STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056313	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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** Based on observation, interview and record review the facility failed to ensure the resident was free from physical abuse and was not punched on the face multiple times by another resident for one of three sampled residents (Resident 1). The facility failed to: 1. Supervise Resident 1 and Resident 2 who were smoking on the patio and having an argument on 4/12/2025 at 3:45 a.m. as indicated in both residents' Smoking Assessment Form. 2. Assess and monitor Resident 2 when he was restless and had an escalating behavior manifested by yelling and demanding staff for a cigarette to smoke, pacing (to walk in one direction and then back again) back and forth at the facility's nursing station and hallways on 4/12/2025, from 12:00 a.m. to 3:30 a.m. 3. Ensure Certified Nursing Assistant (CNA) 1 knew the whereabouts of Resident 1 and Resident 2 while she was assigned to care for them on 4/12/2025. 4. Inform Resident 2's physician when Resident 2 was exhibiting behavior manifested by yelling, demanding staff to give him cigarettes, pacing in the hallways and verbalizing that a guy was giving him Methamphetamine (stimulant [substance that raises nervous activity in the body] that is highly addictive). . These failures resulted in Resident 1 and Resident 2 smoking unsupervised on 4/12/2025 at 3:35 a.m. leading to Resident 2 and Resident 1 having an argument resulted in Resident 2 punching Resident 1 multiple times on the mouth and face. Resident 1 sustained mid left corner of the lower lip a cut/tear on his mid left corner of the lower lip and swelling. Findings: (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
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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	During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia(a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and chronic obstructive pulmonary disease(COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1's History and Physical (H&P the process of a healthcare provider obtaining a thorough medical history from a patient and performing a physical examination) dated 8/16/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/19/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 1 required set up or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, toileting hygiene, bathing, dressing, and personal hygiene. The MDS indicated Resident 1 was independent in walking, rolling left to right on the bed, and transferring to and from a bed to a chair. During a review of Resident 1's Smoking Assessment Form (a questionnaire used to understand a person's current smoking habits, their interest in quitting, their level of nicotine [an addictive chemical found in tobacco] dependence) dated 2/7/2025, the Smoking Assessment Form indicated Resident 1 utilizes tobacco, must be supervised at all times and had to wear a protective non-flammable apron (designed to protect the user from ash or other cigarette debris that could be a danger to resident) when smoking. During a review of Resident 1's Body assessment dated [DATE], the Body Assessment indicated Resident 1 had a cut on the lower lip. During a review of Resident 1's Change in Condition (COC-a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) Evaluation dated 4/12/2025 at 4:21 a.m., the COC Evaluation indicated Resident 1 was hit in the face by Resident 2 and sustained a cut /tear at the mid left corner of the lower lip. The COC Evaluation indicated Resident 1 was in distress when he reentered the facility from the patio where he was smoking. The COC Evaluation indicated Resident 1 stated he was hit by Resident 2 on the mouth and face after an argument with Resident 2. The COC indicated Resident 1 sustained a cut to mid-bottom corner of his lip with a minimal bleeding. The COC indicated LVN 1 applied ice pack. During a review of Resident 1's Care Plan, titled Resident 1 has the potential for injury related to smoking, initiated on 4/28/2025, the Care Plan indicated the interventions included maintaining the resident within line of sight of personnel supervising smoking schedule, strict implementation of smoking schedule (start at 8 a. m. and ends at 7:30 p.m.) and maintain safety at all times. During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses including bipolar disorder, major depressive disorder(mental health disorder characterized by persistently depressed mood or loss of interest causing impairment in daily life) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition. The MDS indicated Resident 2 was independent in walking, rolling left to right on the bed, and transferring to and from bed to a chair. During a review of Resident 2's Smoking Assessment Form dated 3/7/2025, the Smoking