognitive score of 15, indicating cognition was intact. Per the Functional Abilities section, Resident 1 was independent for activities of daily living (eating, dressing, showering), and used a manual wheelchair to move around. There was no documented evidence that an IDT was conducted after the 3/19/25 incident. The last documented IDT meeting for Resident 1 was dated 6/1/24. No other IDT or care conferences were documented. (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review were conducted with the Social Service Director (SSD) on 4/11/25 at 11: 43 A.M. The SSD stated that she was on vacation when the 3/19/25 incident occurred and learned about it when she returned. The SSD stated that Resident 1 left the facility several times a month and there was never an issue. The SSD stated she scheduled the IDTs, which were required quarterly (every three [3] months), and if there were problems, such as a change of condition. The SSD stated that when she returned to the facility (from vacation), she was informed that an IDT was conducted after the OOP incident. The SSD reviewed Resident 1 ' s IDT log and could not locate an IDT for the March OOP incident. The SSD stated she could only locate one IDT which was dated June 2024. The SSD continued looking through Resident 1 ' s medical record and could not find any documented evidence that other IDTs were conducted. The SSD stated that if Resident 1 refused an IDT, it would be documented in the SSD notes. The SSD stated there was no documented evidence that IDTs were refused. The SSD continued, and stated that after IDTs were conducted, the resident ' s care plans were usually updated and revised to reflect the changes or improvement, and new goals and interventions would be applied. The SSD stated that since there were no documented IDTs for Resident 1, there was no collaborative review of the resident ' s care. The SSD stated this was considered a resident right to be involved in their planning and care, however there was no documented evidence that Resident 1 was involved. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/11/25 at 12:10 P.M. The ADON stated IDTs were conducted for every resident quarterly and more often, if problems were identified, or a change of condition occurred. The ADON stated IDTs were important for the head of department staff to discuss issues and suggest solutions. The ADON stated when IDTs were completed, the resident ' s care plans were updated, so new goals and interventions could be listed, and staff were all aware of the changes. The ADON stated if IDTs were not conducted, there was no collaboration of care with the resident, so there was no meeting of the minds. An interview and record review were conducted with licensed nurse (LN) 1 on 4/11/25 at 12:46 P.M. LN 1 stated IDTs were important to address issues, such as weight loss, wounds, or behaviors. LN 1 stated she assumed an IDT was conducted after Resident 1 was denied entry, after leaving on a pass. LN 1 stated the IDT would address preventing this AMA-triggered discharge from occurring again, so Resident 1 would know the rules and expectations. LN 1 stated she was surprised if an IDT was not done, because this also triggered a change to the resident ' s care plan. LN 1 reviewed Resident 1 ' s record and acknowledged that Resident 1 was not included in an IDT for person-centered care planning after the OOP incident. The Administrator and Director Nursing were unavailable on 4/11/25 for an interview. According to the facility ' s policy, titled Comprehensive Person-Centered Care Planning, undated.4. The facility IDT will develop and implement a comprehensive person-centered care plan for each resident .will include the resident needs identified .and resident ' s goals and desired outcomes, preferences for future discharge .		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a care plan related to Out on Pass (OOP; also referred to as a day pass; a physician ' s order that allows the resident to leave the facility for an approved time period) was revised for one resident (Resident 1). This failure had the potential for staff and Resident 1 to be confused on the facility ' s rules when leaving on an Out on Pass. (Cross Reference F-550 and F-553) Findings: According to the facility ' s admission Record, Resident 1 was admitted on [DATE], with diagnoses which included multiple fractures of the pelvis and right ribs. An interview was conducted with Resident 1 on 4/11/25 at 10:12 A.M. Resident 1 stated that he has always been allowed to leave on a day pass to spend time with friends. Resident 1 stated that on 3/18/25, the facility would not allow him back inside, because it was after midnight and those were their rules. Resident 1 stated that his friend ' s car had broken down on the way back to the facility, and he was never informed of a rule of that he would not be allowed back inside the facility, after midnight. Resident 1 stated he was finally allowed back into the building three hours later, after he called the police. Resident 1 stated he was never informed that he could only be gone (out on pass) for a certain number of hours or that he would be locked out after midnight. On 4/11/25, Resident 1 ' s medical record was reviewed. According to the physician ' s order, dated 9/30/24, Resident 1 was able to go Out on Pass. According to the quarterly Minimum Data Set (a clinical assessment tool), dated 2/13/25, Resident 1 had a cognitive score of 15, indicating cognition was intact. Per the Functional Abilities section, Resident 1 used a manual wheelchair to move around. There was no documented evidence that an Interdisciplinary Team Meeting (IDT- head of department staff and the resident meet to discuss incidences or concerns) was conducted after the 3/19/25 incident. The care plan titled, Elopement Risk related to not informing licensed nurses when going out on pass, and exceeding the required number of hours allowed, revised 1/16/25, listed the following interventions: . Licensed nurse will talk to resident when leaving the facility to wait for MD/NP approval of OOP. Licensed nurse will notify MD/NP if patient left the building without requesting OOP and exceeds the allowable amount of time. Licensed nurses/staff will call the patient before the fourth hour of being OOP to check the well-being of the patient and remind the patient of the time. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with Licensed Nurse 1 (LN 1) on 4/11/25 at 12:10 P.M. LN 1 stated care plans were reviewed and revised regularly and especially after IDT meetings. LN 1 was aware of Resident 1 being refused entry last month (3/19/25) and stated she assumed an IDT was conducted and the OOP care plan was revised, based on the 3/18/25, incident alone. LN 1 reviewed Resident 1 ' s care plan, titled Elopement [NAME] and stated the last time the care plan was revised was 1/16/25. LN 1 stated that because the care plan was not updated, staff were unaware of what the rules were and if there really was a time limit for the resident returning to the facility. LN 1 stated that care plans were important for staff, so everyone knew what interventions to implement and what were being consistency applied. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/11/25 at 1 P.M. The ADON acknowledged that Resident 1 ' s care plan should had been updated and revised, but was not. The ADON stated care plans were important for staff to identify issues and set interventions and expectations. The Administrator and Director of Nursing were unavailable for interview on 4/11/25. According to the facility ' s policy, titled Comprehensive Person-Centered Care Planning, undated, . ^ . The resident ' s comprehensive plan of care will be reviewed and/or revised by the IDT .		