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	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Pacifica Center	3674 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on observation, interview, and record review, the facility failed to provide a safe accident-free environment when the facility did not offer a smoking apron during smoking break for one of two residents (Resident 10). This failure had increased the potential for the resident to experience accidents and injury while smoking. Findings: A review of Resident 10's Admission Record indicated, Resident 10 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a mental disorder), legal blindness, acquired absence of upper limb below elbow. A review of Resident 10's Minimum Data Set (an assessment tool), dated April 9, 2025, indicated a Brief Interview of Mental Status (a short, structured test used to assess cognitive status) score of 4 (cognitively impaired). A review of Resident 10's SMOKING ASSESSMENT, dated April 28, 2025, indicated, .SAFETY .RESIDENT NEED FOR ADAPTIVE EQUIPMENT .Smoking apron .Team Decision .Safe to smoke with supervision . Uses smoking apron . A review of Resident 10's Care Plan, revised dated August 19, 2021, indicated, .Risk for injury r/t (related to) smoking .Intervention .Offer smoking apron during smoking breaks . On April 30, 2025, at 8:30 a.m., during a smoking observation on the North smoking patio, Mental Health Counselor (MHC) 1 lit a cigarette for Resident 10. Resident 10 was not wearing a smoking apron and not offered one. On April 30, 2025, at 8:45 a.m., during an interview with MHC 1, MHC 1 stated, Resident 10 had not been offered a smoking apron. MHC 1 stated an apron should have been offered and further stated, the use of a smoking apron can help prevent accidental burns or injuries while smoking. A review of the facility policy and procedure titled, Resident Smoking, dated April 2024, indicated, To provide the safest means known for residents who smoke .Smoking Aprons .when appropriate .

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25281 Based on observation, interview, and record review, the facility failed to ensure medications were administered as prescribed and used appropriately to meet the needs of the resident when: 1. One injectable antipsychotic medication (used to manage schizophrenia symptoms such as delusions, hallucinations, paranoia, and/or altered sense of reality) was not administered every 28 days as prescribed by the physician and per manufacturer's prescribing information. 2. One Oral Emergency Ekit did not have an accurate expiration date on the outside of the kit. These failures had the potential for residents to receive ineffective or excessive medication therapy. Findings: 1. On May 1, 2025, Resident 46's medical record was reviewed, and the following was noted: Resident 46 was a [AGE] year-old, who was admitted to the facility on [DATE], with diagnoses that included schizophrenia (thought disorder that includes hallucination, delusion, paranoia, and altered sense of reality). There were physician orders for Invega Sustenna (long-acting injectable antipsychotic medication to manage symptoms of schizophrenia), and Haldol Decanoate (long-acting injectable antipsychotic medication to manage symptoms of schizophrenia) as follows: Invega Sustenna Prefilled Syringe 234 mg/1.5 ml (milligram per milliliter - unit of measurement) with the direction to inject intramuscularly (into muscle tissue) once on the 23rd day of every month for delusions/hallucinations related to schizophrenia, ordered on September 23, 2024, and discontinued on February 25, 2025; Invega Sustenna Prefilled Syringe 234 mg/1.5 ml with the direction to inject intramuscularly once every 28 days for delusions/hallucinations related to schizophrenia, ordered March 16, 2025, and discontinued on March 18, 2025; Invega Sustenna Prefilled Syringe 234 mg/1.5 ml with the direction to inject intramuscularly once every 28 days for delusions/hallucinations related to schizophrenia, ordered on April 7, 2025, and currently active; Haldol Decanoate 150 mg/ml with the direction to inject intramuscularly once every 28 days for delusions/hallucinations related to schizophrenia, ordered on September 9, 2024, and currently active; and Resident 46's medication administration record (MAR) indicated one dose of Invega Sustenna was given on February 23, 2025, March 16, 2025, and April 7, 2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March dose of Invega Sustenna was given 21 days after the February dose (7 days earlier than prescribed by the physician). The April dose of Invega Sustenna was given 22 days after the March dose (6 days earlier than prescribed by the physician). On May 5, 2025, at 10:40 a.m., during an interview, the pharmacist from the dispensing pharmacy (RPH 1) stated, after reviewing Resident 46's record, agreed the medication was administered earlier than prescribed. RPH 1 stated the Invega Sustenna doses were administered sooner than recommended by the manufacturer. On May 5, 2025, at 11:30 a.m., during an interview, the Director of Nursing (DON) stated Resident 46 was on two long-acting injectable antipsychotics ([NAME] APs) and the