Assessment Form indicated Resident 2 utilizes tobacco, must be supervised at all times and had to wear a protective non-flammable apron when smoking. During a review of Resident 2's COC Evaluation dated 4/12/2025, timed at 4:19 a.m., the COC Evaluation indicated on 4/11/2025, at 11:00 p.m. Resident 2 asked the licensed nurse at the nursing station to smoke in the patio which was facing the facility's lobby. The COC Evaluation indicated Licensed Vocational Nurse (LVN 1) observed Resident 2 pacing the hallways and nursing station on 4/12/2025 at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m. and 3:30 a.m. The COC indicated at around 3:45 a.m. Resident 1 entered the facility from the patio and was distressed. The COC indicated Resident 1 stated that Resident 2 punched him in the face multiple times and Resident 1 sustained a cut with small amount blood on Resident 1's lip. During a review of Resident 2's Care Plan titled, Resident 2 has a behavior problem (fluctuations of emotions from pleasant to angry) related to diagnosis of bipolar disorder initiated on 4/8/2025.,the Care Plan indicated a goal for Resident 2 was to have fewer episodes of emotional fluctuations by review date on 7/8/2025. The Care Plan indicated the interventions included to assist the resident to develop appropriate methods of coping and interacting with others, monitoring behavior episodes of fluctuations of emotions from pleasant to angry every shift, considering time, location, time of the day, persons involved and situations. During a telephone interview on 4/28/2025, at 8:25 a.m. with Certified Nursing Assistant (CNA 1), CNA1 stated she was assigned to Resident 1 and Resident 2 on 4/12/2025 but did not know that they had a resident-to-resident altercation and did not remember that altercation happened that day of 4/12/2025. CNA 1 stated there were no smoking breaks for residents at night. CNA 1 stated the last daily smoking time for the residents was scheduled at 7:30 p.m. CNA 1 stated Resident 1 and Resident 2 were both ambulatory (able to walk and move around) and independent. During a telephone interview on 4/28/2025, at 9:07 a.m. with LVN 1, LVN 1 stated Resident 2 was getting aggressive at the start of the 11 p.m. to 7 a.m. shift on 4/11/2025, at around 11:00 p.m. LVN 1 stated Resident 2 kept coming to the nursing station and demanding a cigarette to smoke threatening to leave the facility if he did not get a cigarette to smoke. LVN 1 stated Resident 2 was having hallucination (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) when he stated there was a guy giving him methamphetamine. LVN 1 stated they were able to redirect his behavior several times during the night. LVN 1 stated Resident 2 was pacing in and out of the patio and around the facility, yelling and demanding to have a cigarette. LVN 1 stated she was in the nursing station and saw Resident 1 went out to the patio to smoke but did not see Resident 2 going out to the patio LVN 1 stated Resident 1 came inside from the patio and told her Resident 2 was trying to beat him up. LVN 1 stated Resident 1 had a cut on his lip with redness and slight swelling. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 4/28/2025, at 9:30 a.m. and subsequent telephone interview, at 10:57 a.m. with LVN 2, LVN 2 stated the incident between Resident 1 and Resident 2 happened around 3:30 a.m. to 4:00 a.m. on 4/12/2025. LVN 2 stated Resident 1 had been going out to smoke on the patio at random times during the night and carried his own cigarettes. LVN 2 stated Resident 1 was not supervised when he goes out to smoke and smokes by himself because Resident 1 was independent and could pretty much do it on his own. LVN 2 stated on 4/12/2025 the patio was dim and the only light that could be seen was the light coming from the nursing station and the lobby. LVN 2 stated Resident 2 was agitated and had been yelling walking around the facility and asking random staff members for a cigarette during that night (4/12/2025). LVN 2 stated LVN 1 instructed him to go back to his room and gave Resident 2 a cigarette on 4/11/2025, at 11:30 p.m. LVN 2 stated on 4/12/2025 at around 3:30 a.m., she heard a sound coming from the patio door when Resident 1 walked in with blood on his mouth while Resident 2 followed him behind. LVN 2 stated Resident 2 was talking loudly and was agitated while Resident 1 was trying to explain what happened to LVN 1. During an interview on 4/28/2025, at 12:40 p.m. with the Director of Staff Development (DSD), the DSD stated she provided an in-services related to resident-to resident abuse that happened between Resident 1 and Resident 2 on 4/12/2025. The DSD stated if a resident was going to smoke outside on the patio from 3:00 a.m. to 4:00 a.m., the staff must be present to supervise and monitor the residents for safety. The DSD stated the CNAs should be making rounds every two hours to ensure