STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 27000 Based on observation, interview, and record review, the facility failed to provide care according to facility policy and procedures (P&P) when the nursing staff did not check the tube placement and/or residual volume before medication administration for three of three residents (Residents 10, 37, and 61) who were receiving medications via the gastrostomy tube (aka G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). The failure had the potential for complications related to enteral feeding such as aspiration (foreign material into the lungs) due to undetected tube displacement, nausea, vomiting, etc. Findings: a. During a medication administration observation on 1/27/25 at 10:02 a.m., Licensed Vocational Nurse (LVN) B was observed preparing a medication, doxazosin (medication to treat high blood pressure), for Resident 37. She crushed and diluted the medication with water. On 1/27/25 at 10:08 a.m., at the resident's bedside, LVN B was observed attaching the 60-milliliter (mL, unit of measurement) syringe to the resident's G-tube and pulling back on the plunger to see the residual volume, then she flushed the tube with about 30 mLs of water. After several minutes of manipulation to get the water to go down into the tube, LVN B poured the diluted medication into the tube. LVN B did not check the tube placement (to confirm the placement of the tube) before the medication administration. b. During a medication administration observation on 1/27/25 at 10:38 a.m., LVN B was observed preparing 5 medications for Resident 61. On 1/27/25 at 10:47 a.m., at Resident 61's bedside, LVN B was observed checking the residual volume but did not check the tube placement before the medication administration. During an interview on 1/27/25 at 10:55 a.m., when asked about the tube placement check before medication administration, LVN B stated, I just check residuals before medication administration. She stated she would not typically check the tube placement before medication administration. c. During a medication administration observation on 1/28/25 at 8:28 a.m. with RN C, she was observed preparing 2 medications for Resident 10. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at at 8:36 a.m., at the resident's bedside, RN C turned off the resident's feeding pump, attached the syringe to the resident's tube, added about 50 mLs of water into the syringe, then poured each diluted medication into the tube with flushing of water in between the medications. RN C did not check the tube placement and the residual volume before administering the medications. During an interview on 1/28/25 at 8:45 a.m., RN C was asked about checking the tube placement and the residual volume. She stated, We usually do placement check with 30cc of air using the stethoscope, and check the residual first before administration. She stated she got nervous and forgot to do it. During an interview with the Director of Nursing on 1/28/25 at 11:35 a.m., she stated nurses should check the tube placement by injecting air into the stomach and listening for the sound with the stethoscope, and checking the residual volume, before medication administration. A review of the facility's policy and procedures titled Administering Medications through an Enteral Tube, dated 11/2018, indicated the staff verify placement of feeding tube before medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 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. 27000 Based on observation, interview, and record review, the facility failed to ensure discontinued and unused controlled medications (medications that can be easily abused and are under strict government control) for three residents (65, 123, and 174) were promptly removed from one of three inspected medication carts. The failure had the potential for medication errors or loss/abuse of controlled medications. Findings: 1. During an inspection of the Station 1 medication cart with Licensed Vocational Nurse (LVN D) on 1/27/25 at 11:06 a.m., two opened bottles, one 180-milliliters (mL) and one 120-mL, of morphine (a potent narcotic medication for pain) 2 milligrams (mg) per mL for Resident 174 were identified in the locked compartment of the cart. The Controlled Drug Record (CDR or Count Sheet, an inventory sheet documenting the medication, count, date, time, amount given, the amount left, and the signature of the user) for each bottle was wrapped around the bottle with a rubber band. LVN D stated each bottle has zero count left, meaning the count on the CDR had zero (0) amount remaining but in reality there was some left-over amount in the bottle (an over-fill from the manufacturer). She stated the nursing staff did not count them during shift changes because the count on the CDRs was zero. She stated the bottles were supposed to be given to the DON for destruction. A review of two CDRs indicated one was zero'ed out on 1/14/24 (13 days before the survey); and the other reached zero count on 1/20/25 (7 days before the survey). On 1/28/25 at 1:12 p.m., at Station 1 medication cart with Registered Nurse C (RN C), the same two morphine bottles were observed inside the locked compartment of the cart. Further inspection of the bottles with RN C revealed the 180-mL bottle had about 12 mLs remaining; and the 120-mL bottle had about 10 mLs left. RN C verified this finding and stated they are there for the DON to pick up. 2. During the inspection of Station 1 medication cart on 1/28/25 at 1:12 p.m. with RN C also identified two blister cards (card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles or blisters) containing lacosamide (a controlled medication to treat seizures) 100 mg tablets. One had 30 tablets, and the other had 24 tablets. Their CDRs were wrapped around the cards. RN C stated they belonged to Resident 123 who left the facility. A review of Resident 123's clinical record indicated the resident requested to leave AMA [against medical advice] on 1/13/25 (or 15 days prior to the survey). 