STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055806	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Las Palmas Healthcare Center	622 South Anza Street El Cajon, CA 92020

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 1) was free from verbal and mental abuse when: Certified Nursing Assistant (CNA) 2 yelled at Resident 1 and made disparaging comments to the resident about their ability to perform bed mobility while also making humiliating comments to the resident regarding their weight and size. Cross reference F607. As a result: Resident 1 cried, experienced depressed mood, psychosocial (the influence of social factors on an individual's mind or behavior) distress, and felt unsafe in the facility and worthless. Findings: A review of Residents 1 ' s Admission Record dated 5/1/25, indicated the resident was readmitted to the facility on [DATE]. On 5/1/25 at 9:05 A.M., an onsite visit was conducted to investigate an allegation of abuse between CNA 2 and Resident 1. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/1/25 at 10:15 A.M., an observation and interview were conducted with Resident 1 while inside the resident ' s room. Resident 1 ' s husband was also present. Resident 1 stated there was an incident that occurred around 11 P.M. (on 4/22/25) after she had requested help to be pulled up in bed. Resident 1 stated CNA 1 was her assigned CNA and CNA 1 went to get assistance. Resident 1 stated CNA 1 entered her room with CNA 2. Resident 1 stated CNA 2 told her, Oh, it ' s you. You been here long enough and should be able to pull yourself up. Resident 1 stated CNA 2 laughed and pointed at her while saying, Look at you, you ' re four times bigger than me. Resident 1 stated CNA 2 told her she did not want to break her back by pulling her up and that the resident was too big. Resident 1 was observed wiping her tears away during the interview. Resident 1 stated after the incident occurred, she called her husband on the phone and told him what had happened. Resident 1 stated, I just want to go home with my family. Resident ' s 1 husband stated they had been married for [AGE] years, and that this incident had a bad effect on his wife. Resident 1 stated when the incident occurred, she was in disbelief at first and then she felt bad and it made her feel worthless. Resident 1 stated the incident felt like abuse because CNA 2 had been yelling at her, it happened at night, and she was alone and in a helpless state. Resident 1 stated, I didn ' t feel safe. Resident 1 further stated, Everyone knows [CNA 2] is rude. Even housekeepers know [this]. On 5/1/25 at 10:35 A.M., an interview was conducted with the Housekeeper (HK). The HK stated when she was cleaning a resident ' s room on another unit, about three to four weeks ago, a resident told her CNA 2 was rude to them. The HK stated she did not report what the resident told her to anyone. A review of CNA 2 ' s employee file indicated: -Employee Counseling Form dated 5/6/24, and signed by CNA 2 indicated, .2. Employee was rude to a family member -Employee Disciplinary Action Form dated 4/2/25, indicated, .concerns regarding your ongoing comments about resident [sic] and staff. It has been observed and reported that you have repeatedly spoken about residents in a negative manner .Corrective Action Plan [:] Speak about residents respectfully at all times, regardless of frustrations or concerns. Bring up any care-related concerns to management or nursing leadership privately CNA 2 refused to sign the form. -Employee Disciplinary Action Form dated 4/10/25, indicated, .This disciplinary action is being issued due to ongoing unprofessional conduct that is detrimental to team cohesion and the overall work environment CNA 2 refused to sign the form. -(Facility Name) Notice of Termination of Employment dated 4/28/25, indicated, .Following a resident ' s [Resident 1] complaint, an internal investigation determined that verbal comments were made which in turn negatively affected the resident ' s emotional well-being, causing her significant distress (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/1/25 at 12:11 P.M., a telephone interview was conducted with CNA 2. CNA 2 stated CNA 1 had asked for assistance to pull Resident 1 up in bed and, She ' s overweight this patient. CNA 2 stated she did not want to hurt her back and that, This lady [Resident 1] is more than 400 pounds. I can get hurt. CNA 2 denied making any comments about Resident 1 in front of the resident. CNA 2 was asked about her training on how to pull up a