the whereabouts of each resident. The DSD stated the CNAs should be aware where their assigned residents were to prevent falls, any change in condition, injury and/or elopement (the act of leaving the facility unsupervised and without prior authorization). The DSD stated residents unsupervised smoking could lead to injury and physical abuse. The DSD stated the residents (in general) were not allowed to have cigarettes in their possession because the residents could burn, hurt themselves, or hurt other residents. During an interview on 4/28/2025, at 1:10 p.m. with the Director of Nursing (DON), the DON stated residents do not smoke at night and if the residents carry a cigarette, the staff should confiscate their lighter and cigarette. The DON stated the licensed nurse should have assigned a CNA to monitor Resident 2's aggressive behavior and notify the physician to manage his behavior on 4/12/2025. The DON stated there should be staff supervising Resident 1 and Resident 2's while smoking to prevent the risk of injury. The DON stated this incident was avoidable and preventable if only the staff supervised Resident 1 when he went out to smoke in the patio, and the licensed nurse identified and managed Resident 2's aggressive behavior. During a review of facility's policy and procedure (P&P), titled Abuse, Neglect and Exploitation (undated), the P&P indicated Each resident had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The P&P indicated the residents must not be subject to abuse by anyone in the facility and will make efforts to protect the residents. The facility will observe residents' behavior and their reaction to other residents, and train staff about appropriate interventions to deal with aggressive reactions by residents. The P&P indicated the facility will assess, monitor and develop appropriate plans of care with needs and behaviors which might lead to conflict or neglect like residents with history of aggressive behaviors to prevent abuse, neglect and exploitation of residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's P&P titled, Resident Smoking, (undated), the P&P indicated Residents who smoke will be further assessed using Resident Safe Smoking Assessment to determine if the resident would need supervision or not or will be allowed to smoke in designated smoking areas, at designated times and in accordance with the resident's care plan. The P&P indicated smoking materials of residents requiring supervision will be maintained by nursing staff. Cross referenced F689

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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** Based on interview and record review the facility failed to monitor resident for signs and symptoms of neurological decline (brain and nervous system are not working correctly which can lead to problems with thinking, memory, movement or change in level of consciousness[loc-person ' s awareness and responsiveness to their surroundings]) for one of three sampled residents (Resident 4) after being struck on the face by Resident 5. This deficient practice had the potential to lead to serious life-threatening effect that could go unnoticed without a neurological assessment (assessment of a patient ' s mental status , level of consciousness, changes in pupil size and reaction to external stimulus , motor strength, sensation and movement of arms and legs). Findings: During a review of Resident 4 ' s admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including human immunodeficiency virus disease (HIV- virus that attacks the body ' s immune system [defends the body against disease causing microorganism and harmful substances]), morbid obesity (patient weight is significantly higher than what is considered healthy) , schizophrenia (a mental illness that is characterized by disturbances in thought), and left and right knee contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 4 ' s History and Physical (H&P) dated 4/18/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4 ' s Minimum Data Set (MDS- a resident assessment tool) dated 5/8/2025, the MDS indicated Resident 4 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision makingand was dependent (helper completed all the activities for the resident) on staff with bathing, dressing, toileting hygiene, transfer to and from a bed to chair and bed mobility. During a review of Resident 4 ' s Change in Condition (COC- a sudden clinically important deviation from a patient ' s baseline in physical, cognitive, behavioral or functional condition) Form dated 5/30/2025 and timed at 8:45 a.m., the COC Form indicated on 5/30/2025, at 5:30 a.m. Resident 4 was found with five centimeters (cm-unit of measurement) long laceration above his left eyebrow with minimal bleeding and slight swelling. During an observation and interview on 6/5/2025, at 10 a.m. in the activity room and subsequent interview with Resident 4 on 6/6/2025, at 4:30 p.m., Resident 4 was observed sitting in a recliner chair. Resident 4 was observed with purplish discoloration around his left eye and a dressing above the left eye. Resident 4 stated on 5/30/2025 at 5:30 a.m., he was asleep when he was awakened when Resident 5 hit him on the face. Resident 4 stated Resident 5 punched him on the face once. Resident 4 stated after he was hit, Resident 5 remain in the room looking at him, then walked back to his bed. Resident 4 stated he did not know why he did not ask for help when Resident 5 hit him. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025, at 2:55 p.m. with RNS 1, Resident 4 ' s EHR was reviewed. RNS 1 stated there was no neurological check and observation of Resident 4 ' s neurological status after Resident 4 came back from general acute care Hospital (GACH) on the same day the incident occurred (5/30/2025). During an interview on 6/6/2025, at 7:31 a.m., with LVN 3, LVN 3 stated staff should have checked Resident 4 ' s neurological status after being struck on his face. LVN 3 stated Resident 4 could die from possible bleeding in the brain. During a concurrent interview and review of Resident 4 ' s medical record on 6/5/2025, at 12:40 p.m. with the DON, the DON stated the staff initiated the neurological check on 5/30/2025 before Resident 4 was transferred to the GACH but was not continued after he came back from the hospital on 5/30/2025 at 7:49 p. m. The DON stated Resident 4 could have serious injury to the brain after being hit on the face. The DON stated the staff should have performed a neurological check to monitor if the resident ' s brain function was affected like change in level of consciousness.

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F 0689 Level of Harm - 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** Based on interview and record review, the facility failed to ensure the residents who were smoking on the patio were supervised and monitored for two of three sampled residents (Resident 1 and Resident 2). The facility failed to: 1. Ensure Resident 1 and Resident 2, who were assessed as needed supervision at all times, were supervised while smoking on the patio on 4/12/2025, at around 3:45 a.m. in accordance with the facility's policy and procedure titled, Smoking Policy-Residents and Resident 1's and Resident 2's Smoking Assessment Forms. 2. Ensure Resident 2's aggressive behavior was monitored and addressed on 4/12/2025. Resident 2 had been manifesting aggressive behavior and asking staff for a cigarette all night before the incident happened on 4/12/2025 at 3:35 a.m. These failures resulted in Resident 1 and Resident 2 unsupervised smoking on 4/12/2025 at 3:35 a.m. leading to Resident 2 and Resident 1 having arguments resulted in Resident 2 punching Resident 1 multiple times on the mouth and face. Resident 1 sustained a cut / tear at the mid left corner of the bottom lip and swelling. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia(a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and chronic obstructive pulmonary disease(COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1's History and Physical (H&P- the process of a healthcare provider obtaining a thorough medical history from a patient and performing a physical examination) dated 8/16/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/19/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 1 was independent in walking, rolling left to right on the bed, and transferring to and from a bed to a chair. During a review of Resident 1's Smoking Assessment Form (a questionnaire used to understand a person's current smoking habits, their interest in quitting, their level of nicotine [an addictive chemical found in tobacco] dependence) dated 2/7/2025, the Smoking Assessment Form indicated Resident 1 utilized tobacco, must be supervised at all times and had to wear a protective non-flammable apron (designed to protect the user from ash or other cigarette debris that could be a danger to resident) when smoking. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Body assessment dated [DATE], the Body Assessment indicated Resident 1 had a cut on the lower lip. During a review of Resident 1's Change in Condition (COC-a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) Evaluation dated 4/12/2025 at 4:21 a.m., the COC Evaluation indicated Resident 1 was hit in the face by Resident 2 and sustained a cut / tear at the mid left corner of the bottom lip. The COC Evaluation indicated Resident 1 was in distress when he reentered the facility from the patio, where he was smoking. The COC Evaluation indicated Resident 1 stated he was hit by Resident 2 on the mouth and face after an argument and Resident 1's mid left corner of his lip had minimal bleeding. During a review of the facility's Incident Report dated 4/12/2025 and timed at 3:45 a.m., the