STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056330	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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 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** The facility failed to report alleged abuse of two of eleven sampled residents (Resident 11 & 2) to the State Survey Agency when it did not report when:Resident 1 allegedly kicked Resident 11 in the lower torso.Resident 4 allegedly threw a cup of water on Resident 2 while resting in bed. In addition, the facility failed to send a 5-day follow-up investigation report for both alleged abuse incidents to the State Survey Agency.This failure had the potential for alleged abuse to continue indefinitely and put alleged victims at risk of further physical and psychological harm related to the alleged abuse.Cross Reference: F610Findings:1. Record review of admission Record for Resident 1 indicated he was admitted on [DATE] for diagnoses which included: Fracture of Right Tibia (a break in the large lower leg bone), Collision with car while on peda-cycle (pedal powered multi-person tour vehicles), Hypertension (high blood pressure), and Alcohol Dependence with Withdrawal (a chronic condition where the brain develops a physical need for alcohol to function).Record review of Minimum Data Set (MDS- federally mandated, standardized, and comprehensive assessment tool used in Medicare and Medicaid-certified nursing facilities) Section C-Cognitive (thinking processes) Patterns for Resident 1, dated 11/28/25, indicated a Brief Interview for Mental Status (BIMS) of 12, which indicated moderate cognitive impairment. Record review of MDS Section E-Behaviors for Resident 1, dated 11/28/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering.Record review of MDS Section GG-Functional Abilities, dated 11/28/25, for Resident 1, indicated he was independent for: Self Care, Indoor Mobility, Stairs, and functional cognition. Resident 1 had impairment on one Lower Extremity (hip, knee, ankle, foot). Resident 1 also had no prior use of devices such as wheelchair or walker. Record review of admission Record for Resident 11 indicated Resident 11 was admitted on [DATE] for diagnoses which included: Epilepsy (disorder marked by sudden recurrent episodes of sensory disturbance or loss of consciousness associated with abnormal electrical activity in the brain) , Gastroenteritis (short-term swelling of the stomach and intestines, usually caused by viruses, bacteria, or parasites) , Colitis (swelling of your colon), Anxiety (feeling of fear, apprehension) and, Depression (persistent sadness, loss of interest, and changes in mood, sleep, eating, and thinking that interfere with daily functioning).Review of MDS Section C-Cognitive patterns for Resident 11, dated 11/13/25, indicated a BIMS of 15 indicating intact cognitive abilities. Review of MDS Section E-Behaviors for Resident 11, dated 11/13/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering .Review of MDS Section GG-Functional Abilities for Resident 11, dated 11/13/25, indicated no impairment for upper and lower extremities, and resident usage of walker and wheelchair.On 1/27/26 at 12:50 P.M., a concurrent interview with the Quality Nurse (QN) and record review of the Electronic Medical Record (EMR- digital, computer-stored versions of patient's paper charts) was conducted. The QN stated that the process for resident to resident abuse was to: 1. separate the residents and make sure they are safe, 2. do (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	head-to-toe assessment on each resident, 3. report to the Administrator (ADM), and he should initiate investigation and report to the following authorities: a. Physician (MD), b. Responsible Party (RP-is the person or entity legally and financially accountable for paying a patient's medical bills and invoices), c. Police Department (PD), d. Ombudsman (an independent, neutral advocate who helps patients), and e. California Department of Public Health (CDPH), 4. Document alleged abuse and finding in Change in Condition (CIC) note, progress note, and Care plan. The QN stated the expectation for resident-to-resident abuse was to report immediately to Abuse coordinator. The QN stated in this facility the abuse coordinator is the ADM. The QN stated that the incident between Resident 1 and Resident 11 was brought up during the interdisciplinary team (IDT- a group of professionals from different disciplines working interdependently to achieve patient focused goals through shared decision-making) meeting, but there was no follow up on the incident. The QN stated that the DON and Social Services Assistant (SSA) were arguing about the incident, and then DON stated that they (the DON & SSA) would talk about it later. The QN was unable to find any follow up about the incident in the EMR about the incident. The QN stated the importance of reporting and investigating immediately is to keep residents that were being abused safe, and to prevent it from happening again.On 1/27/26 at 1:25 P.M., a concurrent interview with the SSA and record review of SSA's notes was conducted. The SSA stated that Resident 1 came to her on 1/19/26 at 9 A.M. to vent about a situation that happened with Resident 11, his roommate, the week before. The SSA stated Resident 11 asked Resident 1 to lower the TV volume, when Resident 1 barged into his side of the room and verbalized the threat .If you don't lower the TV, I'm going to hurt you. The SSA stated, Resident 1 said he kicked Resident 11 in the lower torso to protect himself. The SSA stated the Director of Nursing (DON) and her had disagreement about her note during the IDT meeting, and they met after the IDT meeting to discuss her note. The SSA stated that DON said that she did know Resident 1 had kicked Resident 11. The SSA stated that the DON said, I doubt he (Resident 1) is telling the truth. The SSA stated at the standup meeting on 1/20/26, DON asked her to strike out the original note and write a new note. The SSA stated that the expectation for alleged abuse was to report the alleged abuse to the Abuse Coordinator immediately. The SSA stated the Abuse Coordinator was the ADM. The SSA stated that she reported to the DON and assumed that she had reported to the ADM. Further review of the EMR with SSA indicated there was no follow up, investigation, or IDT meeting done regarding the incident. The SSA stated that the importance of reporting immediately to Abuse Coordinator, investigating, and reporting to the proper authorities was to prevent further abuse. Record review of SSA's note in the EMR dated 1/19/26 at 9:42 A.M., indicated note was documented as incorrect documentation and was crossed out with a line through it. The SSA's note indicated Resident met with SS [Social Services] to discuss room incompatibility. Resident stated around 4:30 P.M.