STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055361	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Pacifica Convalescent Hospital	3662 Pacific Avenue Jurupa Valley, CA 92509

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure a comprehensive Minimum Data Set (MDS - a standardized resident assessment tool) assessment was conducted after a significant change in status assessment (SCSA- an assessment that indicates a major decline or improvement in the resident's status), for one of two residents reviewed for resident assessments (Resident 24), when Resident 24 was admitted and discharged from hospice (a specialized form of medical care provided to individuals who are nearing the end of their life and have a prognosis of six months or less to live) care. This failure had the potential for Resident 24 to not receive the care and services necessary to maintain her highest possible level of care. Findings: On February 25, 2025, at 1:59 p.m., Resident 24 was observed lying in her bed. On February 27, 2025, Resident 24's record was reviewed. Resident 24 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss). A review of Resident 24's Minimum Data Set, dated dated [DATE], indicated Resident 24 had a BIMS (Brief Interview for Mental Status - a tool used to assess cognition) score of 00, which indicated severe cognitive impairment. A review of Resident 24's Family Notification of Room and Board, dated September 18, 2024, indicated Resident 24 was admitted to hospice with diagnosis of senile degeneration of brain (a decline in mental abilities that occurs with aging) under routine level of care on September 18, 2024. A review of Resident 24's Progress Notes, dated September 18, 2024, at 6:36 p.m., indicated Resident 24 was admitted to hospice services effective September 18, 2024. A review of Resident 24's Progress Notes, dated January 6, 2025, at 2;58 p.m., indicated Resident 24 was no longer on hospice services and the facility would resume full care of resident, effective January 6, 2025. (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 24's record indicated there was no documented evidence of an MDS Assessment was conducted for a significant change in status assessment for Resident 24 when the resident was admitted to hospice services on September 18, 2024 and discharged from hospice on January 6, 2025. On February 26, 2025, at 9 a.m., during a concurrent interview and record review with the MDS Nurse (MDSN). The MDSN stated if a resident gets admitted or discharged from hospice care, it would be considered a significant change. The MDSN also stated if a significant change was identified, a SCSA should have been completed within 14 days. The MDSN stated a SCSA should have been done for Resident 24 when the resident was admitted and discharge from hospice care. The MDSN further stated, I should have asked my DON (Director of Nursing) if I needed to do SCSA for Resident 24. On February 27, 2025, at 7:43 a.m., during an interview with the DON, the DON stated she expected the MDS nurses to follow the facility's policy and procedure for resident assessment. The DON stated the MDS nurses should have conducted a significant change in status assessment for residents who were admitted and discharged from hospice care. The DON further stated if there was no significant change assessment, the staff would not identify appropriate interventions and services necessary to maintain the highest possible level of care. A review of the facility's undated policy and procedure titled, Resident Assessments Policy & Procedure, indicated, .A comprehensive assessment of every resident's needs is made at intervals designated by OBRA (Omnibus Budget Reconciliation Act-an act that improve care in nursing homes) and PPS (Prospective Payment System-type of assessment) requirements .The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessment and reviews according to the following requirements .Significant Change in Status Assessment (Comprehensive) . Conducted when there has been a significant change in the resident's condition .A Significant Change in Status Assessment (SCSA) is completed within 14 days of the interdisciplinary team determining that the resident meets the guidelines for major improvement or decline .A SCSA is required when a resident .Enrolls in a hospice program .Discontinues hospice services .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observation, interview, and record review the facility failed to ensure Midodrine (a blood pressure medication used to increase the blood pressure) was administered according to the physician's orders, for one of 17 residents reviewed (Resident 34). This failure had the potential to inadequately control Residents 34's blood pressure, which could affect overall health condition. Findings: On February 27, 2025, Resident 34's record was reviewed. A review of Resident 34's Admission Record, indicated, Resident 34 was admitted to the facility on [DATE], with diagnoses which included hypertension (elevated blood pressure). A review of Resident 34's Physicians Order, dated October 8, 2024, indicated, Midodrine HCL Oral tablet 10 mg (milligrams - unit of measurement), give one tablet via G-tube (gastrostomy tube - tube inserted through the abdomen that brings nutrition directly to the stomach) three times a day for hypotension, hold if SBP is greater than 110. A review of Resident 34's, Medication Administration Record (MAR), for February 2025, indicated, Midodrine HCL was not administered to Resident 34, according to the physician's order on the following dates: - February 3, 2025, at 12 p.m.; Midodrine was administered when the SBP was 121 (above 110 - Midodrine should have been held); - February 9, 2025, at 5 p.m.; Midodrine was administered when the SBP was 139 (above 110 - Midodrine should have been held); - February 20, 2025, at 8 a.m.; Midodrine was administered when the SBP was 126 (above 110 - Midodrine should have been held); - February 20, 2025, at 12 p.m.; Midodrine was administered when the SBP was 121 (above 110 - Midodrine should have been held); and - February 23, 2025, at 8 a.m.; Midodrine was administered when the SBP was 132 (above 110 - Midodrine should have been held). Further review of Resident 34's MAR, indicated Midodrine was administered to Resident 34 on February 21, 2025, at 8 a.m., when the SBP was 89. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, at 12:28 p.m., a concurrent observation of Resident 34's Midodrine bubble pack and interview was conducted with Licensed Vocational Nurse (LVN) 1. Resident 34's bubble pack for the AM dose of Midodrine was observed to have one tablet still present on the slot for February 21, 2025. LVN 1 stated, it looks like it got stuck in the bubble pack, LVN 1 stated, Midodrine should have been given to Resident 34 on February 21, 2025, at 8 a.m. On February 27, 2025, at 12:37 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON acknowledged the Midodrine HCL should have been administered according to the physician's order. A review of the facility's undated policy and procedure titled, Administering Medications, indicated, . Medications must be administered in accordance with the orders .the following information must be checked /verified for each resident prior to administering medications .vital signs .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50204 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled for eight consecutive hours in a 24-hour period on January 12, 2025. This failure had the potential to adversely affect oversight and direction regarding residents' quality of care and quality of life directly impacting overall health and well-being. Findings: On February 27, 2025, at 9:26 a.m., during a review of the Licensed Nurse Schedule, dated January 2025, indicated there was no RN coverage for January 12, 2025. A review of the facility's nursing staffing assignment and sign-in sheet indicated there was no RN coverage on January 12, 2025. On February 27, 2025, at 10:12 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated there was no RN scheduled to cover the facility on January 12, 2025. The DON stated there should have been RN coverage for January 12, 2025. The DON further stated an RN was essential for a higher level of expertise in assessing, planning, implementing and evaluating nursing care for residents. A review of facility's undated policy and procedure titled, Staffing Policy & Procedure, indicated, .Our facility provides adequate staffing to meet needed care and services for our resident population .Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. License nursing staff are available to provide and monitor the delivery of resident care services . A review of the undated facility's policy titled, Staffing Policy & Procedure, had no verbiage stating, a licensed registered nurse will be onsite at least eight consecutive hours a day, seven days a week to provide and monitor the delivery of resident care services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to implement infection control and prevention program when: 1. For one of three residents reviewed (Resident 12), the facility did not ensure the oxygen nasal cannula (a plastic device that delivers oxygen through a tube and into the nose) was stored in an appropriate container or bag when not in use; and 2. For 16 of 47 residents reviewed (Residents 2, 5, 6, 8, 13, 16, 20, 26, 28, 30, 31, 36, 39, 40, 46, and 47), annual TB (tuberculosis-a type of contagious respiratory infection) skin test (test used to diagnosed TB) was not conducted timely. These failures increased the potential for the spread of infection to an already medically compromised resident population of 47 residents. Findings: 1. On February 25, 2025, at 9:51 a.m., a concurrent observation and interview was conducted with Resident 12 in her room. Resident 12's oxygen cannula was placed inside an open white translucent unlabeled bag and was tied on an oxygen concentrator (medical device that delivers oxygen). In a concurrent interview, Resident 12 stated she used the plastic bag as her trash bag. Resident 12 further stated, I tossed my trash into the bag. On February 26, 2025, at 9:47 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2. Resident 12's oxygen cannula was placed inside the white translucent bag and was widely opened to air. LVN 2 stated the facility used similar plastic bags for oxygen tube storage and trash bag. LVN 2 stated, It could potentially misidentify a trash bag and not an oxygen bag. LVN 2 further stated, the plastic bag currently used to store Resident 12's nasal cannula should be changed with a better container bag to prevent infection. On February 27, 2025, Resident 12's record was reviewed. Resident 12 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (lung disease). A review of Resident 12's Minimum Data Set (MDS - a tool for assessment), dated March 6, 2024, indicated Resident 12 had a BIMS (Brief Interview for Mental Status - a tool used to assess cognition) score of 6 which indicated severe cognitive impairment. A review of Resident 12's Order Summary, included a physician's order, dated September 23, 2024, which indicated, .Administer oxygen @(at) 2-4L (Liter - unit of measurement) via (through) NC (nasal cannula) as needed related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE (lung disease) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 27, 2025, at 7:44 a.m., an interview with the Infection Preventionist (IP) was conducted. The IP stated the bag to store the nasal cannula for Resident 12 should have been replaced with a clear respiratory set up bag. The IP stated if the bag appeared similar to a trash bag, there could be a possibility a resident would put trash in the bag and contaminate the oxygen cannula inside the bag. On February 27, 2025, at 7:44 a.m., during an interview with the Director of Nursing (DON), the DON stated she expected for all nurses to follow the policy of the infection control program. The DON stated the oxygen cannula should have been stored in an appropriate respiratory bag and should not been left open to air to prevent contamination. A review of facility's undated policy and procedure titled, Respiratory Care-Prevention of infection Policy & procedure, indicated, .The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff .Infection Control Considerations Related to Oxygen Administration .Keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when not in use .store .in plastic bag .marked with date and residents name . 2. On February 26, 2025, at 2:20 p.m., a concurrent interview and record review with the IP was conducted. The IP stated he conducted surveillance of all immunizations which included influenza (a highly contagious respiratory illness), pneumonia (lung disease) and TB test. The IP stated the process of administering TB test included a two-step TB skin test to be administered upon admission of a resident. The IP further stated, for long term residents, an one-step TB skin test would be administered annually thereafter. During a concurrent resident's record review and the facility's Immunization Report, with the IP, the following were found: - Resident 2, Step 1 TB test administered on March 18, 2023, missing TB test for 2024; - Resident 5, Step 2 TB test administered on July 21, 2023, missing TB test for 2024; - Resident 6, Step 1 TB test administered on March 18, 2023, missing TB test for 2024; - Resident 8, Step 1 TB Test administered on August 15, 2023, missing TB test for 2024; - Resident 13, Step 1 TB test administered on September 27, 2023, missing TB test for 2024; - Resident 16, Step 2 TB test administered on March 23, 2023, missing TB test for 2024; - Resident 20, Step 1 TB test administered on September 13, 2022, missing TB test for 2023 and 2024; - Resident 26, Step 1 TB test administered on May 1, 2023, missing TB test for 2024; - Resident 28, Step 1 TB test administered on March 31, 2022, missing TB test for 2023 and 2024; - Resident 30, Step 1 TB test administered on December 12, 2023, missing TB test for 2024; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 31, Step 1 TB test administered on December 12, 2022, missing TB test for 2023 and 2024; - Resident 36, Step 2 TB test administered on February 2, 2024, missing TB test for 2025; - Resident 39, Step 2 TB test administered on December 2, 2022, missing TB test for 2023 and 2024; - Resident 40, Step 2 TB test administered on February 2, 2024, missing TB test for 2025; - Resident 46, Step 1 TB test administered on May 19, 2023, missing TB test for 2024; and - Resident 47, Step 2 TB test administered on June 23, 2023, missing TB test for 2024. In a concurrent interview, the IP stated there was no documentation in the electronic medication administration record (eMAR) of Residents 2, 5, 6, 8, 13, 16, 20, 26, 28, 30, 31, 36, 39, 40, 46, and 47 received the required TB skin test as ordered. The IP stated the TB skin test was required to all residents to screen and make sure they were not exposed or had active TB disease. The IP stated TB test should have been administered as part of the screening and prevention of tuberculosis infection. The IP further stated, If not tested , TB infection would spread like a wildfire and facility would have a TB outbreak. On February 27, 2025, at 7:41 a.m., an interview was conducted with the DON. The DON stated she expected the IP and the nurses to follow facility's infection control program in TB screening and infection prevention. The DON stated the nurses should have administered the TB test and should have followed the schedule of administration of TB skin test upon admission and annually to the residents. A review of facility's undated policy and procedure titled, Screening Residents for Tuberculosis Policy & Procedure, indicated, .This facility shall screen all residents for tuberculosis infection and disease (TB) . admission and readmission for information regarding exposure to, or symptoms of TB and will check results of recent (within 12 months) tuberculin skin tests (TST) .or chest X-rays .Any resident without documented TST .within the previous 12 months will receive a baseline (two-step) TST or (one step) .upon admission .If the first TST is negative, a follow up TST will be administered 1 to 3 weeks after the initial test is read . Screening of new admissions or readmissions for Tuberculosis infection and disease will be in compliance with State regulations .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 41459 Based on observation, interview, and record review, the facility failed to ensure the required 80 square feet for each resident was met, for 6 of 25 resident bedrooms (Rooms 1, 9, 11, 12, 14 and 26). This failure had the potential to limit the movements of the residents in their rooms, potentially affecting their health and safety. Findings: On February 24, 2025, at 1:08 p.m., during the entrance conference, the Administrator (ADM) was interviewed regarding the room sizes for resident rooms 1, 9, 11, 12, 14 and 26. The ADM acknowledged the rooms did not meet the space requirement of at least 80 square feet per resident in the above-mentioned rooms. Rooms 1, 9, 11, 12, 14, and 26 had been set up as two-bed bedrooms. The facility document titled, Client Accommodations Analysis, undated, was provided by the ADM. The document indicated the rooms set up as two-bed bedrooms measured 143 square feet or 71.5 square feet per resident (143/2 = 71.5). During the survey dates of February 24, 25, 26, and 27, 2025, the above listed rooms were observed at different times of the day. All care and services provided to the residents residing in the listed rooms were able to be conducted without restrictions. Residents who were able to be interviewed stated they were comfortable in the space provided. Health record reviews did not indicate the health and safety of the residents residing in these rooms were compromised, based on the room measurements. The facility requested a continued waiver for Rooms 1, 9, 11, 12, 14, and 26. Approval of the waiver was recommended. Granting this waiver will not adversely affect the resident health and safety and is in accordance with the special needs of the residents. A review of the policy and procedure titled, Bedroom Policy and Procedure, undated, indicated, .bedrooms measure at least 80 squre feet (sq ft - a unit of measurement) of space per resident in double rooms, and at least 100 square feet of space in single rooms. (Note: Individual variations on this may be permitted by federal authorities if it is demonstrated that the variation is in accordance with special needs of the resident and will not adversely affect the resident's health and safety.) .