resident in bed and CNA 2 did not answer the question. CNA 2 spoke non-stop and frequently did not answer interview questions. CNA 2 was asked about the disciplinary actions in her employee file. CNA 2 changed the topic. CNA 2 was again asked about the contents of her employee file and CNA 2 denied there being any disciplinary actions in her file. CNA 2 stated she did go back to Resident 1 ' s room with the charge nurse and a different CNA and assisted in pulling Resident 1 up in bed. CNA 2 stated the resident was fine. CNA 2 further stated, I never called [Resident 1] fat. On 5/1/25 at 3:15 P.M., a telephone interview was conducted with CNA 1. CNA 1 stated around 11:00 P.M., on 4/22/25, at the start of her shift, she asked CNA 2 for help to pull Resident 1 up in bed. CNA 1 stated they were in the hallway outside of Resident 1 ' s room when CNA 2 stated she was not going to break her back. CNA 1 stated CNA 2 continued talking loudly and stated, The resident ' s 500 times my weight. CNA 1 stated CNA 2 followed her into Resident 1 ' s room while stating, How could someone let themselves get that big? CNA 1 stated that CNA 2 told Resident 1, We ' re not going to do this, you ' re going to do it. [NAME] ' t you see how big you are? CNA 1 stated Resident 1 started crying while CNA 2 kept talking about how big Resident 1 was. CNA 1 stated CNA 2 would not stop talking about the resident ' s weight and the resident kept crying. CNA 1 stated, I couldn ' t take it anymore and told [CNA 2] she was rude and to get out of my resident ' s room. CNA 1 stated this was the first time she had worked with CNA 2. CNA 1 stated she had reported the incident to the Charge Nurse (CN) 3 and she also emailed the Director of Staff Development (DSD) about the incident. CNA 1 stated she was emotional after witnessing the incident and had to take a break. CNA 1 stated based on her facility-provided abuse prevention training, the incident was emotional abuse. CNA 1 stated the incident was, Emotionally damaging [to] the resident. CNA 1 stated Resident 1 was very sweet, never got mad, and was considerate. CNA 1 stated Resident 1 was not the type to complain and if she had not spoken up, the resident would have kept it inside and not said anything about it. On 5/1/25 at 3:42 P.M., a telephone interview was conducted with CN 3. CN 3 stated she was in charge of the building during the night shift (11 P.M. to 7 A.M.). CN 3 stated around the start of the shift on 4/22/25, CNA 1 reported to her that CNA 2 was rude to Resident 1 and had made the resident cry. CN 3 stated she asked CNA 2 what had happened, and CNA 2 stated that she did not say anything to Resident 1. CN 3 stated she spoke to Resident 1 about the incident and the resident did not want to talk about what had occurred. CN 3 was informed of what Resident 1 and CNA 1 said had happened on 4/22/25. CN 3 stated, Oh no, that ' s abuse. CN 3 stated based on her facility-provided abuse prevention training, the incident on 4/22/25 that occurred between CNA 2 and Resident 1 was verbal, emotional, and mental abuse. A review of Resident 1 ' s progress notes titled IDT [Interdisciplinary Team-different disciplines who meet and discuss resident care issues] Note dated 4/23/25, indicated when the IDT interviewed Resident 1 regarding the incident that occurred on 4/22/25, the resident had cried for 10 seconds. The IDT referred Resident 1 to the psychiatrist and psychologist for evaluation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/5/25 at 10:12 A.M., an interview was conducted with the DSD. The DSD stated she was involved in investigating the incident that occurred on 4/22/25 between Resident 1 and CNA 2. The DSD stated it had been determined that verbal abuse had occurred, and that Resident 1 had suffered emotional distress. The DSD stated Resident 1 frequently became teary-eyed since the incident. The DSD stated prior to the incident Resident 1 seemed happier. The DSD stated this incident affected Resident 1 and, It was verbal and mental abuse. The DSD stated Resident 1 was a two-person assist to pull up in bed. The DSD stated CNA 2 received training on how properly move and position a resident. On 5/5/25 at 11:00 A.M., an interview was conducted with the Director of Operations (DOO) and the Director of Nursing (DON). The DOO stated initially they did not think what happened on 4/22/25 to Resident 1 was as bad as it was. The DOO stated the incident was abuse considering how Resident 1 perceived the incident and how it made her feel. The DON stated what happened was, Verbal abuse as [Resident 1] experienced emotional distress from it. A review of the facility ' s policy titled Identifying Types of Abuse revised September 2022, indicated, .1. Abuse of any kind against residents is strictly prohibited .1. Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. 2. Verbal abuse may be considered to be a type of mental abuse . 3. Examples of mental and verbal abuse include but are not limited to: a. Harassing a resident; b. Mocking, insulting, ridiculing; c. Yelling or hovering over a resident, with the intent to intimidate A review of facility ' s policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program revised April 2021, indicated, Residents have the right to be free from abuse

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51541 Based on observation, interview, and record review, the facility failed to ensure staff were fully trained to correctly identify mental, emotional, and verbal abuse when: 1. Certified Nursing Assistant (CNA) 2 yelled at Resident 1 and made disparaging comments to the resident about their ability to perform bed mobility while also making humiliating comments to the resident regarding their weight and size. Staff considered CNA 2 ' s behavior as rudeness instead of abuse. 2. Charge Nurse (CN) 3 was not adequately trained to collect pertinent information to make an accurate determination of abuse during the incident regarding CNA 2 and Resident 1. As a result, CNA 2 was permitted to finish her eight-hour shift providing care to residents after the incident involving Resident 1. This failure had the potential for other residents to experience abuse. Cross reference F600. Findings: A review of Residents 1 ' s Admission Record dated 5/1/25, indicated resident was readmitted to the facility on [DATE]. On 5/1/25 at 9:05 A.M., an onsite visit was conducted to investigate an allegation of abuse between CNA 2 and Resident 1. On 5/1/25 at 10:15 A.M., an interview and observation was conducted with Resident 1 while inside the resident ' s room. Resident 1 ' s husband was also present. Resident 1 stated there was an incident that occurred around 11 P.M. (on 4/22/25) after she had requested help to be pulled up in bed. Resident 1 stated CNA 1 was her assigned CNA, and CNA 1 went to get assistance. Resident 1 stated CNA 1 entered her room with CNA 2. Resident 1 stated CNA 2 told her, Oh, it ' s you. You been here long enough and should be able to pull yourself up. Resident 1 stated CNA 2 laughed and pointed at her while saying, Look at you, you ' re four times bigger than me. Resident 1 stated CNA 2 told her she did not want to break her back by pulling her up and that the resident was too big. Resident 1 was observed wiping her tears away during the interview. Resident 1 stated she called her husband on the phone and told him what had happened. Resident 1 stated, I just want to go home with my family. Resident 1 ' s husband stated they had been married for [AGE] years, and this incident had a bad effect on his wife. Resident 1 stated when the incident occurred, she was in disbelief at first and then she felt bad and it made her feel worthless. Resident 1 stated the incident felt like abuse because CNA 2 had been yelling at her, it happened at night, and she was alone and in a helpless state. Resident 1 stated, I didn ' t feel safe. Resident 1 further stated, Everyone knows [CNA 2] is rude. Even housekeepers know [this]. On 5/1/25 at 10:35 A.M., an interview was conducted with the Housekeeper (HK). The HK stated when she was cleaning a resident ' s room on another unit, about three to four weeks ago, a resident told her CNA 2 was rude to them. The HK stated she did not report what the resident told her to anyone. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 3:15 P.M., a telephone interview was conducted with CNA 1. CNA 1 stated at the start of her shift around 11:00 P.M., on 4/22/25, she asked CNA 2 for help to pull Resident 1 up in bed. CNA 1 stated they were in the hallway outside of Resident 1 ' s room when CNA 2 stated she was not going to break her back. CNA 1 stated CNA 2 continued talking loudly and stated, The resident ' s 500 times my weight. CNA 1 stated CNA 2 followed her into Resident 1 ' s room while stating, How could someone let themselves get that big? CNA 1 stated that CNA 2 told Resident 1, We ' re not going to do this, you ' re going to do it. [NAME] ' t you see how big you are? CNA 1 stated Resident 1 started crying while CNA 2 kept talking about how big Resident 1 was. CNA 1 