physician wanted to stagger the [NAME] APs two weeks apart over the period of few doses. On May 5, 2025, at 1 p.m., during an interview, the Medical Director (MD) stated the reason for two [NAME] APs to be spaced two weeks apart could be to potentially prevent wearing off of the [NAME] APs to towards the last few days of the dosing interval if given together and by staggering one [NAME] AP would still provide steady dosing effect even if the effect from the other [NAME] AP wore off. However, the MD stated the staggering of two [NAME] APs two weeks apart did not make a significant difference. The MD stated it would not be okay to extend and/or shorten the dosing interval of two [NAME] APs over a period in the attempt to stagger the two drugs two week apart. On May 5, 2025, review of Resident 46's medical record indicated there was a physician order to administer two [NAME] APs two weeks apart. On May 5, 2025, at 1:30 p.m., during an interview, the Consultant Pharmacist (CP) stated there was no published data which supported the use of two [NAME] APs in such a way that they were administered two weeks apart from each other. The prescribing information for Invega Sustenna, provided by the facility, indicated: .After the recommended initiation regimen of Invega Sustenna, the third and subsequent injections are recommended to be given monthly. To avoid a missed monthly dose, patients may be given the injection upto 7 days before or after the monthly time point. However, this does not imply that the dosing interval can be changed to 3 or 5-week cycle There are no data from clinical trials to support the routine administration of Invega Sustenna maintenance doses at intervals shorter or longer than 4 weeks . The facility's policy and procedure titled, Administration of Medications and Treatments, last revised, April 18, 2024, was reviewed, and it indicated: .Medications and treatments shall be administered as prescribed . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On April 29, 2025, at 9:30 a.m., during an inspection of Emergency Kits (a sealed container of various medications for use in emergencies) located in the Northside Nursing Station, it was noted the expiration written on the outside of the Oral Emergency Kit was July 2025. The inspection of the content of the Oral Emergency Kit indicated there were four tablets of doxycycline (antibiotic for infection) 100 mg with the expiration date of June 2025. During a concurrent interview, LVN 10 confirmed the expiration date of doxycycline 100 mg tablets and agreed the expiration date on the outside of the Oral Emergency Kit was not correct. The facility's policy and procedure titled, Emergency Pharmacy and Emergency Kits, undated, was reviewed, and it indicated: .The [Emergency] Kits are inventoried by the provider pharmacy at monthly for completeness and expiration dating of the contents. The date of earliest expiring medication is noted on the outside of the kit .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 25281 Based on observation, interview, and document review, the facility failed to ensure proper storage of one medication in accordance with manufacturer's specifications by not protecting it from light. This failure had the potential for one resident to receive ineffective medication therapy. Findings: On April 30, 2025, at 10:25 a.m., during an inspection of the Medication Cart A located in Southside Nursing Station, it was noted there were four ipratropium/albuterol (medication used to open airways in lungs to help breathing) 0.5/3 mg (milligram - unit of measurement) unit dose inhalation solution vials, which belonged to Resident 47, stored outside the original manufacturer's foil pouch. During a concurrent interview and review of the manufacturer's storage instruction, LVN 11 acknowledged the unit dose vials should have remained in the foil pouch to protect from light. The manufacturer of ipratropium/albuterol 0.5/3 mg indicated, Protect from light. Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week . The facility's policy and procedure titled, Storage of Medications, last revised, January 2018, was reviewed, and it indicated: .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44505 Based on observation, interview, and record review, the facility failed to ensure dietary staff were able to carry out the functions of food and nutrition services safely and effectively when: 1. Two Dietary staff were unable to demonstrate the correct concentration for the red bucket sanitizer solution. 2. One Dietary staff did not wear gloves while sanitizing the food preparation table. 