Incident Report indicated Resident 1 was smoking on the patio near the lobby at 3:45 a.m. The Incident Report indicated Resident 1 verbalized to Licensed Vocational Nurse (LVN 1) that Resident 2 hit him due to argument over a cigarette. The Incident Report indicated Resident 2 hit Resident 1 multiple times in the face and Resident 1 had lost his balance. During a review of Resident 1's Care Plan, titled Resident 1 has the potential for injury related to smoking, initiated on 4/28/2025, the Care Plan indicated the interventions included maintaining within line of sight of personnel supervising smoking schedule, strict implementation of smoking schedule and maintain safety at all times. During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnosis that included bipolar disorder, major depressive disorder(mental health disorder characterized by persistently depressed mood or loss of interest causing impairment in daily life) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 2 was independent in walking, rolling left to right on the bed, and transferring to and from a bed to a chair. During a review of Resident 2's Smoking Assessment Form dated 3/7/2025, the Smoking Assessment Form indicated Resident 2 utilized tobacco, must be supervised at all times, and had to wear a protective non-flammable apron when smoking. During a review of Resident 2's COC Evaluation dated 4/12/2025, timed at 4:19 a.m., the COC Evaluation indicated on 4/11/2025, at 11:00 p.m. Resident 2 asked staff at the nursing station, which was facing the facility lobby, to smoke in the patio The COC Evaluation indicated the licensed nurse (unknown) observed Resident 2 pacing the hallways and nursing station on 4/12/2025 at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a. m. and 3:30 a.m. The COC indicated at around 3:45 a.m. Resident 1 entered the facility from the patio and was distressed. The COC indicated Resident 1 stated that Resident 2 punched him in the face multiple times and Resident 1 sustained a cut with a small amount of blood on Resident 1's lip. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's Care Plan titled, The Resident 2 has a behavior problem (fluctuations of emotions [changes in mood or feelings] from pleasant to angry) related to bipolar disorder, initiated on 4/8/2025, the Care Plan indicated a goal for Resident 2 was to have fewer episodes of fluctuations of emotions by review date on 7/8/2025. The Care Plan indicated the interventions included monitoring behavior episodes of fluctuations of emotions from pleasant to angry and attempting to determine underlying cause. During a telephone interview on 4/28/2025, at 8:25 a.m. with Certified Nursing Assistant (CNA 1), CNA1 stated she was assigned to Resident 1 and Resident 2 on 4/12/2025 but did not know that they had a resident-to-resident altercation and did not remember that it happened that day of 4/12/2025. CNA 1 stated there were no smoking breaks for residents at night, on 11 p.m. to 7 a.m. shift. CNA 1 stated the last smoking time for the residents was at 7:30 p.m. daily. CNA 1 stated Resident 1 and Resident 2 were both ambulatory (able to walk and move around) and independent. During an interview on 4/28/2025, at 11:00 a.m. with CNA 2, CNA 2 stated she was assigned as a Smoking Monitorer on 4/28/2025 and her responsibilities were to provide cigarettes, smoking aprons, lighting the cigarette and monitoring the residents while smoking for safety. CNA 2 stated the facility provides Resident 1 and Resident 2 cigarettes during regular smoking schedule. CNA 2 stated there were no smoking times at night from 11:00 p.m. to 7:00 a.m. shift. During an interview on 4/28/2025, at 11:39 a.m. with Activity Assistant (AA 1), AA 1 stated the Smoking Monitorer was in charge of passing out cigarettes, providing smoking aprons to residents, ensure residents do not have a lighter in their possession for safety. AA 1 stated the residents cannot smoke whenever they want, and facility staff should supervise residents while residents were smoking. During a telephone interview on 4/28/2025, at 9:07 a.m. with LVN 1, LVN 1 stated Resident 2 was getting aggressive at the start of 11 p.m. to 7 am. shift on 4/11/2025, around 11:00 p.m. LVN 1 stated Resident 2 kept coming to the nursing station and demanding to smoke, threatening to leave the facility if he did not get a cigarette to smoke. LVN 1 stated Resident 2 was having hallucination (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) when he stated there was a guy giving him Methamphetamine (stimulant [substance that raises nervous activity in the body] that is highly addictive). LVN 1 stated Resident 2 was pacing in and out the patio and around the facility, yelling and demanding to have a cigarette. LVN 1 stated she was at the nursing station on 4/12/2025 and saw Resident 1 going out to the patio to smoke but did not see Resident 2 going out to the patio. LVN 1 stated Resident 1 came inside from the patio and told LVN 1 that Resident 2 was trying to beat him up. LVN 1 stated Resident 1 had a cut on his lip with redness and slight swelling. LVN 1 stated it was all about Resident 2 getting cigarettes and throwing tantrums. LVN 1 stated she does not know where Resident 1 got his cigarette to smoke on 4/12/2025, at around 3:45 a.m. (continued on next page)

