

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 04/21/2025
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on interview and record review, the facility failed, for one of five sampled residents (Resident 1) to notify Resident 1's representative (conservator) following an incident involving contraband (a metal fork) found in the resident's room.</p> <p>This failure had the potential to exclude the resident's representative from being involved in the care planning and decision-making regarding resident's safety and psychosocial status.</p> <p>Findings:</p> <p>A review of Resident 1's medical records, titled, Resident Information, dated, April 8, 2025, at 9:38 p.m., indicated, resident was admitted to the facility on [DATE], with a diagnosis of unspecified Schizophrenia (a mental health disorder that affects thoughts, feelings and behaviors, characterized by a disconnection from reality, including delusions, hallucinations).</p> <p>A review of Resident 1's Minimum Data Set (an assessment tool) indicated, Resident 1 had a Brief Interview of Mental Status (cognitive assessment) score of 09 out of 15 (moderate cognitive impairment).</p> <p>A review of Resident 1's Progress notes, dated, April 2, 2025, at 8:50 a.m., by Program Counselor (PC) 1, indicated, . At approximately 8:30 A.M. staff conducting a routine room check found a metal fork in (Resident 1's) room, which is considered contraband per unit policy. Staff retrieved the (fork) . (resident) was informed of the unit rules regarding (no) unauthorized items (on the unit). (PC 2) to follow up with 1:1 (one to one) counseling to reinforce unit expectations and discuss appropriate alternatives .</p> <p>A further review of Resident 1's progress notes, indicated, there was no documentation that Resident 1's representative had been notified of the incident.</p> <p>On April 8, 2025, at 1:57 p.m., an interview was conducted with PC 1, who stated, the PC were expected to notify the resident's representative when contraband was found. PC 1 stated, she did not make the notification, believing PC 2 would notify the resident's representative.</p> <p>(continued on next page)</p>		

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of Resident 1's Progress notes, dated, April 2, 2025, at 9:20 a.m., by PC 2, indicated, . PC met with the resident to discuss the report of the resident hiding a metal fork under his mattress. When asked about the report, (Resident 1) stated, I forgot I had it . PC encouraged (resident) to seek staff assistance when he feels unsafe . PC will continue to monitor (behavior), and interventions as needed .</p> <p>On April 9, 2025, at 1:10 p.m., an interview was conducted with PC 2, who stated, he spoke with Resident 1 about the incident where a contraband was found in the resident's room. PC 2 stated he did not notify the resident's representative and he should have done so.</p> <p>On April 9, 2025, at 1:35 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON), the DON stated, the facility policy required staff to notify the resident's representative when contraband was found. The DON stated, Resident 1's representative was not notified after the incident on April 2, 2025.</p> <p>On April 9, 2025, at 2:55 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1, who stated, when a resident was found with contraband, LVN was to notify the resident's representative. LVN 1 stated, she was the charge nurse on April 2, 2025, when she was informed by PC 1, resident was found with contraband. LVN 1 stated, she did not notify Resident 1's representative, because she thought this was an on-going issue, and did not realize the incident had just happened. LVN 1 stated, she should have notified Resident 1's representative.</p> <p>A facility policy, titled, Change in a Resident's Condition or Status, revised, December 2008, indicated, . Policy Statement: Our facility shall promptly notify the resident . representative . of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care . resident rights, etc.). Policy Interpretation and Implementation . 2. A significant change' of condition is a decline . in the resident's status that: a. Will not normally resolve itself without intervention by staff . c. Requires interdisciplinary review and/or revision to the care plan . 3. Unless otherwise instructed by the resident, the (Facility) will notify the resident's family or representative . when: . b. There is a significant change in the resident's physical, mental, or psychosocial status .