-5:30 P.M. Wednesday 01/14 he was in bed watching tv show when Resident 11 barged into his side of room and threatened to hit him if he didn't lower the tv volume. Resident [1] stated that he felt threatened, so he retaliated with kicking the resident near his lower torso. Resident stated he did not want to report it the day of because he feared getting arrested. SS notified resident we would notify administration and DON about incident. SS will follow up as needed. Strike out reason: Incorrect Documentation. Strike out date: 1/20/26 10:42 Record review of handwritten follow-up note, not in EMR, by the SSA on paper indicated: On 1/19/26, Resident [1] met with SS to discuss ongoing roommate incompatibility. Resident [1] stated there had been disagreements over the tv. Resident [1] states roommate verbally threatened him, so he felt unsafe during the interaction. Resident [1] stated that he did not report the incident sooner because he feared getting arrested. Further investigation did not warrant any change. Resident [1] was offered room change to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accommodate incompatibility. Resident [1] refused any changes. SS will follow up as needed.On 1/27/26 at 2 P.M., an observation and interview with Resident 11 was conducted. Resident 11 was observed in the hallway in his wheelchair. Resident 11 was alert and oriented and agreeable to interview. Resident 11 stated that he felt safe at the facility and currently had no problems with staff or other residents. Resident 11 stated that a few weeks ago, his previous roommate, Resident 1, had kicked him with his foot and he fell back onto his wheelchair and got a bruise on his lower back from landing on the wheelchair's brake lever. Resident 11 stated he and Resident 1 did not like each other. Resident 11 stated he thinks he owns the room.he thinks he special, he's not special here. Resident 11 stated he didn't report the kick because he was afraid of Resident 1 and thought he might beat him up. Resident 11 stated he reported he fell that day to the staff. On 1/27/26 at 2:15 P.M., a concurrent interview with Charge Nurse (CRN) 2 and record review of EMR for Resident 11 was conducted. CRN 2 stated that a resident kicking another resident or a resident throwing water on another resident was resident-to-resident abuse. CRN 2 stated that the process for resident to resident abuse was: 1. separate the residents and make sure they are safe, 2. do head-to-toe assessment on each resident, 3. report to the ADM, and he should initiate investigation and report to the following authorities: a. MD, b. RP, c. PD, d. Ombudsman, and e. CDPH, 4. document alleged abuse and finding in Change in CIC note, progress note, and Care plan. CRN 2 stated she could not find any follow up notes or IDT notes about alleged abuse investigation in the EMR. CRN 2 stated after reporting to ADM, the ADM should follow, investigate, and report the alleged abuse. CRN 2 stated if not reported or investigated, victims could continue to be abused. Record review of Resident 11's EMR was conducted with CRN 2. A Nurse's note dated, 1/12/26 at 8:15 P.M., indicated Resident 11 had a fall which matched description of type of injury that Resident 11 described in his interview. Nurse's Note indicated Resident [11] .claims that he had a fall @ around 1600[4 P.M.] in his room and also claims that he hit his back on his wheelchair, showed his back and notice a reddish discoloration measuring about 14x6 cm(centimeters) at this time. Res[ident 11] verbalizes that he came from the bathroom and is trying to go back to his bed when he tries to squeeze himself between the bed and wheelchair, he lost his balance and landed his back on his wheelchair. Res[ident 11] claims he stood up by himself and did not inform anyone until he feels pain on his back. Res[ident 11] did not report incident earlier when evening meds were administered. Head to toe check done, no further injuries noted at this time. Neuro-check initiated, no changes in LOC. Primary MD notified with orders. On 1/27/26 at 2:30 P.M., an interview with the Assistant Director of Nursing (ADON) was conducted. The DON was currently out of state. The ADON stated that she was unaware of any recent alleged abuse cases that were being investigated at the facility, including the incident involving Resident 1 and Resident 11, and the incident involving Resident 2 and Resident 4. The ADON stated the Abuse Coordinator was the ADM. The ADON stated if an alleged abuse incident was reported to her, she would immediately report it to the ADM. The ADON stated it was important to report the alleged abuse immediately so they can conduct and investigation and do the appropriate reporting to: 1. MD, 2. RP, 3. PD, 4. Ombudsman, & 5. CDPH. The ADON stated there should be documentation of investigation and follow-up in the EMR. The ADON stated the importance of timely reporting and investigation was for patient safety, preventing emotional distress, and self-isolation of the victim. On 1/27/26 at 2:45 P.M., an interview with the ADM was conducted. The ADM stated he was the abuse coordinator. The ADM stated that the incident for Resident 1 versus Resident 11 was not reported to him. The ADM stated the expectation was if the alleged abuse was reported to him, he would have conducted an investigation and reported per policy and procedure to the appropriate authorities and send a 5-day investigation summary to the State Survey Agency. The ADM (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he did not conduct an investigation, report to the appropriate authorities, or do a 5-day summary for the alleged abuse for this incident. The ADM stated the importance of reporting immediately was to prevent further abuse from happening to the victim. On 1/28/26 at 7:43 A.M., a phone interview was conducted with the DON. The DON stated she would consider the allegation of Resident 1 kicking Resident 1, resident-to-resident abuse. The DON stated that she did not investigate the incident between Resident 1 and Resident 11 because the SSA told her it happened a couple of weeks ago, and Resident 1 who confessed the abuse allegation was already discharged . The DON stated she thought it was only words and no physical interaction occurred. The DON stated she thought a misunderstanding happened between her and the SSA, and the DON asked the SSA to strike her note from 1/19/26 .because it seemed like abuse that was not reported. The DON stated that she is new to the facility and they are changing processes to follow up, and staff are not used to the new system yet. The DON stated the QA was supposed to start the investigation and follow up with her but never did. The DON stated that the investigation was not on the follow up list, so it was not reported to the Abuse Coordinator, and an investigation was not conducted. The DON stated that the ADM is the abuse coordinator. The DON stated, I am responsible as the DON. The DON stated that alleged abuse should be reported to the appropriate authorities per policy within 2 hours of the allegation of abuse. The DON stated that by not reporting and investigating immediately after abuse was alleged, there was potential for the victim to keep being abused. On 2/13/26 at 10 A.M., a follow-up interview was conducted with the ADM. The ADM confirmed that he did not do full investigations, 5-day investigation summaries, or report to the ombudsman for either incident of alleged abuse.A record review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, indicated Reporting Allegations to the Administrator and Authorities.1. If the resident abuse.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law, 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility, b. The local/state ombudsman, c. The resident's representative, e. law enforcement officials, f. the resident's physician.3.Immediatedly is defined as: a. within two hours of an allegation involving abuse or serious bodily injury, 4. Verbal/written notices to agencies are submitted via.fax, email, or by telephone.6.Upon receiving any allegations of abuse.the administrator is responsible for determining what actions are needed for the protection of the residents.Investigating Allegations.1. All allegations are thoroughly investigated. The administrator initiates the investigations.7. The individual conducting the investigation as a minimum: a. reviews documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or resident's representative.h. interviews staff members(on all shifts) who have had contact with the resident during period of alleged incident; h. interviews resident's roommate;.l. documents the investigation completely and thoroughly. 2. Record review of admission Record for Resident 2 indicated he was admitted on [DATE] for diagnoses which included: sepsis (body's extreme, dysfunctional response to an infection), urinary tract infection (an infection occurring in any part of the urinary system), epilepsy (disorder marked by sudden recurrent episodes of sensory disturbance or loss of consciousness associated with abnormal electrical activity in the brain), and malignant neoplasm of brain(a cancerous brain tumor). Record review of Minimum Data Set (MDS- (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	federally mandated, standardized, and comprehensive assessment tool used in Medicare and Medicaid-certified nursing facilities) section C-Cognitive (thinking processes) patterns for Resident 2 dated 12/17/25, indicated a BIMS of 11 which indicated Moderate Cognitive impairment. Record review of MDS section E-Behaviors for Resident 2, dated 12/17/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering.Record review of MDS section GG-Functional Abilities for Resident 2, dated 12/17/25, indicated Resident 2 had no impairments for his upper and lower extremities, and usage of a wheelchair. Review of admission Record for Resident 4 indicated he was admitted on [DATE] for diagnoses which included: Myopathy (diseases that cause primary dysfunction, weakness, or degeneration of skeletal muscle fibers), Encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), Major Depressive Disorder (common mood disorder characterized by persistent, intense feelings of sadness, hopelessness, and a loss of interest in activities for at least two weeks), Opioid Dependence a physical and psychological state where the body relies on opioids to function normally), and Chronic pain syndrome condition where pain persists for more than 3 to 6 months).Review of MDS Section C-Cognitive patterns for Resident 4, dated 10/31/25, indicated a BIMS of 15 indicated intact cognition. Review of MDS Section E-Behaviors for Resident 4, dated 10/31/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering.Review of MDS Section GG-Functional Abilities for Resident 4, dated 10/31/25, indicated no impairment for his upper or lower extremities and usage of a wheelchair. On 1/27/26 at 10:15 A.M., a concurrent observation and interview was conducted with Resident 2. Resident 2 was observed in therapy in his wheelchair doing arm exercises. Resident 2 was outside enjoying some sun with his therapist. Resident 2 was alert and oriented and agreeable to interview. Resident 2 stated that about a week ago, someone threw water at him while he was resting in bed. Resident 2 stated that the alleged abuser said You snore too much. after he threw water on him. Resident 2 stated he didn't know exactly who it did, but it may have been one of his roommates. Resident 2 stated that he reported it to staff, but they didn't say anything else to him. Resident 2 stated that he felt safe in the facility at time of investigation.On 1/27/26 at 10:30 A.M., a concurrent observation and interview was conducted with Resident 3. Resident 3 was in his wheelchair outside of Resident 2' s room. Resident 3 was alert and oriented and agreeable to interview. Resident 3 stated that he felt safe in the facility and had no problems with staff and most residents. Resident 3 stated he only had problems with one resident, Resident 4, (Resident 2' roommate) who was mean to him every time they saw each other. Resident 3 stated Resident 4 called him Gay whenever he saw him in the hallway. Resident 3 seemed angry when talking about Resident 4's actions toward him and had reported to staff in the past. On 1/27/26 at 10:40 A.M., an interview with Certified Nursing Assistant 1(CNA) was conducted. CNA 1 stated that on 1/15/26 in the afternoon he went to Resident 2 to check if he needed a brief change. CNA 1 stated that when he saw Resident 2 was covered with water, and his clothes were soaked. CNA 1 stated that he had showered and changed Resident 2's clothes that morning and was dry the last time he saw him. CNA 1 stated that Resident 2 told him that the man in the wheelchair threw water on me. CNA 1 stated that throwing water on another resident was resident-to-resident abuse. CNA 1 stated the process for resident-to-resident abuse was: 1. separate the residents, 2. make sure they are safe, 3. report to the Charge Nurse (CRN), the Director of Nursing (DON), and the Administrator (ADM). CNA 1 stated that the ADM was the abuse coordinator. CNA 1 stated he immediately reported to CRN 1, the DON and the ADM. CNA 1 stated he was unsure if the ADM followed up and investigated the alleged abuse. CNA 1 stated the ADM should have investigated the abuse to prevent further abuse. On 1/27/26 at 11:50 A.M. an interview with CNA 2 was conducted. CNA 2 stated she (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was working with Resident 2, the day he complained about getting water thrown at him. CNA 2 stated she was working with CNA 1 on 1/15/26 and remembered that she and CNA 1 had showered Resident 2 that morning and had changed all his clothing and was dry when they left him that morning. CNA 2 stated that when CNA 1 checked on Resident 2 in the afternoon, Resident 2 was soaking wet. CNA 2 stated that Resident 2 stated the guy in the wheelchair threw water on me. CNA 2 stated she thought the person who threw the water on him was Resident 4, Resident 2's roommate. CNA 2 stated Resident 4 had a history of being aggressive with other residents. CNA 2 stated the process for resident-to-resident abuse was: 1. separate the residents, 2. make sure they are safe, 3. report to the CRN, the DON, and the ADM. CNA 2 stated that the ADM was the abuse coordinator. CNA 2 stated that throwing water on another resident or kicking another resident was resident-to-resident abuse and it should be reported and investigated to prevent further abuse.On 1/27/26 at 12:25 P.M, an observation and interview with Resident 4 was conducted. Resident 4 observed in his bed resting. Resident 4 was alert and oriented, but agitated during attempt to interview, and was not agreeable to interview. Resident 4 stated I don't want to talk with you.On 1/27/26 at 12: 35 P.M., a concurrent interview with CRN 1, observation of her mobile phone texts, and record review of electronic medical record (EMR- digital, computer-stored versions of patient's paper charts) was conducted. CRN 1stated that she was the charge nurse the day that Resident 2 had water thrown on him. CRN 1 stated that the incident was reported to her at 11 A.M. CRN 1 stated that she considered the incident to be resident to resident abuse case and it should be reported to abuse coordinator. CRN 1 stated the abuse coordinator in the facility was the ADM. CRN 1 stated that she wrote a note that Resident 2 had water thrown on him by another resident, and that it was reported to the DON and the ADM. CRN 1 presented a copy of the text she made to the interdisciplinary team(IDT- a group of professionals from different disciplines working interdependently to achieve patient focused goals through shared decision-making), which included the ADM, DON, Social Services Director (SSD), and Quality (QN) Nurse, notifying them that Resident 2 had water thrown on him by another resident. EMR was reviewed with CRN 1, CRN 1 stated that she did not see any IDT report on the alleged abuse or any follow-up by Social Services (SS) or ADM. CRN 1 stated that after reporting the alleged abuse to the abuse coordinator, she would expect him to report to proper authorities and conduct an investigation. CRN 1 stated she would expect they would separate the residents involved. CRN 1 stated a possible outcome of not reporting or investigating the alleged abuse it that the abuse can keep happening to the victim.Record review of Nurse's Note for Resident 4, dated 1/13/26 at 2:26 P.M., indicated Res(ident 4) was verbally aggressive and displayed threatening behavior to CNA who informed him he is not allowed to have coffee in stainless mug due to potential risk of burns from hot beverages. Staff observed stainless mugs were full of hot coffee. Educated on risks of keeping hot beverages and conduct with staff.Record review of nursing note for Resident 2, dated 1/15/26 at 3:22 P.M., indicated Resident [2] claims that someone threw water on him but cannot recall the face upon assessment resident gown is wet.Record review of Nurse's Note for Resident 4, dated 1/26/26 at 2 P.M., indicated CNA reported that [Resident 4] may become upset if roommate is assisted back to bed at this time. CNA was informed that writer would speak with resident to provide explanation.Writer was also informed by staff that Resident 4 had previously expressed agitation related to noise and there is concern he may throw water or potentially harm his roommate if the roommate becomes noisy.Staff were advised to continue monitoring interaction closely and to report any escalation in behavior immediately. DON.,and Administrator.were informed.On 1/27/26 at 12:50 P.M., an interview with the Quality Nurse (QN) and review of EMR for Resident 2 was conducted. The QN stated that she found out about Resident 2 getting water thrown on him, during the IDT team meeting. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	QN stated she spoke to the DON who stated she was going to talk to Social Services about investigating the alleged abuse on 1/26/26. The QN stated the ADM was the abuse coordinator. The QN stated that typical process for resident-to-resident abuse was to:1. separate the residents and make sure they are safe, 2. do head-to-toe assessment on each resident, 3. report to the ADM, and he should initiate investigation and report to the following authorities: a. Physician (MD), b. Responsible Party (RP- is the person or entity legally and financially accountable for paying a patient's medical bills and invoices), c. Police Department (PD), d. Ombudsman (an independent, neutral advocate who helps patients), and e. California Department of Public Health (CDPH), 4. Document alleged abuse and findings in Change in Condition (CIC) note, progress note, and Care plan. The QN stated alleged abuse should be reported to the ADM, and he should report to the appropriate authorities and investigate the incident. The QN stated the importance of reporting immediately is for patient safety and preventing further abuse. The QN stated that she could not find any notes regarding the investigation or followup of the alleged abuse in the EMR. On 1/27/26 at 2:30 P.M., an interview with the Assistant Director of Nursing (ADON) was conducted. The DON was currently out of state. The ADON stated that she was unaware of any recent alleged abuse cases that were being investigated at the facility, including the incident involving Resident 1 and Resident 11, and the incident involving Resident 2 and Resident 4. The ADON stated the Abuse Coordinator was the ADM. The ADON stated if an alleged abuse incident was reported to her, she would immediately report it to the ADM. The ADON stated it was important to report the alleged abuse immediately so they can conduct and investigation and do the appropriate reporting to: 1. MD, 2. RP, 3. PD, 4. Ombudsman, & 5. CDPH. The ADON stated there should be documentation of investigation and follow-up in the EMR. The ADON stated the importance of timely reporting and investigation was for patient safety, preventing emotional distress, and self-isolation of the victim.On 1/27/26 at 2:45 P.M., an interview with the ADM was conducted. The ADM stated he was the abuse coordinator. The ADM stated he investigated the alleged abuse for Resident 2 versus Resident 4 but didn't report it because Resident 2 did not complain about water being thrown on him when he interviewed him. The ADM stated that Resident 2 and Resident 4 were offered room changes but both refused so they did not pursue the incident as alleged abuse and did not further investigate. The ADM stated that the investigation was not documented in the EMR and he was unsure why. The ADM stated he was not sure if the abuse had occurred and was unsure if he should have reported it. The ADM stated that not reporting the abuse immediately and properly investigating the alleged abuse could have .the abuse repeated, escalated, and put the victims at further risk.On 1/28/26 at 7:43 A.M., a phone interview was conducted with the DON. The DON stated that Resident 2 getting a cup of water thrown on him by another resident was resident-to-resident abuse. The DON stated that the ADM conducted an investigation of this incident. The DON stated that QA nurse was supposed to be the one starting the investigation, and she (the DON) would follow up. The DON stated that she could not follow up on the investigation. The DON stated that the ADM did talk to both residents involved and both refused room change. The DON stated for alleged abuse, they should report to the appropriate authorities per policy and procedure within 2 hours of the allegation of abuse. The DON stated the facility did not report this alleged abuse to the appropriate authorities because She believed that the incident did not happen. The DON stated that not reporting and investigating alleged abuse in a timely manner could put the residents at risk for more abuse. On 2/13/26 at 8:39 A.M., an attempt to contact ombudsman for interview was made. A message was left with the ombudsman service as ombudsman was on vacation until 2/17/26. On 2/13/26 at 10 A.M., a follow-up interview was conducted with the ADM. The ADM confirmed that he did not do full investigations, 5-day investigation summaries, or report to the ombudsman (continued on next page)

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	056330	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for either incident of alleged abuse.A record review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, indicated Reporting Allegations to the Administrator and Authorities.1. If the resident abuse.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law, 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility, b. The local/state ombudsman, c. The resident's representative, e. law enforcement officials, f. the resident's physician.3.Immediatedly is defined as: a. within two hours of an allegation involving abuse or serious bodily injury, 4. Verbal/written notices to agencies are submitted via.fax, email, or by telephone.6.Upon receiving any allegations of abuse.the administrator is responsible for determining what actions are needed for the protection of the residents.Investigating Allegations.1. All allegations are thoroughly investigated. The administrator initiates the investigations.7. The individual conducting the investigation as a minimum: a. reviews documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or resident's representative.h. interviews staff members(on all shifts) who have had contact with the resident during period of alleged incident; h. interviews resident's roommate;.I. documents the investigation completely and thoroughly.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to thoroughly investigate alleged abuse of two of eleven sampled residents (Resident 11 & 2) when it did not adequately investigate the following incidents:1. Resident 1 allegedly kicked Resident 11 in the lower torso.2. Resident 4 allegedly threw a cup of water on Resident 2. This failure had the potential for alleged abuse to continue indefinitely and put alleged victims at risk of further abuse, bodily, and mental harm related to the alleged abuse.Cross Reference: F609Findings:1. Record review of admission Record for Resident 1 indicated he was admitted on [DATE] for diagnoses which included: Fracture of Right Tibia (a break in the large lower leg bone), Collision with car while on peda-cycle (pedal powered multi-person tour vehicles), Hypertension (high blood pressure), and Alcohol Dependence with Withdrawal (a chronic condition where the brain develops a physical need for alcohol to function).Record review of Minimum Data Set (MDS- federally mandated, standardized, and comprehensive assessment tool used in Medicare and Medicaid-certified nursing facilities) Section C-Cognitive (thinking processes) Patterns for Resident 1, dated 11/28/25, indicated a Brief Interview for Mental Status (BIMS) of 12, which indicated moderate cognitive impairment. Record review of MDS Section E-Behaviors for Resident 1, dated 11/28/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering.Record review of MDS Section GG-Functional Abilities, dated 11/28/25, for Resident 1, indicated he was independent for: Self Care, Indoor Mobility, Stairs, and functional cognition. Resident 1 had impairment on one Lower Extremity (hip, knee, ankle, foot). Resident 1 also had no prior use of devices such as wheelchair or walker. Record review of admission Record for Resident 11 indicated Resident 11 was admitted on [DATE] for diagnoses which included: Epilepsy (disorder marked by sudden recurrent episodes of sensory disturbance or loss of consciousness associated with abnormal electrical activity in the brain) , Gastroenteritis (short-term swelling of the stomach and intestines, usually caused by viruses, bacteria, or parasites) , Colitis (swelling of your colon), Anxiety (feeling of fear, apprehension) and, Depression (persistent sadness, loss of interest, and changes in mood, sleep, eating, and thinking that interfere with daily functioning).Review of MDS Section C-Cognitive patterns for Resident 11, dated 11/13/25, indicated a BIMS of 15 indicating intact cognitive abilities. Review of MDS Section E-Behaviors for Resident 11, dated 11/13/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering .Review of MDS Section GG-Functional Abilities