3. Inspection of the Station 1 medication cart with RN C on 1/28/25 at 1:18 p.m. also identified a bottle containing 8 tablets of lorazepam (a controlled medication to treat anxiety) 0.5 mg for Resident 65. RN C stated the lorazepam was discontinued. A review of Resident 65's clinical record indicated the lorazepam was discontinued on 1/14/25 (14 days before the survey). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 01/28/25 at 1:57 p.m., she stated the nursing staff should remove the excess morphine liquid for Resident 174 as soon as possible. Regarding those discontinued medications for residents 65 and 123, she stated they should be given to her immediately after discontinued, to prevent loss. A review of the facility's policy and procedures titled Controlled Substances, revised 4/2019, indicated, Empty or discontinued medication containers, must be discarded with two nurses or given to Director of Nursing for proper destruction, and continued in narcotic count until discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52080 Based on observation, interviews, and record review, the facility had a medication error rate of 13.79% when four medication errors occurred out of 29 opportunities during the medication administration observation for four out of nine residents (Residents 3, 8, 10, and 37). Resident 37 did not receive one medication as scheduled; Resident 8 received insulin with incorrect priming; and Residents 3 and 10 did not receive one medication as prescribed. The failures resulted in the residents not receiving the medications as prescribed and had the potential for complications of their medical conditions (such as high/low blood sugar or blood pressure). Findings: 1. During the medication administration observation on 1/27/25 at 10:02 a.m., Licensed Vocational Nurse B (LVN B) was observed preparing one medication, doxazosin (a medication to treat high blood pressure) for Resident 37. LVN B stated, I don't have chlorhexidine [an antiseptic mouthwash with broad-spectrum antimicrobial activity against bacteria, viruses, and fungi], will have to order from pharmacy. On 1/27/25 at 10:08 a.m., LVN B was observed going into Resident 37's room and informing the resident she did not have his mouthwash. During an interview on 1/27/25 at 10:59 a.m., LVN B confirmed the chlorhexidine was due this morning, but it was not available for administration. A review of Resident 37's clinical record indicated a physician's order, dated 7/29/2024, for chlorhexidine gluconate mouth/throat solution 0.12%, give 15 ml orally three times a day for oral care. The facility scheduled it to be administered at 9 a.m., 1 p.m., and 9 p.m. On 1/27/25 at 1:49 p.m., a review of Resident 37's January 2025 Medication Administration Record (MAR) indicated a 9 (meaning, Other/See Progress Notes) in the 1/27/25 9 a.m. entry for chlorhexidine administration. A review of the corresponding progress notes, charted by LVN B on 1/27/25 at 10:04 a.m., indicated: pending supply. A review of the facility's 4/2019 policy and procedures (P&P) titled Pharmacy Services Overview indicated, Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a medication administration observation on 1/27/25 at 12:08 p.m., with LVN D, she was observed preparing an insulin (medication to treat high blood sugar) injection for Resident 8. She stated the resident's blood sugar was 255. At the medication cart, LVN D removed Resident 37's Humalog Kwikpen (a pre-filled insulin pen containing a short acting insulin called insulin lispro) from the medication cart, cleaned the rubber seal (area connecting the insulin chamber to the needle), attached a needle on it, inverted the pen, and squeezed out some of the insulin drops. Then she removed the needle, cleaned the the rubber seal again, attached a second needle on the rubber seal, and then turned the dose dial to 8 units. On 1/27/25 at 12:13 p.m. LVN D was observed injecting the Humalog into Resident 8's left lower abdomen. During an interview on 1/27/25 at 12:15 p.m., LVN D stated she primed the insulin pen by placing a new needle, turning the dial to 1 unit, and pressing the pen to make sure it worked. Then she would take off the needle, put a new needle on, and turn the dial to the prescribed dose. She stated that is the way she has always done it, by making sure the pen works. A review of Resident 8's clinical record indicated a physician order, dated 12/11/2024, for insulin lispro solution, to inject per sliding scale (a set of instructions for administering insulin dosages based on specific blood glucose readings), to give 8 units for blood sugar between 251 - 300. During a follow-up interview with LVN D regarding insulin pen priming on 1/27/2025 at 2:21 p.m., she stated she learned only use one needle and to prime it (the needle) with 1 unit first to make sure the pen works before turning to the ordered dose. She verified she did not prime the insulin pen correctly before injecting it to Resident 8. During an interview on 01/28/25 at 11:35 a.m. conducted with the Director of Nursing (DON) regarding the priming of insulin pens, she stated to prime the needle before each medication administration. A review of the drug manufacturer's INSTRUCTIONS FOR USE HUMALOG ([NAME]-ma-log) KwikPen, dated 7/2023, indicated the following instructions for priming the pen: Prime before each injection, priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units . Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top . Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0' is seen in the Dose Window . Turn the Dose Knob to select the number of units you need to inject . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Administering Medications, dated 4/2019, indicated, insulin pen needles must be changed and primed between administration doses. 3. During the medication administration observation on 1/27/25 at 4:28 p.m., LVN E was observed administering two medications with water to Resident 3, one included metformin (used to treat diabetes) 1, 000 milligrams (mg, unit of measurement) tablet. On 1/27/25 at 4:32 p.m., in a concurrent interview with LVN E, and review of Resident 3's metformin medication, LVN E confirmed the prescription label indicated to give with meals. LVN E stated, We give the medication between 4 to 6 p.m., usually give it with snacks. She said the administration time varies each day. A review of Resident 3's clinical record indicated a physician order, dated 8/3/2024, for metformin 1,000 mg, give 1 tablet by mouth two times a day for diabetes administer with meal. On 1/27/25 at 5:01 p.m., a cart of meal trays was observed about 20 feet from Resident 3's room. The staff stated the cart was for downstairs residents as downstairs always get their meal trays first. This indicated, by 5:01 p.m. on that day (or 33 minutes after metformin administration), Resident 3 did not get his dinner yet. An interview and record review regarding the administration of Resident 3's metformin was conducted with the DON on 1/28/25 at 11:35 a.m. She explained medication ordered with meals means it should be given with a meal. She stated metformin is an irritant and can cause nausea so it should be given with a meal. A review of the Package Insert (provides detailed information of the drugs uses, contraindications, dosage ranges, side effects and how to administer the drug) for metformin indicated: Metformin should be given in divided doses with meals to reduce gastrointestinal side effects. A review of the facility's P&P titled Administering Medications, revised April 2019, indicated, Medications are administered within 1 hour of their prescribed time, unless otherwise specified (for example before and after meal orders). 4. On 1/28/2025 at 8:28 a.m., while preparing medications for Resident 10, registered nurse (RN) C stated she will hold the resident's amlodipine and lisinopril (medications used to treat high blood pressure or hypertension). She stated resident's blood pressure was 108/80 (the upper number is the systolic blood pressure, also known as SBP; the lower number is the diastolic blood pressure, also known as DBP). A review of Resident 10's clinical record indicated a physician's order, dated 11/6/2024, for amlodipine 10 mg, 1 tablet one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION HOLD FOR SBP <100. It was scheduled to be administered daily at 9 a.m. A review of the resident's January 2025 MAR indicated a 4 (4= vitals outside of parameters for administration) in the 1/28/2025 9 a.m. entry for amlodipine administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 11:25 a.m., during a follow up interview and concurrent record review with RN C, she confirmed holding both amlodipine and lisinopril for Resident 10. RN C confirmed the physician's order indicated to hold the amlodipine for SBP <100 while the resident's SBP was 108. She stated, .in general the hold for blood pressure is 110. An interview was conducted 1/28/2025 at 2:09 p.m. with the DON regarding the amlodipine hold parameters for Resident 10. The DON confirmed the hold parameter for amlodipine is to hold if blood pressure is less than 100. A review of the facility's P&P titled Administering Medications, revised April 2019, indicated, Medications are administered in accordance with prescriber orders, including any required time frame, vitals parameters .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50120 Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in a clean environment, within standards for safety when: 1. Floor drains were not maintained clean; 2. Kitchen tile floors were not clean and were not maintained in good repair; 3. Kitchen wall had an opening in the wall around the drain; 4. Kitchen backsplash, where dishes were cleaned, had food and black substance buildup; 5. A kitchen cleaning schedule was not maintained according to facility policy; 6. Frozen meat did not have date received, date placed in freezer, use by date, and expiration date; 7. Produce and food were not labeled with use by date and were not rotated with FIFO, First in-First out per facility policy; 8. Food in refrigerator had expired. These failures had the potential to result in contamination of food leading to food borne illness, for 69 residents who resided in the facility. Findings: During an observation on [DATE], at 9:30 a.m., in the kitchen, a drain cover over the floor drain in the middle of the dish room was not secured with tile, and there was black build up around the drain. The wall was exposed to wooden structure, the wall around the perimeter of the drain was open with a large gap, the backsplash behind the sink had buildup of black sludgy material, and the tile and flooring to the wall of the sink had missing grout with noted buildup of black substance and food particles. Tiles around the floor drain were loose and not attached. There were additional tiles around the floor that were broken off, had missing grout, and were collecting pools of water. There was separation from the wall and the floor tile with no grout, with a length of approximately 2 feet. The gap with no grouting had dark residue particles resembling food crumbs, and small pieces of debris collected in the area. There were loose wall tiles along the right and behind the area of the manual dish washing sink, which created a gap between the wall and the tiles. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE], at 9:30 a.m., with Certified Dietary Manager (CDM 1), there was exposed wood on the wall as the protective plastic molding against the lower part of the wall was missing. This area had a collection of dirt and debris with openings on the wall. CDM 1 stated a request had been put in to the Maintenance Director (MD) around one month ago to have this repaired, along with the other areas of missing grout and exposed walls. CDM 1 stated loose tiles and pooled water on the floor could harbor bacteria and was a safety hazard. During a concurrent interview and record review on [DATE], at 9:30 a.m., with MD, MD stated there was a maintenance log where staff put in maintenance requests. A review of the log indicated there was no request to repair the kitchen tile, flooring, and walls. During an interview on [DATE], at 10:04 a.m., with MD, MD stated there was no record of when a deep cleaning was last done in the kitchen. During an interview on [DATE], at 11:01 a.m., with the Janitor, CDM 1 and MD, Janitor stated it was difficult to do a deep cleaning when the surfaces were not maintained. The Janitor stated the area with missing grout and tile could collect food and dirt and develop mold if the sealant was not maintained. During an observation on [DATE], at 9:45 a.m., in the kitchen, Refrigerator #1 contained a bag of turkey slices covered in plastic with expiration date [DATE] and a jar of jelly with expiration date of [DATE]. During an observation on [DATE], at 10:15 a.m., in the kitchen, Freezer 1 had five bags of five pounds of ground beef and seven bags of 12 chicken breasts per bag, with no date when the ground beef and chicken breasts were received, no use by dates, and no expiration dates. During an observation on [DATE], at 11 a.m., the facility received a large order of onions. During an observation on [DATE], at 10:15 a.m., in the storage room, onions received on [DATE] were in a box labeled [DATE]. During an interview on [DATE], at 10:31 a.m., with the Dietary Manager (DM 1) and Cook, [NAME] stated that onions were received on [DATE] and were put in the box with the older onions. The box had a date of [DATE]. DM 1 stated the onions should have been placed in a box with the date they were received, and the onions from the previous shipment should have been placed in a box on top of the box of new onions. The [NAME] stated the new onions should have been put in a separate container with the date of delivery posted on the container. During a concurrent observation and interview on [DATE], at 10:30 a.m., in the storage pantry, with CDM 1, clear containers containing large loose black items were on a cupboard shelf with no open, use by or expiration dates on the containers. CDM 1 stated they were unwrapped raisins. DM 1 stated the raisins needed to be disposed of as they may be contaminated. During an interview on [DATE], at 9:46 a.m., with CDM 1, CDM 1 stated not having received and use by dates on food put residents at risk for acquiring a food borne illness. CDM 1 stated exposed openings in the area where dishes were cleaned made the area susceptible to food and mold build up and made it difficult to sanitize and clean the area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the policy and procedure (P&P) titled, Sanitation and Infection Control subject cleaning schedules, dated 2023, best practice would include a deep cleaning in the kitchen by an outside cleaning agency quarterly. Cleaning schedules should include drains and walls weekly. During a review of the facility's P&P titled, For food purchasing receiving and production, subject receiving food, dated 2023, expiration dates will be checked on predated packages to ensure food and beverages are not expired. Items not predated will be labeled with the date received to ensure FIFO first in and first out. During a review of the facility's P&P titled, Sanitation and infection control, subject, canned and dry food storage, dated 2023, new stock must be placed behind the old stock so that the oldest items will be used first. Product should be dated to assure FIFO - first in and first out. During a review of the P&P titled, Sanitation, and Infection Control, subject for your freezer