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	056313	A. Building B. Wing	04/28/2025

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Pacific Villa, Inc	3501 Cedar Avenue Long Beach, CA 90807

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 4/28/2025, at 9:30 a.m. and subsequent telephone interview, at 10:57 a.m. with LVN 2, LVN 2 stated the incident happened between 3:30 a.m. and 4:00 a.m. on 4/12/2025. LVN 2 stated Resident 1 had been going out to smoke on the patio at random times during the night and carried his own cigarettes. LVN 2 stated Resident 1 was not supervised when he goes out to smoke and smokes by himself because Resident 1 was independent and could pretty much do it on his own. LVN 2 stated Resident 2 was agitated and had been yelling, walking around the facility and asking random staff members for a cigarette during that night (4/12/2025). LVN 2 stated LVN 1 instructed him to go back to his room and gave Resident 2 a cigarette on 4/11/2025, at 11:30 p.m. LVN 2 stated on 4/12/2025 at around 3:30 a.m., she heard a sound coming from the glass door, leading to the patio, when Resident 1 walked in with blood on his mouth while Resident 2 followed him behind. LVN 2 stated Resident 2 was talking loudly and was agitated while Resident 1 was trying to explain to staff what happened. During a concurrent interview and record review on 4/28/2025, at 12:40 p.m. with the Director of Staff Development (DSD), Resident 1's and Resident 2's Smoking Assessment Forms dated 3/7/2025, were reviewed. The DSD stated Resident 1 and 2 required supervision while smoking. The DSD stated Resident 1 should have staff supervision on 4/12/2025 at around 3:00 a.m. and 4:00 a.m. when Resident 1 went out to the patio to smoke for safety. The DSD stated the CNAs should be making rounds every two hours to ensure the whereabouts of each resident. DSD stated the CNAs should be aware where their residents were to prevent fall, any change in condition, injury and elopement (the act of leaving the facility unsupervised and without prior authorization). The DSD stated the residents (in general) were not allowed to have cigarettes in their possession because the residents could burn, hurt themselves or an altercation can occur between residents. During an interview on 4/28/2025, at 1:10 p.m. with the Director of Nursing (DON), the DON stated residents do not smoke at night and if the residents carry a cigarette, the staff should confiscate their lighter and cigarette. The DON stated the licensed nurse should have assigned a CNA to monitor Resident 2's aggressive behavior and notify the physician to manage his behavior. The DON stated there should have been a staff supervising Resident 1's while smoking to prevent the risk of injury. The DON stated this incident was avoidable and preventable if only staff supervised Resident 1 when he went out to smoke on the patio, and the licensed nurse identified and managed Resident 2's aggressive behavior. During a review of facility's policy and procedure (P&P) titled, Accidents and Supervision, undated, the P&P indicated the resident's environment should remain free of accident hazards and each resident receives adequate supervision to prevent accidents. During a review of facility's P&P titled, Smoking Policy- Residents, undated, the P &P indicated smoking articles for residents without independent smoking privileges may not have or keep any type of smoking articles, including cigarettes, tobacco except when they are under direct supervision. The P &P indicated any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Cross referenced F600

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility ' s Quality Assurance (Q A)/ Quality Assurance and Performance Improvement (QAPI) (a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee failed to address , maintain, and develop an effective plan to correct identified problems after the deficient practices were identified related to abuse and accident on 4/28/2025 during an investigation of a facility reported incident (FRI- process by which a healthcare facility documents and reports an event that occurred within the facility and potentially affected the safety of residents, staff or the facility itself). This failure resulted into a repeated deficient practice about abuse and supervision which could affect the health and safety of the residents. Findings: During an interview on 6/6/2025, at 11:50 a.m. with the Director of Nursing (DON), the DON stated she did not address the identified problems related to abuse and smoking supervision in their QAPI/QA Committee agenda. The DON stated it did not dawn on me to do it and did not have to wait for a quarterly meeting in July for the identified problems with regards to abuse and smoking supervision. The DON stated the facility had a QAPI meeting last April 2 but did not address identified problems concerning abuse and smoking supervision. The DON stated the facility conducts meeting every three months. The DON stated QAPI was important to prevent reoccurrences of abuse providing a safe environment for the residents. The DON stated the facility should have enough staff to cover supervision of residents to prevent occurrences of abuse. During an interview on 6/6/2025, at 1:57 p.m. with the Administrator (ADM) , the ADM stated that the facility includes the issue of abuse , smoking and supervision on their next QAPI meeting. The ADM stated the facility will review issues in the facility , will plan and address the issues affecting the facility like monitoring residents , smoking and abuse. During a review of facility ' s policy and procedure (P&P) titled, QAPI Change Process, undated, the P&P indicated the facility will establish and utilize a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained. The P &P indicated once the root cause of a problem is identified, QAA committee will develop appropriate corrective actions plans and will continue to track performance to ensure that improvements are sustained. Based on interview and record review, the facility ' s Quality Assurance (Q A)/ Quality Assurance and Performance Improvement (QAPI) (a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee failed to address , maintain, and develop an effective plan to correct identified problems after the deficient practices were identified related to abuse and accident on 4/28/2025 during an investigation of a facility reported incident (FRI- process by which a healthcare facility documents and reports an event that occurred within the facility and potentially affected the safety of residents, staff or the facility itself). This failure resulted into a repeated deficient practice about abuse and supervision which could affect the health and safety of the residents. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: During an interview on 6/6/2025, at 11:50 a.m. with the Director of Nursing (DON), the DON stated she did not address the identified problems related to abuse and smoking supervision in their QAPI/QA Committee agenda. The DON stated it did not dawn on me to do it and did not have to wait for a quarterly meeting in July for the identified problems with regards to abuse and smoking supervision. The DON stated the facility had a QAPI meeting last April 2 but did not address identified problems concerning abuse and smoking supervision. The DON stated the facility conducts meeting every three months. The DON stated QAPI was important to prevent reoccurrences of abuse providing a safe environment for the residents. The DON stated the facility should have enough staff to cover supervision of residents to prevent occurrences of abuse. During an interview on 6/6/2025, at 1:57 p.m. with the Administrator (ADM) , the ADM stated that the facility includes the issue of abuse , smoking and supervision on their next QAPI meeting. The ADM stated the facility will review issues in the facility , will plan and address the issues affecting the facility like monitoring residents , smoking and abuse. During a review of facility's policy and procedure (P&P) titled, QAPI Change Process, undated, the P&P indicated the facility will establish and utilize a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained. The P &P indicated once the root cause of a problem is identified, QAA committee will develop appropriate corrective actions plans and will continue to track performance to ensure that improvements are sustained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review , the facility failed to observe infection control practice by failing to ensure four of ten sampled staff members wear a mask when the facility was in a Covid outbreak(two or more linked cases of the same illness caused by Covid 19 virus[infectious and contagious disease caused by coronavirus]). This failure had the potential to spread and transmit infection to the residents and other staff. Findings: During a concurrent observation and interview on 6/5/2025, at 8:00 a.m. and subsequent interview on6/6/2025, at 9:00 a.m. with Certified Nursing Assistant (CNA 2) who was the screener for Covid 19 signs and symptoms was not wearing a mask. Observed a housekeeper (HSK 1) vacuuming the carpet at the lobby of the facility not wearing a mask. CNA 2 stated there were residents who were positive for Covid 19 in the facility. CNA 2 stated she did not wear a mask