for Resident 11, dated 11/13/25, indicated no impairment for upper and lower extremities, and resident usage of walker and wheelchair.On 1/27/26 at 12:50 P.M., a concurrent interview with the Quality Nurse (QN) and record review of the Electronic Medical Record (EMR- digital, computer-stored versions of patient's paper charts) was conducted. The QN stated that the process for resident to resident abuse was to: 1. separate the residents and make sure they are safe, 2. do head-to-toe assessment on each resident, 3. report to the Administrator (ADM), and he should initiate investigation and report to the following authorities: a. Physician (MD), b. Responsible Party (RP-is the person or entity legally and financially accountable for paying a patient's medical bills and invoices), c. Police Department (PD), d. Ombudsman (an independent, neutral advocate who helps patients), and e. California Department of Public Health (CDPH), 4. Document alleged abuse and finding in Change in Condition (CIC) note, progress note, and Care plan. The QN stated the expectation for resident-to-resident abuse was to report immediately to Abuse coordinator. The QN stated in this facility the abuse coordinator is the ADM. The QN stated that the incident between Resident 1 and Resident 11 was brought up during the interdisciplinary team (IDT- a group of professionals from different disciplines working interdependently to achieve (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient focused goals through shared decision-making) meeting, but there was no follow up on the incident. The QN stated that the DON and Social Services Assistant (SSA) were arguing about the incident, and then DON stated that they (the DON & SSA) would talk about it later. The QN was unable to find any follow up about the incident in the EMR about the incident. The QN stated the importance of reporting and investigating immediately is to keep residents that were being abused safe, and to prevent it from happening again.On 1/27/26 at 1:25 P.M., a concurrent interview with the SSA and record review of SSA's notes was conducted. The SSA stated that Resident 1 came to her on 1/19/26 at 9 A.M. to vent about a situation that happened with Resident 11, his roommate, the week before. The SSA stated Resident 11 asked Resident 1 to lower the TV volume, when Resident 1 barged into his side of the room and verbalized the threat .If you don't lower the TV, I'm going to hurt you. The SSA stated, Resident 1 said he kicked Resident 11 in the lower torso to protect himself. The SSA stated the Director of Nursing (DON) and her had disagreement about her note during the IDT meeting, and they met after the IDT meeting to discuss her note. The SSA stated that DON said that she did know Resident 1 had kicked Resident 11. The SSA stated that the DON said, I doubt he (Resident 1) is telling the truth. The SSA stated at the standup meeting on 1/20/26, DON asked her to strike out the original note and write a new note. The SSA stated that the expectation for alleged abuse was to report the alleged abuse to the Abuse Coordinator immediately. The SSA stated the Abuse Coordinator was the ADM. The SSA stated that she reported to the DON and assumed that she had reported to the ADM. Further review of the EMR with SSA indicated there was no follow up, investigation, or IDT meeting done regarding the incident. The SSA stated that the importance of reporting immediately to Abuse Coordinator, investigating, and reporting to the proper authorities was to prevent further abuse. Record review of SSA's note in the EMR dated 1/19/26 at 9:42 A.M., indicated note was documented as incorrect documentation and was crossed out with a line through it. The SSA's note indicated Resident met with SS [Social Services] to discuss room incompatibility. Resident stated around 4:30 P.M.-5:30 P.M. Wednesday 01/14 he was in bed watching tv show when Resident 11 barged into his side of room and threatened to hit him if he didn't lower the tv volume. Resident [1] stated that he felt threatened, so he retaliated with kicking the resident near his lower torso. Resident stated he did not want to report it the day of because he feared getting arrested. SS notified resident we would notify administration and DON about incident. SS will follow up as needed. Strike out reason: Incorrect Documentation. Strike out date: 1/20/26 10:42 Record review of handwritten follow-up note, not in EMR, by the SSA on paper indicated: On 1/19/26, Resident [1] met with SS to discuss ongoing roommate incompatibility. Resident [1] stated there had been disagreements over the tv. Resident [1] states roommate verbally threatened him, so he felt unsafe during the interaction. Resident [1] stated that he did not report the incident sooner because he feared getting arrested. Further investigation did not warrant any change. Resident [1] was offered room change to accommodate incompatibility. Resident [1] refused any changes. SS will follow up as needed.On 1/27/26 at 2 P.M., an observation and interview with Resident 11 was conducted. Resident 11 was observed in the hallway in his wheelchair. Resident 11 was alert and oriented and agreeable to interview. Resident 11 stated that he felt safe at the facility and currently had no problems with staff or other residents. Resident 11 stated that a few weeks ago, his previous roommate, Resident 1, had kicked him with his foot and he fell back onto his wheelchair and got a bruise on his lower back from landing on the wheelchair's brake lever. Resident 11 stated he and Resident 1 did not like each other. Resident 11 stated he thinks he owns the room.he thinks he special, he's not special here. Resident 11 stated he didn't report the kick because he was afraid of Resident 1 and thought he might beat him up. Resident 11 stated he reported he fell that day to the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff. On 1/27/26 at 2:15 P.M., a concurrent interview with Charge Nurse (CRN) 2 and record review of EMR for Resident 11 was conducted. CRN 2 stated that a resident kicking another resident or a resident throwing water on another resident was resident-to-resident abuse. CRN 2 stated that the process for resident to resident abuse was: 1. separate the residents and make sure they are safe, 2. do head-to-toe assessment on each resident, 3. report to the ADM, and he should initiate investigation and report to the following authorities: a. MD, b. RP, c. PD, d. Ombudsman, and e. CDPH, 4. document alleged abuse and finding in Change in CIC note, progress note, and Care plan. CRN 2 stated she could not find any follow up notes or IDT notes about alleged abuse