stated CNA 2 would not stop talking about the resident ' s weight and the resident kept crying. CNA 1 stated, I couldn ' t take it anymore and told [CNA 2] she was rude and to get out of my resident ' s room. CNA 1 stated this was the first time she had worked with CNA 2. CNA 1 stated she had reported the incident to the Charge Nurse (CN) 3 and she also emailed the Director of Staff Development (DSD). CNA 1 stated she was emotional after witnessing the incident and had to take a break. CNA 1 stated based on her facility-provided abuse prevention training, the incident was emotional abuse. CNA 1 stated the incident was, Emotionally damaging [to] the resident. CNA 1 stated Resident 1 was very sweet, never got mad, and was considerate. CNA 1 stated Resident 1 was not the type to complain and if she did not speak up the resident would have kept it inside. On 5/1/25 at 3:42 P.M., a telephone interview was conducted with CN 3. CN 3 stated she was in charge of the building during the night shift (11P.M. to 7 A.M.) that started on 4/22/25. CN 3 stated around the start of the shift CNA 1 reported to her that CNA 2 was rude to Resident 1 and had made the resident cry. CN 3 stated she asked CNA 2 what had happened, and CNA 2 stated that she did not say anything to Resident 1. CN 3 stated she spoke to Resident 1 about the incident and the resident did not want to talk about what had occurred. CN 3 stated what CNA 1 told her was vague and that she had not clarified what was told to her. CN 3 was informed of what Resident 1 and CNA 1 stated had happened on 4/22/25. CN 3 stated, Oh no, that ' s abuse. CN 3 stated based on her facility-provided abuse prevention training, the incident on 4/22/25 that occurred between CNA 2 and Resident 1 was verbal, emotional, and mental abuse. CN 3 stated if she had known all the details of what had happened, she would have sent CNA 2 home. CN 3 stated CNA 2 had worked the whole night shift providing care to residents. On 5/5/25 at 8:50 A.M., an interview was conducted with CN 5. CN 5 stated there were times she was in charge of the building. CN 5 stated if an incident of staff rudeness to a resident was reported to her, she would have to, Get all the facts. CN 5 stated she would contact the Director of Operations (DOO) and Director of Nursing (DON) to get guidance to determine if the incident was considered rudeness or abuse. CN 5 stated if staff rudeness looked like abuse took place, she would send the staff home. CN 5 stated she received abuse training here at the facility but had received extra training in her role as a CN while employed at a hospital. CN 5 stated this extra training involved following up on allegations and asking pertinent questions to determine if abuse had occurred. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 10:12 A.M., an interview and record review was conducted with the DSD. The DSD stated she was involved in investigating the incident that occurred on 4/22/25 between Resident 1 and CNA 2. The DSD stated it had been determined that verbal abuse had occurred, and that Resident 1 had suffered emotional distress. The DSD stated this incident affected Resident 1 and, It was verbal and mental abuse. The DSD stated CNA 2 had a history of negatively talking about residents, constantly complaining about management and staff, and speaking loudly where everyone could hear. The DSD stated on 4/2/25 and 4/10/25, CNA 2 was given written warnings about her behavior. The DSD stated she had received an email from CNA 1 after midnight (4/23/25) indicating that unnecessary comments were made by CNA 2 to Resident 1. The DSD stated, In my head, I thought [CNA 2] was being negative again and I could address it the morning. The DSD stated there should have been additional training provided to Licensed Nurses in the CN position on how to gather all the facts and to report to the DOO and the DON for additional guidance to determine if abuse had occurred so appropriate action could take place. The DSD reviewed the lesson plan for identifying different types of abuse, reporting, and documentation dated 4/24/25. The DSD stated this was the same lesson plan used during in-services related to abuse. The lesson plan indicated, .mental/emotional abuse-actions or words that inflict psychological abuse or trauma. Examples: A staff member tells a resident ' You ' re useless, ' causing the resident to cry .verbal abuse- The use of words to cause emotional pain, fear, or distress. Examples: A nurse yells at a resident in front of others: ' You ' re a burden