3. Four Dietary Staff could not demonstrate the proper procedure for testing dish sanitization. These failures had the potential to cause food borne illness (stomach illness acquired from ingesting contaminated food) to the residents in the facility. Findings: 1. On April 29, 2025, at 1:12 p.m., a concurrent observation and interview were conducted with the [NAME] (CK). The CK was observed demonstrating how to prepare the bleach sanitizer solution for the red bucket. The CK placed water in the red bucket, and stated the ratio was approximately two quarts of water to one tablespoon of bleach. The CK pointed inside the red bucket and stated it contained two quarts. The red bucket was observed halfway filled with water, and it did not contain the required one gallon of water. On May 1, 2025, at 9:25 a.m., a concurrent observation and interview were conducted with Dietary Aide 4 (DA 4). DA 4 was observed demonstrating how to prepare the bleach sanitizer solution in the red bucket. DA 4 poured water into the red bucket and stated the correct ratio is one gallon of water to one tablespoon of bleach. DA 4 pointed to the inside of the bucket, indicating that it contained one gallon of water. The red bucket was observed filled to approximately three-quarters full and did not contain the required one gallon. On May 5, 2025, at 1:21 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated, the proper concentration for the red bucket sanitizer is one gallon of water to one tablespoon of bleach. The RD further stated, if the sanitizing solution was not prepared at the correct concentration, it could result in foodborne illness among residents. A review of the Red Sanitizer Bucket Log Checklist, indicated, .check concentration every 3 hours per shift . acceptable PPM (parts per million) range: 200 PPM .1T to 1 gallon of water . A review of U.S. FDA (Food and Drug Administration) Food Code 2022, Section 4-501.114 Manual and Mechanical Ware washing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness, indicated, .The effectiveness of chemical sanitizers can be directly affected by the temperature, pH, concentration of the sanitizer solution used, and hardness of the water . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On May 1, 2025, at 3:41 p.m., during a concurrent observation and interview with [NAME] Aide 1 (CA 1), CA 1 was observed demonstrating how to sanitize the preparation table using the green and red bucket solutions without wearing gloves. CA 1 stated he had forgotten to wear gloves and that he should have worn them for safety and to avoid contaminating the preparation table. On May 5, 2025, at 2:01 PM, during an interview with the Director of Dietary Services (DDS), the DDS stated that it is best practice for the staff to wear gloves when wiping down the preparation table with the bleach solution. He further stated this was for safety reasons as bleach can be absorbed through the skin and enter the bloodstream. 3. On April 29, 2025, at 8:50 a.m., a concurrent observation and interview regarding the dish machine were conducted with DA 1 and DDS. DA 1 and DDS dipped a test strip into the water compartment to test the chlorine sanitization level. Both stated this was the correct location to check the concentration of the sanitizer in the dish machine. On May 1, 2025, at 9:10 a.m., a concurrent observation and interview regarding the dish machine were conducted with DA 2. DA 2 dipped a test strip into the water compartment to test the chlorine sanitization level and stated this was the proper procedure to check for dish sanitization. On May 1, 2025, at 11:05 a.m., a concurrent observation and interview regarding the dish machine were conducted with DA 3. DA 3 dipped a test strip into the water compartment to test the chlorine sanitization level and stated this was the correct procedure to check for dish sanitization. On May 5, 2025, at 2:01 p.m., an interview was conducted with the DDS. The DDS stated the proper procedure for checking dish sanitization involved dipping the test strip both into the water compartment and onto the surface of a glass that had just been cleaned. The DDS further stated that he could not provide a written policy indicating that testing in the water compartment alone was acceptable. A review of the facility owner manual titled, CMA Dish machine Owner's manual, undated, indicated, .Low Temperatures chemical sanitizing dish machines must not exceed 6% sodium hypochlorite solution (beach) as the sanitizing agent .Follow the direction precisely that are on the litmus paper vial and test the water on the surface of the bottom of the glasses .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51063 Based on interview and record review, the facility failed to ensure the resident's food preference was honored for one of three residents reviewed for nutrition (Resident 22). This failure had the potential to result in the resident refusing meals and experiencing decreased nutritional intake. Findings: During an interview on April 29, 2025, at 9:55 a.m., with Resident 22, Resident 22 stated, she had informed the dietitian of her food preference for cottage cheese but had only been receiving fruit cups. A review of Resident 22's Admission Record, dated May 5, 2025, indicated Resident 22 was admitted on [DATE]. A review of Resident 22's History and Physical, dated March 23, 2025, the indicated Resident 22 was admitted with a diagnoses which included unspecified severe protein-calorie malnutrition (a form of undernutrition caused by a deficiency in both protein and total caloric intake) and type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar) without complications. A review of Resident 22's Minimum Data Set (an assessment tool), dated March 24, 2025, indicated Resident 22 had a Brief Interview of Mental Status (a tool to assess cognitive function of an individual) score of 15 (intact cognitive response). A review of Resident 22's Nutritional assessment dated [DATE], indicated, .FOOD PREFERENCE DATE . Food requests .lowfat cottage cheese for HS (bedtime) snack . A review of Resident 22's care plan, dated March 20, 2025, indicated, .one half cup soft canned fruit TID (three times a day) between meals . A review of Resident 22's snack labels, undated, indicated, .one half cup soft canned fruit . During a concurrent interview and record review of Resident 22's Nutritional Assessment, care plan, and snack labels, with the Dietary Manager (DM) on May 1, 2025 at 11:27 a.m., the DM stated, cottage cheese was listed as a food request and should have been provided to the resident. The DM stated, the resident should have received cottage cheese, instead of fruit cups. The DM stated all snack labels for Resident 22 indicated one-half cup of soft canned fruit, and there were no labels for cottage cheese. The DM stated Resident 22's food request was not followed and further stated, Resident 22's food preference had not been honored. A review of Resident 22's diet order, dated March 18, 2025, indicated, .CCHO (Consistent Carbohydrate - consistent amount of carbohydrates at each meal and snack) diet, Regular texture . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review of Resident 22's diet order with the RD, on May 1, 2025 at 3:23 p. m., the RD stated, there were no contraindications with Resident 22 receiving cottage cheese and the resident should have received it. The RD stated resident's preferences should have been honored. During an interview on May 5, 2025 at 2:15 p.m. with the Director of Nursing (DON), the DON stated if the dietician did not indicate any contraindications for the resident to have cottage cheese, the resident's food preference should have been honored. A review of the facility's policy and procedure titled, Resident Food Preferences, dated November 2008, indicated, .the staff and physician will strive to .accommodate those preferences .resident's clinical record (. care plan .) will document the resident's likes .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44505 Based on observation, interview, and record reviews, the facility failed to maintain a sanitary environment, prepare, and serve food in accordance with professional standards for food service safety when three cutting boards with deep indentations were found in the kitchen. This failure had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) among the residents in the facility. Findings: On May 5, 2025, at 2:01 p.m., a concurrent observation and interview was conducted with the Director of Dietary Services (DDS) in the kitchen. Three cutting boards (brown, green and red color measuring at 24 inches [(a unit measurement of length)] in width and 18 inches in length) were observed with deep indentations and rough surfaces. The DDS stated, the cutting boards had indentations and should have had smooth surfaces to prevent microorganisms (germs) from growing in the grooves, which could lead to foodborne ilness among residents. A review of the U.S FDA Food Code 2022, Section 4-501.12 Cutting Surfaces, indicated, .Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51063 Based on observation, interview, and record review, the facility failed to provide a safe environment when the Laundry Aide (LA) did not clean the lint trap in the dryer resulting in the lint accumulation. This failure had the potential to result in a fire hazard, putting residents at risk. Findings: On May 1, 2025, at 9 a.m., during a concurrent observation and interview in the laundry room, the Laundry Aide (LA) stated, she cleaned the dryer lint trap every two hours. Dryer # 3 lint trap was checked and observed to have a thick layer of lint covering the entire trap. A review of the facility document titled, Laundry Lint Cleaning Log, undated, indicated the following: .Lint must be cleaned every two hours . Further review of the Laundry Lint Cleaning Log, dated May 1, 2025, indicated: - 7:30 a.m. - signed with initials; - 9 :30 a.m. - signed with initials; - 11:30 a.m. - signed with initials; and - 1:30 p.m. - signed with initials. An additional review of the log indicated that it had been signed ahead of the scheduled times. On May 1, 2025, at 9:18 a.m., during a concurrent interview and record review of the Laundry Lint Cleaning Log with the Laundry Aide, the LA stated, the log should have been completed accurately. The LA stated, the log should reflect the actual time the lint was cleaned and the signature should only be entered once the task was truly completed. On May 1, 2025, at 9:21 a.m., during an interview with LA, LA stated the lint in Dryer # 3 was quite a bit and if not removed , the lint could become a fire hazard. On May 1, 2025, at 9:51 a.m., during an interview with the House Keeping Supervisor, he stated the L.A. should have followed the policy, which requires cleaning the lint trap every two hours. A review of the facility policy and procedure titled, House Keeping/Laundry, dated March 8, 2013, indicated . Remove all lint from dryer every 2 hours and at the end of each shift .