investigation in the EMR. CRN 2 stated after reporting to ADM, the ADM should follow, investigate, and report the alleged abuse. CRN 2 stated if not reported or investigated, victims could continue to be abused. Record review of Resident 11's EMR was conducted with CRN 2. A Nurse's note dated, 1/12/26 at 8:15 P.M., indicated Resident 11 had a fall which matched description of type of injury that Resident 11 described in his interview. Nurse's Note indicated Resident [11] .claims that he had a fall @ around 1600[4 P.M.] in his room and also claims that he hit his back on his wheelchair, showed his back and notice a reddish discoloration measuring about 14x6 cm(centimeters) at this time. Res[ident 11] verbalizes that he came from the bathroom and is trying to go back to his bed when he tries to squeeze himself between the bed and wheelchair, he lost his balance and landed his back on his wheelchair. Res[ident 11] claims he stood up by himself and did not inform anyone until he feels pain on his back. Res[ident 11] did not report incident earlier when evening meds were administered. Head to toe check done, no further injuries noted at this time. Neuro-check initiated, no changes in LOC. Primary MD notified with orders. On 1/27/26 at 2:30 P.M., an interview with the Assistant Director of Nursing (ADON) was conducted. The DON was currently out of state. The ADON stated that she was unaware of any recent alleged abuse cases that were being investigated at the facility, including the incident involving Resident 1 and Resident 11, and the incident involving Resident 2 and Resident 4. The ADON stated the Abuse Coordinator was the ADM. The ADON stated if an alleged abuse incident was reported to her, she would immediately report it to the ADM. The ADON stated it was important to report the alleged abuse immediately so they can conduct and investigation and do the appropriate reporting to: 1. MD, 2. RP, 3. PD, 4. Ombudsman, & 5. CDPH. The ADON stated there should be documentation of investigation and follow-up in the EMR. The ADON stated the importance of timely reporting and investigation was for patient safety, preventing emotional distress, and self-isolation of the victim. On 1/27/26 at 2:45 P.M., an interview with the ADM was conducted. The ADM stated he was the abuse coordinator. The ADM stated that the incident for Resident 1 versus Resident 11 was not reported to him. The ADM stated the expectation was if the alleged abuse was reported to him, he would have conducted an investigation and reported per policy and procedure to the appropriate authorities and send a 5-day investigation summary to the State Survey Agency. The ADM stated he did not conduct an investigation, report to the appropriate authorities, or do a 5-day summary for the alleged abuse for this incident. The ADM stated the importance of reporting immediately was to prevent further abuse from happening to the victim. On 1/28/26 at 7:43 A.M., a phone interview was conducted with the DON. The DON stated she would consider the allegation of Resident 1 kicking Resident 1, resident-to-resident abuse. The DON stated that she did not investigate the incident between Resident 1 and Resident 11 because the SSA told her it happened a couple of weeks ago, and Resident 1 who confessed the abuse allegation was already discharged . The DON stated she thought it was only words and no physical interaction occurred. The DON stated she thought a misunderstanding happened between her and the SSA, and the DON asked the SSA to strike her note from 1/19/26 .because it seemed like abuse that was not reported. The DON stated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she is new to the facility and they are changing processes to follow up, and staff are not used to the new system yet. The DON stated the QA was supposed to start the investigation and follow up with her but never did. The DON stated that the investigation was not on the follow up list, so it was not reported to the Abuse Coordinator, and an investigation was not conducted. The DON stated that the ADM is the abuse coordinator. The DON stated, I am responsible as the DON. The DON stated that alleged abuse should be reported to the appropriate authorities per policy within 2 hours of the allegation of abuse. The DON stated that by not reporting and investigating immediately after abuse was alleged, there was potential for the victim to keep being abused. On 2/13/26 at 10 A.M., a follow-up interview was conducted with the ADM. The ADM confirmed that he did not do full investigations, 5-day investigation summaries, or report to the ombudsman for either incident of alleged abuse.A record review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, indicated Reporting Allegations to the Administrator and Authorities.1. If the resident abuse.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law, 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility, b. The local/state ombudsman, c. The resident's representative, e. law enforcement officials, f. the resident's physician.3.Immediatedly is defined as: a. within two hours of an allegation involving abuse or serious bodily injury, 4. Verbal/written notices to agencies are submitted via.fax, email, or by telephone.6.Upon receiving any allegations of abuse.the administrator is responsible for determining what actions are needed for the protection of the residents.Investigating Allegations.1. All allegations are thoroughly investigated. The administrator initiates the investigations.7. The individual conducting the investigation as a minimum: a. reviews documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or resident's representative.h. interviews staff members(on all shifts) who have had contact with the resident during period of alleged incident; h. interviews resident's roommate;.l. documents the investigation completely and thoroughly. 