STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A264	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Pacifica Center	3674 Pacific Avenue Jurupa Valley, CA 92509

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 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** 46509 Based on interview and record review, the facility failed to ensure, for one of three residents sampled (Resident A) did not receive candy infused with cannabis (dried leaves and flowering tops of the Cannabis sativa or Cannabis indica plant which contains active chemicals that cause drug-like effects all through the body) while at facility. This failure had the potential to cause untoward effects of the cannabis to Resident A's overall health and mental condition. Findings: On August 13, 2024, at 11:00 a.m., an unannounced investigation was conducted at the facility for a complaint of resident abuse and quality of care. On August 13, 2024, at 1:30 p.m., an interview was conducted with Program Counselor (PC) 1. PC 1 stated staff donate candy to the facility on a regular basis, the counseling program would collect the candies, and would give out the candy as a reward to the residents. PC 1 stated some canabis infused candies which contained THC (the substance primarily responsible for the effects of marijuana on a person's mental state and gives a high) were mixed in with the regular candies about two weeks ago. PC 1 stated Resident A came to the counselor ' s department, after he received his candy, and Resident A told them that he felt loose, odd. PC 1 stated Resident A did not have drug seeking behaviors and had no history of drug use. PC 1 stated Resident A was the resident who got the candy with cannabis in it. PC 1 stated once we were aware there was candy with cannabis in it, we contacted the Program Director (PD) and the Director of Nursing (DON) and threw away the entire batch of candy to ensure, no one else got the cannabis infused candy. On August 13, 2024, at 1:55 p.m. an interview was conducted with Resident A. Resident A stated he did get candy that made him sick, it was a candy gummy which contained cannabis, and it made him feel weird. Resident A stated he knew the candy had cannabis in it because the label on the package stated it contained cannabis,. Resident A stated never had cannabis before eating the candy, he ate half of the candy in the bag, and it tasted a little weird. Resident A stated the counselors would give out candy to all the residents who turn in the attendance sheets for group each week, and could pick the candy they wanted. Resident A stated he told PC 1 about the candy, another counselor told Resident A he did not have to attend groups the rest of the day. Resident A stated after he ate the candy no one evaluated him. Resident A stated he was nauseous and felt he might throw up, felt mostly sweaty, and went to his room to lay down. (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: 05A264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Vista Pacifica Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3674 Pacific Avenue Jurupa Valley, CA 92509	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 13, 2024, at 2:40 p.m., an interview was conducted with PC 2. PC 2 stated the counselors give candy out to the residents for participating in group activities, their attendance, and answering questions. PC 2 stated counselors bring in candy and donate it, someone received candy with cannabis in it. PC 2 stated Resident A came to the counselors and stated the candy Resident A received had cannabis in it. PC 2 stated label on the package stated the candy had cannabis in it. PC 2 stated one of the counselors on the unit had brought in the cannabis infused candy. PC 2 stated he spoke with Resident A and Resident A said he did not share the candies with other residents. PC 2 stated we informed our Assistant Program Director (APD) and Program Director (PD) what had happened and a full unit search was conducted and did not find anything. PC 2 stated it was recommended for Resident A to go to his room and rest. PC 2 stated Resident A was not sent out for an evaluation. On August 13, 2023, at 3:02 p.m., an interview was conducted with the Assistant Program Director (APD). The APD stated there was no policy regarding outside candy being brought into the facility. The APD stated there was absolutely no tolerance for bringing in outside drugs, and the staff was aware of this. On August 13, 2023, at 3:25 p.m., an interview was conducted with PC 3. PC 3 stated she was not aware the candies she had brought in from home contained cannabis. PC 3 stated her partner had put the candy in a bag, she took the candy to work, and put them in the candy bowl for the resident to take as a reward. PC 3 stated Resident A came to her and told her about the candy with cannabis and gave her the package, she reviewed the candy label and it stated there was 600 mg (milligrams-a unit of measure) total of cannabis in the bag. PC 3 stated the bag contained six candies, making each candy containe 100 mg each of cannabis. PC 3 stated Resident A took four of the cannabis infused candies as there was still two candies left in the package. On August 13, 2024, at 6:10 p.m., an inerview was conducted with the Program Director (PD). The PD stated after the incident occurred, PC 3 came to her office and told her about the candy with cannabis in it. The PD stated she went to the DON, and both of them went to the Administrator ' s (Admin) office and explained the situation. On August 13, 2024, a review of Resident A ' s medical record was conducted. Resident A's Admission Record, indicated Resident A was admitted to the facility on [DATE], with a diagnosis of schizophrenia (a mental and behavioral disorder). Resident A ' s Order Summary Report, included physician's order for multiple medications for hallucinations (false thoughts of experience affecting your senses) and delusions (a false belief about external reality). Further review of Resident A ' s medical record did not provide any documentation regarding an incident in which Resident A ate cannabis infused candy, nor monitoring of Resident A after eating the cannabis infused candy, brought in by a staff member. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 14, 2024, at 9:18 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated one of the counselors brought in some candy with cannabis in it, a resident took it, and self-reported. The DON stated the nurses took vital signs (temperature, pulse rate, blood pressure and respiratory count) on Resident A and were normal. The DON stated Resident A had no obvious complication from the ingestion of the cannabis candy. The DON stated all unusual occurrences should be reported to the state, a staff member bringing in cannabis would be considered an unusual occurrence, it was not reported to the state. The DON stated we do not have a protocol when a resident was under the influence of an illegal substance, however we would monitor the resident's vital signs every two hours, and document in the resident's health record. The DON stated there was not an evaluation completed on Resident A, there was no documentation of the incident, no change of condition was written, and there was no incident report done on Resident A. The DON stated Resident A did take cannabis that was not prescribed by the physician, the nurses informed the doctor and should have written a note in the chart. The DON stated Resident A was monitored through the end of the shift, every two hours, for about six hours. The DON stated no testing was required for Resident A if he had cannabis. The DON stated she believed all the staff, have training on how to deal with a resident under the influence of a substance, after she was informed of the incident the nurses took care of the resident, and nothing else after that. A review of the facility ' s policy and procedure titled Resident Drug Testing Procedure, dated December 5, 2017, indicated, .to create and maintain a working environment free from substance abuse that could result in safety and health hazards to the residents .the following residents will receive an in-house urine drug screen: Resident ' s .who are suspected of having used illegal substances . A review of the facility ' s undated policy and procedure titled Report Abuse & Unlawful Conduct to State Agencies and Other Entities/Individuals, indicated .All suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate agencies and other entities or individuals as may be required by law .Should an alleged/suspected violation or substantiated incident .which affects the welfare, safety, or health of resident .notify the following persons or agencies .of such incident .state licensing/certification agency responsible for surveying/licensing the facility . A review of the facility ' s policy and procedure titled Reporting a Change in Condition, dated April 22, 2024, indicated, .A change of condition in a resident can adversely affect his/her medical and psychological status, therefore all significant changes in condition are to be reported .The Director of Nursing will ensure that proper follow up .will be accomplished in a timely manner to ensure the health and safety to all residents .A change of condition will be completed by the charge nurse in the unit when the change of condition was first noted .she will gather .vital signs, do a complete assessment, mental status as well as physical status . document in the medical record the resident ' s change of condition and any new orders received . A review of the facility ' s undated policy and procedure titled Outside Food-Beverage, indicated, .foods and beverages brought from outside facility are to be examined by nurse for quality (.packaging) to identify potential concerns .