to everyone here! ' The DSD stated rudeness should be covered in the abuse prevention training. The DSD stated staff needed to be able to tell the difference between rudeness and abuse and report it. On 5/5/25 at 11:00 A.M., an interview was conducted with the DOO and DON. The DOO stated initially they did not think what happened on 4/22/25 to Resident 1 was as bad as it was. The DOO stated considering how Resident 1 perceived the incident and how it made her feel was abuse. The DON stated what happened was, Verbal abuse as [Resident 1] experienced emotional distress from it. The DOO stated during the incident the CN 3 could have asked more questions and tried to gather more details of the situation and dig deeper. The DOO stated gathering more details would have provided CN 3 with enough information to make the decision to send CNA 2 home. The DOO stated the CN should have reached out to the DOO and the DON for guidance in identifying CNA 2 ' s behavior as abuse. The DOO stated the facility abuse prevention training should include more focused training to ask more thorough questions to understand the full scope of the situation for staff in charge of the building. The DOO stated all staff should be trained and capable of identifying verbal and mental abuse. A review of the facility ' s policy titled Identifying Types of Abuse revised September 2022, indicated, As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents. 1. Abuse of any kind against residents is strictly prohibited .1. Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. 2. Verbal abuse may be considered to be a type of mental abuse . 3. Examples of mental and verbal abuse include, but are not limited to: a. Harassing a resident; b. Mocking, insulting, ridiculing; c. Yelling or hovering over a resident, with the intent to intimidate .4. Staff are trained on abuse reporting and investigation (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021, indicated, .5. Establish and maintain a culture of compassion and caring for all residents . 6. Provide staff orientation and training/orientation programs that include .identification and reporting of abuse .10. Protect residents from any further harm during investigations

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51374 Based on interview and record review, the facility failed to ensure a baseline care plan was developed for two of three residents (Resident 6 and 7), reviewed for fall care plans. This failure to develop the baseline care plan for fall risk within 48 hours of admission placed Resident 6 and 7 at risk for falls. Findings: Resident 6 was admitted to the facility on [DATE] with diagnoses which included unsteadiness on feet per the facility's Admission Record. A review of Resident 6 ' s Fall Risk Observation/assessment dated [DATE], documented a score of 22, which indicated the resident was identified as being high risk for falls. Resident 7 was admitted to the facility on [DATE] with diagnoses which included repeated falls per the facility's Resident Admission Record. A review of Resident 7 ' s Fall Risk Observation/assessment dated [DATE], documented a score of 26, which indicated the resident was identified as being high risk for falls. On 5/5/25 at 8:50 A.M., an interview was conducted with Licensed nurse (LN) 4. LN 4 stated the purpose of completing an admission fall risk assessment was to identify a resident who was a high fall risk and to develop interventions to prevent falls. LN 4 stated the fall care plan was used to communicate to the staff that a resident was a high fall risk and identified interventions to prevent falls. On 5/5/25 at 10:47 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the purpose of doing a fall risk assessment on admission was to identify residents who were at high risk for falls so that interventions could be developed to prevent falls. The DON stated interventions to prevent falls should have been in place immediately for Residents 6 and 7. On 5/5/25 at 11:02 A.M., a joint interview and record review was conducted with the DON. The DON stated there was no baseline care plan for fall risk in Resident 6 and Resident 7 ' s clinical record. The DON stated it was important to initiate a fall care plan within 48 hours of admission based on the fall risk assessment, so interventions regarding the residents' care could be communicated to the care team. A review of the facility policy titled Care Plan - Baseline revised March 2022, indicated, A baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission