| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056313 | A. Building<br>B. Wing | 12/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pacific Villa, Inc | 3501 Cedar Avenue<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that the attending physician was notified of a change in condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death ) for one of three sampled residents (Resident 1), after Resident 1 reported being struck and expressed fear, indicating a psychosocial change ( shifts in a person's thoughts, feelings, behaviors, and relationships) in condition. This failure had the potential to delay or prevent medical and mental health evaluation, resulting in unaddressed psychosocial distress, continued fear, lack of appropriate interventions, and increased risk to resident safety and well-being.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 major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities). During a review of Resident 1's History and Physical (H&P) dated 10/18/2025, the H&P indicated Resident 1 had the capacity to understand and make own decisions. During a review of Resident 1's Minimum Data Set ([MDS]resident assessment tool) dated 11/19/2025, the MDS indicated Resident 1 had moderate cognitive impairment (problems with memory and thinking and dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral care, toileting hygiene, and shower/bathe self. During an interview on 12/16/2025 at 8:32 a.m. with Resident 1, Resident 1 stated that he could not recall the allegation of an unknown black male striking him in the stomach and was unable to provide additional details related to the reported incident. Resident 1 stated I feel safe while you were here, but I won't feel safe when you leave, because he believes nothing will be done to address his concerns when surveyor leave. During a concurrent interview and record review on 12/16/2025 at 10:10 a.m. with License Vocational Nurse (LVN) 1, Resident 1's Care Plan was reviewed, the Care Plan indicated that there was no documentation indicating Resident 1's care plan was reviewed or updated in response to the resident's reported allegation of unknown black male striking him in the stomach. LVN 1 stated that he was first made aware of the alleged allegation on 12/9/2025 at approximately 9:00 a.m. to 10:00 a.m. by the ombudsman (an official appointed to investigate individuals' complaints). LVN 1 stated that the ombudsman informed him that Resident 1 reported that an unknown black man struck him, in the stomach, and that the date of the alleged incident could not be verified. LVN 1 stated that if a resident reports being struck and expressing fear, it would be considered a change in condition including a psychosocial change. LVN 1 stated that when a resident experiences a change in condition, the primary physician should be notified, the notification should be documented, and the resident's care plan should be reviewed and updated to address the identified concern. LVN 1 stated that failure to notify the physician and update the care plan could result in the residents' needs not being addressed, including unresolved fear, psychosocial distress, and lack of appropriate medical or mental health interventions. LVN 1 stated that he did not notify Resident 1's physician or document the incident because he believed it was not required, explaining that the resident has a history of making similar statements or allegations and that he therefore did not feel documentation was necessary. During an interview on 12/16/2025 at 10:30 a.m. with Registered Nurse Supervisor (RNS), the RNS stated that she was first made aware of the alleged incident on 12/9/2024 at approximately 2:00 p.m. by the Social Service Director (SSD). The RNS stated that the SSD stated that Resident 1 had reported that a black man came into his room and hit him in the stomach. The RNS stated that a resident reporting being struck and expressing fear would be considered a change in condition, including a psychosocial change. The RNS stated that when a resident experiences a change in condition, residents' physician should be notified, the notification should be documented, and the resident's care plan should be reviewed and updated to reflect the identified needs. The RNS stated that failure to follow these procedures could result in the residents' needs not being appropriately addressed, including continued fear, unresolved psychosocial distress, delay in medical or mental health evaluations, and staff being unaware of interventions necessary to ensure the resident's safety and well-being. The RNS stated that it was her role and responsibility to ensure that staff review and update resident's care plans. During an interview on 12/16/2025 at 11:00 a.m. with the Director of Nursing (DON), the DON stated that her role and responsibilities includes oversight of nursing operations, including supervision of nursing staff, ensuring compliance with facility policies and procedures, and ensuring |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the comprehensive care plan (a personalized, written guide detailing a patient's health status, specific needs, goals, and the nursing actions [interventions]) was developed and implemented for one of three sampled residents (Resident 1) following a change in condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death), when Resident 1 reported being struck and expressed fear, indicating a psychosocial change ( shifts in a person's thoughts, feelings, behaviors, and relationships) in condition. This deficient practice had the potential to result in staff being unaware of the residents' psychosocial and safety needs leading to inconsistent care, lack of protective interventions, continued fear, unaddressed psychosocial distress, and increased risk to resident safety and well-being. 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 major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities). During a review of Resident 1's History and Physical (H&P) dated 10/18/2025, the H&P indicated Resident 1 had the capacity to understand and make own decisions. During a review of Resident 1's Minimum Data Set ([MDS]resident assessment tool) dated 11/19/2025, the MDS indicated Resident 1 had moderate cognitive impairment (problems with memory and thinking and dependent ( helper does all of the effort, resident does none of the effort to complete the activity) for oral care, toileting hygiene, and shower/bathe self. During an interview on 12/16/2025 at 8:32 a.m. with Resident 1, Resident 1 stated that he could not recall the allegation of an unknown black male striking him in the stomach and was unable to provide additional details related to the reported incident. Resident 1 stated I feel safe while you were here, but I won't feel safe when you leave, because he believes nothing will be done to address his concerns when surveyor leave. During a concurrent interview and record review on 12/16/2025 at 10:10 a.m. with License Vocational Nurse (LVN) 1, Resident 1's Care Plan was reviewed, the Care Plan indicated that there was no documentation indicating Resident 1's care plan was developed and implemented after Resident 1's reported allegation of an unknown black male striking him in the stomach. LVN 1 stated that he was first made aware of the alleged allegation on 12/9/2025 at approximately 9:00a.m. to 10:00 a.m. by the ombudsman (an official appointed to investigate individuals' complaints). LVN 1 stated that the ombudsman informed him that Resident 1 reported that an unknown black man struck him, in the stomach, and that the date of the alleged incident could not be verified. LVN 1 stated that if a resident reports being struck and expressing fear that it would be considered a change in condition including a psychosocial change. LVN 1 stated Resident 1's care plan should be reviewed and updated to address the identified concern. LVN 1 stated that failure update the care plan could result in the residents' needs not being addressed, including unresolved fear, psychosocial distress, and lack of appropriate medical or mental health interventions. During an interview on 12/16/2025 at 10:30 a.m. with Registered Nurse Supervisor (RNS), the RNS stated that she was first made aware of the alleged incident on 12/9/2024 at approximately 2:00 p.m. by the Social Service Director (SSD). The RNS stated that the SSD stated that Resident 1 had reported that a black man came into his room and hit him in the stomach. The RNS stated that a resident reporting being struck and expressing fear would be considered a change in condition, including a psychosocial change. The RNS stated that when a resident experiences a change in condition, resident's care plan should be reviewed and updated to reflect the identified needs. The RNS stated that failure to follow these procedures could result in the residents' needs not being appropriately addressed, including continued fear, unresolved psychosocial distress, delay in medical or mental health evaluations, and staff being unaware of interventions necessary to ensure the resident's safety and well-being. The RNS stated that it is her role and responsibility to ensure that staff review and update resident's care plans. During an interview on 12/16/2025 at 11:00 a.m. with the Director of Nursing (DON), the DON stated that if a resident reports being struck and expressing fear a change in condition would be considered, including a psychosocial change. The DON stated that when a resident has a change in condition, resident's care plan should be reviewed and updated to reflect the identified needs. The DON acknowledged that the change in condition was not documented, and the residents' care plan was not reviewed or updated as required. The DON stated that failure to update the care plan could result in delayed |