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on interview and record review, the facility failed to revise the care plan and implement appropriate interventions for one of five sampled residents (Resident 1) after the resident was found with contraband (a metal fork) under his mattress.</p> <p>This failure had the potential for Resident 1 to retain or collect additional contraband without staff knowledge, placing the resident and others at risk for harm.</p> <p>Findings:</p> <p>A review of Resident 1's medical records, titled, Resident Information, dated, April 8, 2025, at 9:38 p.m., indicated, resident was admitted to the facility on [DATE], with a diagnosis of unspecified Schizophrenia (a mental health disorder that affects thoughts, feelings and behaviors, characterized by a disconnection from reality, including delusions, hallucinations). Further review indicated a Brief Interview of Mental Status ((BIMS)-cognitive assessment) score of 09 out of 15 (moderate cognitive impairment).</p> <p>A review of Resident 1's progress notes, dated April 2, 2025, at 8:50 a.m., by Program Counselor (PC) 1, indicated, . At approximately 8:30 A.M. staff conducting a routine room check found a metal fork in (Resident 1's) room, which is considered contraband per unit policy. Staff retrieved the (fork) . (resident) was informed of the unit rules regarding (no) unauthorized items (on the unit). (PC 2) to follow up with 1:1 (one to one) counseling to reinforce unit expectations and discuss appropriate alternatives .</p> <p>A review of Resident 1's care plan titled, Inappropriate Behavior . as evidenced by . (Resident 1) taking a metal fork from dining and leaving it in his room . initiated April 2, 2025, by PC 1, indicated, no behavioral interventions to help prevent resident from taking contraband out of the dining room.</p> <p>On April 8, 2025, at 1:57 p.m., an interview was conducted with PC 1, who stated, when a resident is found with contraband in their room a care plan is updated and/or initiated. PC 1 stated, on (April 2, 2025, at approximately 8:30 a.m.) she was notified by unit staff, a fork was found under Resident 1's mattress, during room checks. PC stated, staff removed the fork from resident's room, PC followed-up with Resident 1, and resident stated he did not remember how the fork got under his mattress. PC stated, she reviewed the unit rules of no contraband with resident, notified Resident 1's assigned Program Counselor (PC 2), other appropriate staff and documented the incident in resident's progress notes. PC stated, she and unit staff discussed starting the new intervention of checking Resident 1 for contraband after meals/prior to leaving the dining room. PC 1 verified, she did update Resident 1's care plan, titled, Inappropriate Behaviors, on April 2, 2025, . As Evidenced by (Resident 1) taking a fork from dining and leaving in his room . PC 1 verified, she did not add the intervention to check Resident 1 for contraband after meals, because she was not Resident 1's assigned PC, stating (PC 2) is (Resident 1's) assigned PC and responsible to add interventions to (resident's) care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On April 8, 2025, at 2:10 p.m., a concurrent interview and record review, the Director of Nursing (DON) stated that no new interventions were added to Resident 1's care plan following the incident, and they should have been. The DON stated, appropriate interventions would include using plastic utensils and searching the resident for contraband after meals. The DON verified, new behavioral interventions to help prevent Resident 1 from taking contraband out of the dining room was not included in Resident 1's care plan, and should have been added by a PC or Nurse.</p> <p>On April 8, 2025, at 2:40 p.m., an interview was conducted with Mental Health Worker (MHW) 1, who stated, she was aware Resident 1 was using plastic utensils but was not aware that the resident should be searched for contraband after meals.</p> <p>On April 8, 2025, at 2:45 p.m., an interview was conducted with MHW 2, who stated, he did not know Resident 1 was to be searched for contraband, prior to leaving the dining room.</p> <p>A facility policy, titled, Care Plans - Comprehensive, revised, August 2007, indicated, . Policy Statement: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 3. Each resident's . Care Plan has been designed to: a. Incorporate identified problem areas: b. Incorporate risk factors associated with identified problems; . d. Reflect treatment goals and objectives in measurable outcomes; . f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels . 5. Care plans are revised as changes in the resident's condition dictate .</p>		