because she thought it was not mandatory to wear mask even there was a Covid 19 outbreak. During an initial tour observation of the facility on 6/5/2025, at 8:20 a.m., observed several residents not wearing a mask in the hallway. Observed the Administrator, and some facility staff members were not wearing masks in the nursing station and resident care areas. Observed rooms designated the two Covid 19 residents. During an interview on 6/6/2025, at 7:31 a.m. with Licensed Vocational Nurse (LVN 3), LVN 3 agreed she did not wear a mask while in the resident care areas yesterday (6/5/2025). LVN 3 stated she did not wear a mask because she felt hot. LVN 3 stated she should have always worn a mask to prevent spread of infection among the vulnerable residents in the facility and staff. During an interview on 6/6/2025, at 9:05 a.m., with Housekeeping Supervisor (HKS), HKS stated HSK 1 should have worn a mask while vacuuming the lobby for the safety of residents and staff. HKS stated not wearing a mask during a Covid 19 outbreak had the potential to spread the infection. During an interview on 6/6/2025, at 9:20 a.m. with Infection Preventionist Nurse (IPN), IPN stated the facility had a Covid 19 outbreak that started on 5/28/2025 when both residents were presenting cough, and nasal congestion(nasal passages were swollen with excess fluid and mucus) and tested positive for Covid 19. IPN stated she always reminded the staff to wear a mask and was communicated to the charge nurses during huddle in the morning because the facility had an outbreak of Covid 19. IPN stated maybe the staff thought Covid 19 illness was normal according to their perception. IPN stated she should explain the risks and consequences of not wearing mask to help prevent spread of infection. During an interview on 6/6/2025, at 12:40 p.m. with the Director of Nursing (DON) , the DON stated the facility had a Covid 19 outbreak and everyone should be wearing a mask to prevent spread of infection. The DON stated elderly people like their residents have a great risk of contracting the Covid 19 infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025, at 1:33 p.m., with the Administrator (ADM), the ADM stated he did not wear a mask yesterday (6/5/2025) in the nursing station because he forgot to wear a mask. The ADM stated he wears a mask when he goes to the resident areas. During a review of facility ' s Covid 19 Mitigation Plan Manual, undated, the Covid 19 Mitigation Plan Manual indicated facility staff should wear recommended personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for care of all residents when there are Covid-19 cases identified in the facility in line with the most recent California Department of Public Health PPE guidance. The Covid 19 Mitigation Plan indicated All staff should wear a facemask while in the facility. Based on observation, interview and record review , the facility failed to observe infection control practice by failing to ensure four of ten sampled staff members wear a mask when the facility was in a Covid outbreak(two or more linked cases of the same illness caused by Covid 19 virus[infectious and contagious disease caused by coronavirus]). This failure had the potential to spread and transmit infection to the residents and other staff. Findings: During a concurrent observation and interview on 6/5/2025, at 8:00 a.m. and subsequent interview on6/6/2025, at 9:00 a.m. with Certified Nursing Assistant (CNA 2) who was the screener for Covid 19 signs and symptoms was not wearing a mask. Observed a housekeeper (HSK 1) vacuuming the carpet at the lobby of the facility not wearing a mask. CNA 2 stated there were residents who were positive for Covid 19 in the facility. CNA 2 stated she did not wear a mask because she thought it was not mandatory to wear mask even there was a Covid 19 outbreak. During an initial tour observation of the facility on 6/5/2025, at 8:20 a.m., observed several residents not wearing a mask in the hallway. Observed the Administrator, and some facility staff members were not wearing masks in the nursing station and resident care areas. Observed rooms designated the two Covid 19 residents. During an interview on 6/6/2025, at 7:31 a.m. with Licensed Vocational Nurse (LVN 3), LVN 3 agreed she did not wear a mask while in the resident care areas yesterday (6/5/2025). LVN 3 stated she did not wear a mask because she felt hot. LVN 3 stated she should have always worn a mask to prevent spread of infection among the vulnerable residents in the facility and staff. During an interview on 6/6/2025, at 9:05 a.m., with Housekeeping Supervisor (HKS), HKS stated HSK 1 should have worn a mask while vacuuming the lobby for the safety of residents and staff. HKS stated not wearing a mask during a Covid 19 outbreak had the potential to spread the infection. (continued on next page)

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