storage, dated 2023, frozen foods should be labeled with a date it was placed in the freezer. According to the 2022 Federal Food Code, floors and floor coverings are to be constructed so they are smooth and easily cleanable. In addition, when cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures are to be coved and closed to no larger than 1 mm (millimeter). If water flush cleaning methods are used, wall junctures are to be coved and sealed. According to the 2022 Federal Food Code Annex, pooling liquid wastes could attract pests such as insects and rodents or contribute to problems with certain pathogens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 27000 Based on observation, interview, and record review, the facility failed to observe proper infection control practices when: 1. A nursing staff failed to perform hand hygiene after touching potentially contaminated surfaces during the medication administration; 2. A nursing staff touched and opened two medication capsules with bare hands; 3. A nursing staff failed to observe the enhanced barrier precautions (EBP) as per facility policy and procedures (P&P) for two residents (Residents 37 and 61) during the medication administration; These failures had the potential for Residents 37, 54 and 61 to be placed at risk for infections. Findings: 1. During a medication administration observation with Registered Nurse (RN) A on 1/27/25, at 9:29 a.m., RN A was observed preparing two medications, which was put in a small medication cup, for Resident 54. On 1/27/25, at 9:40 a.m., RN A placed the medication cup along with a cup of juice in a medication tray, brought it to Resident 54's bedside, and placed it on the resident's table. Then, with her gloved hands, she moved the resident's wheel chair out of the way. Next, she looked to the bed's remote control cable that was found disconnected and lying on the floor. She connected it to the resident's bed and pressed on the remote to raise the head of the bed while the resident was lying in it. Then, without changing gloves and performing hand hygiene, she picked up the medication cup and handed to the resident to take. She did the same with the juice cup. During an interview on 1/27/25, at 9:48 a.m., RN A confirmed she touched the resident's wheel chair, the bed remote control cable, and the remote control itself with gloved hands, and stated she should have changed her gloves and performed hand hygiene before proceeding with the medication administration. She acknowledged those were potentially contaminated surfaces and had potential for the spreading of infections. 2. During a medication administration observation on 1/27/25, at 10:35 a.m., Licensed Vocational Nurse (LVN) B was observed preparing five medications for Resident 61, who received medications via the gastrostomy tube (also called a G-tube; a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). The medications included two capsules of gabapentin (medication to treat nerve pain) 100 milligrams (mg, unit of measurement). Without donning gloves, LVN B was observed picking up each capsule with her bare hands and opening them to pour the powder contents into a medication cup. During an interview on 1/27/25, at 10:55 a.m., when asked about opening the gabapentin capsules with bare hands, LVN B stated, I should have worn gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Post Acute	3269 D Street Hayward, CA 94541

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 1/28/25, at 11:35 a.m., she stated nurses should avoid touching medications with their hands; and they are supposed to wear gloves when opening capsules. A review of the facility's P&P titled, Administering Medications, revised 4/2019, indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 3. On 1/27/25, at 10:11 a.m., LVN B was observed administering a medication to Resident 37 via the G-tube. On 1/27/25, at 10:35 a.m., LVN B was observed administering five medications to Resident 61 via the G-tube. Resident 37 and Resident 61 were roommates. During the medication administration for both residents, LVN B was observed wearing a facial mask and gloves while administering the medications, but she did not wear a protective gown. A large orange/reddish poster was observed outside the residents' room, which read: STOP. ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS and STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities . Device care or use: central line, urinary catheter, feeding tube . During an interview with LVN B on 1/27/25, at 10:55 a.m., when asked about wearing personal protective equipment (PPE) while administering medications to Residents 37 and 61, LVN B stated she was supposed to gown up during care such as a wound treatment, but for med pass, I am not quite sure on that. During an interview with the DON on 1/28/25, at 11:35 a.m., she stated the nursing staff need to protect the residents from external infections by donning full PPE including a mask, gown, and gloves while providing care such as wound treatment and G-tube administration. 49498 During a review of facility's P&P titled, Enhanced Barrier Precaution, dated 6/18/24, the P&P indicated, EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with chronic wounds or indwelling medical devices) .'High-Contact Resident Care Activities' include . Device care or use . feeding tube . Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.