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	12/04/2025

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 - Minimal harm or potential for 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. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was not subject to abuse when Resident 2, who has history of schizophrenia (a mental illness that is characterized by disturbances in thought), and sudden mood changes threw water on Resident 1. This deficient practice resulted in Resident 1 feeling like she was drowning when the water that Resident 2 threw on her, covered her face, went into her mouth and down her throat.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of hypertensive heart disease (a condition where the heart has been damaged by years of high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 9/10/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 1 was dependent on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was severely impaired, and Resident 2 required partial/moderate assistance (helper does less than half the effort) to complete her ADLs. During an interview on 10/21/2025 at 9:04 a.m., Resident 1 stated while she was receiving ADL care from CNA 1, Resident 2 came over and poured water on her face, and the water went down her throat. During the interview Resident 1 was observed crying and stated she felt like she was drowning when the water was going down her throat. Resident 1 stated Resident 2 did not like her voice and had told her in the past, to shut the f*ck up and facility staff were present in the room when this happened. During an interview on 10/21/2025 at 9:45 a.m., Resident 3 stated she saw Resident 2 pour water on Resident 1's face. Resident 3 stated it looked like attempted murder, and it was intentional, like Resident 2 was drowning someone who could not move. Resident 3 stated the facility should have called the police, but they did not. During an interview on 10/21/2025 at 9:56 a.m., and a subsequent interview at 12:24 p.m., CNA 1 stated while providing ADL care to Resident 1, she (CNA 1) left the room to follow up on Resident 1's treatment. CNA 1 stated when she returned to the room she heard Resident 1 screaming. CNA 1 stated Resident 1 informed her that Resident 2 threw water on her. CNA 1 stated Resident 1 was crying, and her upper body was soaking wet. CNA 1 stated there were times when Resident 1 feared Resident 2 because when Resident 1 watched her television, Resident 2 would get mad at Resident 1 for having the volume up. CNA 1 stated on the same day, before the incident with the water pitcher, she saw Resident 2 move Resident 1's bedside table to her (Resident 2) side of the room, which made Resident 1 upset and caused her to cry. CNA 1 stated she had to remind Resident 2 that it was not her bedside table. During an interview on 10/21/2025 at 11:43 a.m., the Director of Nursing (DON) stated she was not aware of any incident occurring between Resident 1 and Resident 2. The DON stated if Resident 2 poured water on Resident 1, that would be considered abuse and had the potential for Resident 1 to be harmed. During a review of the facility's undated Policy and Procedure (P/P) titled Abuse, Neglect and Exploitation the P/P indicated each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The P/P indicated a resident must not be subject to abuse by anyone, including but not limited to other residents

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse for one of two sample residents (Resident 1), when Resident 1 told Certified Nursing Assistant (CNA) 1, that Resident 2 threw water on her (Resident 1). This deficit practice resulted in the inability of the California Department of Public Health (CDPH) to conduct a timely investigation and had the potential for information to be lost and/or forgotten. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of hypertensive heart disease (a condition where the heart has been damaged by years of high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 9/10/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 1 was dependent on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was severely impaired, and Resident 2 required partial/moderate assistance (helper does less than half the effort) to complete her ADLs. During an interview on 10/21/2025 at 9:04 a.m., Resident 1 stated while she was receiving ADL care from CNA 1, Resident 2 came over and poured water on her face, and the water went down her throat. During the interview Resident 1 was observed crying and stated she felt like she was drowning when the water was going down her throat. Resident 1 stated Resident 2 did not like her voice and had told her in the past, to shut the f*ck up and facility staff were present in the room when this happened. During an interview on 10/21/2025 at 9:56 a.m., and a subsequent interview at 12:24 p.m., CNA 1 stated while providing ADL care to Resident 1, she (CNA 1) left the room to follow up on Resident 1's treatment. CNA 1 stated when she returned to the room she heard Resident 1 screaming. CNA 1 stated Resident 1 informed her that Resident 2 threw water on her. CNA 1 stated Resident 1 was crying, and her upper body was soaking wet. CNA 1 stated the Director of Nursing (DON) came to the room to find out why Resident 1 was screaming, that's when she (CNA 1) reported to the DON about the allegation made by Resident 1 against Resident 2. During an interview on 10/21/2025 at 11:43 a.m., the DON stated she was not aware of any incident occurring between Resident 1 and Resident 2. The DON stated she did not go to Resident 1's room and CNA 1 did not report Resident 1's allegation to her. The DON stated CNA 1 should have reported the allegation of abuse to the charge nurse, to her (DON) or the ADM, so they could investigate, report to CDPH, and the ombudsman. During a review of the facility's undated Policy and Procedure (P/P) titled Reporting Abuse to Facility Management the P/P indicated employees must immediately report any suspected abuse or incidents of abuse to the DON. The P/P indicated any individual observing resident abuse or suspecting resident abuse must immediately report such incident to the ADM or DON.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow enhanced barrier precautions ([EBP] an infection control intervention designed to reduce transmission of multidrug- resistant organisms that employs targeted gown and gloves use during high contact resident care activities) for one sampled resident (Resident 4) when Treatment Nurse (TN) 1 did not wear a gown while providing care to Resident 4's wound. This deficient practice resulted in an increased risk for Resident 4's wound to become infected. Findings: During a review of Resident 4's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with a diagnosis of chronic (constantly recurring) osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the right ankle and foot and peripheral vascular disease ([PVD] a slow progressive narrowing of the blood flow to the arms and legs. During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool) dated 8/14/2025, the MDS indicated Resident 4's cognition was moderately impaired, and Resident 4 was dependent on facility staff to complete his activities daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's Physician's Order dated 8/7/2025, the Physician's Order indicated to use enhanced barrier precautions related to Resident 4's PVD and an ulcer (a small open sore or wound generally found in the stomach or on the skin) to Resident 4's right heel. During a review of Resident 4's Treatment Administration Record (TAR), dated 10/2025, the TAR indicated to cleanse Resident 4's left plantar (sole of the foot) foot with normal saline (a saltwater solution), pat dry, paint with povidone iodine (a solution used to clean and disinfect the skin), and cover with a dry dressing every day. During an observation outside of Resident 4's room on 10/21/2025 at 8:40 a.m., an EBP sign was observed to the left of the doorway to Resident 4's room. During an observation and interview on 10/21/2025 at 8:40 a.m., and 8:55 a. m., TN 1 was observed providing care to Resident 4's left plantar foot wound, wearing gloves only, no gown. TN 1 stated she was not aware a gown was required when providing wound care for residents who were on EBP. During an interview on 10/21/2025 at 11:56 a.m., the Infection Control Nurse (IPN) stated residents who have wounds, who were on dialysis, and had indwelling medical devices were placed on EBP to protect them from infection. The IPN stated facility staff should wear gowns and gloves during high contact activities such as transferring residents and dressing changes. During an interview on 10/21/2025 at 1:38 p.m., the Director of Nursing (DON) stated the purpose of EBP is to prevent the spread of infection especially for those residents who have indwelling medical devices and open wounds. The DON stated if the resident had an open wound, facility staff should wear gloves and gowns when providing wound care. During a review of the facility's Policy and Procedure (P/P) titled Enhanced Barrier Precautions dated 2024, the P/P indicated personal protective equipment ([PPE] - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for enhanced barrier precautions is only necessary when performing high contact care activities and may not need to be donned prior to entering the resident's room. The P/P indicated high contact resident care activities include wound care: any skin opening requiring a dressing.