2. Record review of admission Record for Resident 2 indicated he was admitted on [DATE] for diagnoses which included: sepsis (body's extreme, dysfunctional response to an infection), urinary tract infection (an infection occurring in any part of the urinary system), epilepsy (disorder marked by sudden recurrent episodes of sensory disturbance or loss of consciousness associated with abnormal electrical activity in the brain), and malignant neoplasm of brain(a cancerous brain tumor). Record review of Minimum Data Set (MDS- federally mandated, standardized, and comprehensive assessment tool used in Medicare and Medicaid-certified nursing facilities) section C-Cognitive (thinking processes) patterns for Resident 2 dated 12/17/25, indicated a BIMS of 11 which indicated Moderate Cognitive impairment. Record review of MDS section E-Behaviors for Resident 2, dated 12/17/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering.Record review of MDS section GG-Functional Abilities for Resident 2, dated 12/17/25, indicated Resident 2 had no impairments for his upper and lower extremities, and usage of a wheelchair. Review of admission Record for Resident 4 indicated he was admitted on [DATE] for diagnoses which included: Myopathy (diseases that cause primary dysfunction, weakness, or degeneration of skeletal muscle fibers), Encephalopathy (a disease in which the functioning of the brain is affected by some agent or (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition), Major Depressive Disorder (common mood disorder characterized by persistent, intense feelings of sadness, hopelessness, and a loss of interest in activities for at least two weeks), Opioid Dependence a physical and psychological state where the body relies on opioids to function normally), and Chronic pain syndrome condition where pain persists for more than 3 to 6 months).Review of MDS Section C-Cognitive patterns for Resident 4, dated 10/31/25, indicated a BIMS of 15 indicated intact cognition. Review of MDS Section E-Behaviors for Resident 4, dated 10/31/25, indicated no potential indicator for psychosis, no behavioral symptoms, no rejection of care, and no wandering.Review of MDS Section GG-Functional Abilities for Resident 4, dated 10/31/25, indicated no impairment for his upper or lower extremities and usage of a wheelchair. On 1/27/26 at 10:15 A.M., a concurrent observation and interview was conducted with Resident 2. Resident 2 was observed in therapy in his wheelchair doing arm exercises. Resident 2 was outside enjoying some sun with his therapist. Resident 2 was alert and oriented and agreeable to interview. Resident 2 stated that about a week ago, someone threw water at him while he was resting in bed. Resident 2 stated that the alleged abuser said You snore too much. after he threw water on him. Resident 2 stated he didn't know exactly who it did, but it may have been one of his roommates. Resident 2 stated that he reported it to staff, but they didn't say anything else to him. Resident 2 stated that he felt safe in the facility at time of investigation.On 1/27/26 at 10:30 A.M., a concurrent observation and interview was conducted with Resident 3. Resident 3 was in his wheelchair outside of Resident 2' s room. Resident 3 was alert and oriented and agreeable to interview. Resident 3 stated that he felt safe in the facility and had no problems with staff and most residents. Resident 3 stated he only had problems with one resident, Resident 4, (Resident 2' roommate) who was mean to him every time they saw each other. Resident 3 stated Resident 4 called him Gay whenever he saw him in the hallway. Resident 3 seemed angry when talking about Resident 4's actions toward him and had reported to staff in the past. On 1/27/26 at 10:40 A.M., an interview with Certified Nursing Assistant 1(CNA) was conducted. CNA 1 stated that on 1/15/26 in the afternoon he went to Resident 2 to check if he needed a brief change. CNA 1 stated that when he saw Resident 2 was covered with water, and his clothes were soaked. CNA 1 stated that he had showered and changed Resident 2's clothes that morning and was dry the last time he saw him. CNA 1 stated that Resident 2 told him that the man in the wheelchair threw water on me. CNA 1 stated that throwing water on another resident was resident-to-resident abuse. CNA 1 stated the process for resident-to-resident abuse was: 1. separate the residents, 2. make sure they are safe, 3. report to the Charge Nurse (CRN), the Director of Nursing (DON), and the Administrator (ADM). CNA 1 stated that the ADM was the abuse coordinator. CNA 1 stated he immediately reported to CRN 1, the DON and the ADM. CNA 1 stated he was unsure if the ADM followed up and investigated the alleged abuse. CNA 1 stated the ADM should have investigated the abuse to prevent further abuse. On 1/27/26 at 11:50 A.M. an interview with CNA 2 was conducted. CNA 2 stated she was working with Resident 2, the day he complained about getting water thrown at him. CNA 2 stated she was working with CNA 1 on 1/15/26 and remembered that she and CNA 1 had showered Resident 2 that morning and had changed all his clothing and was dry when they left him that morning. CNA 2 stated that when CNA 1 checked on Resident 2 in the afternoon, Resident 2 was soaking wet. CNA 2 stated that Resident 2 stated the guy in the wheelchair threw water on me. CNA 2 stated she thought the person who threw the water on him was Resident 4, Resident 2's roommate. CNA 2 stated Resident 4 had a history of being aggressive with other residents. CNA 2 stated the process for resident-to-resident abuse was: 1. separate the residents, 2. make sure they are safe, 3. report to the CRN, the DON, and the ADM. CNA 2 stated that the ADM was the abuse coordinator. CNA 2 stated that throwing water on another resident or kicking another resident was (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident-to-resident abuse and it should be reported and investigated to prevent further abuse.On 1/27/26 at 12:25 P.M, an observation and interview with Resident 4 was conducted. Resident 4 observed in his bed resting. Resident 4 was alert and oriented, but agitated during attempt to interview, and was not agreeable to interview. Resident 4 stated I don't want to talk with you.On 1/27/26 at 12: 35 P.M., a concurrent interview with CRN 1, observation of her mobile phone texts, and record review of electronic medical record (EMR-digital, computer-stored versions of patient's paper charts) was conducted. CRN 1stated that she was the charge nurse the day that Resident 2 had water thrown on him. CRN 1 stated that the incident was reported to her at 11 A.M. CRN 1 stated that she considered the incident to be resident to resident abuse case and it should be reported to abuse coordinator. CRN 1 stated the abuse coordinator in the facility was the ADM. CRN 1 stated that she wrote a note that Resident 2 had water thrown on him by another resident, and that it was reported to the DON and the ADM. CRN 1 presented a copy of the text she made to the interdisciplinary team(IDT- a group of professionals from different disciplines working interdependently to achieve patient focused goals through shared decision-making), which included the ADM, DON, Social Services Director (SSD), and Quality (QN) Nurse, notifying them that Resident 2 had water thrown on him by another resident. EMR was reviewed with CRN 1, CRN 1 stated that she did not see any IDT report on the alleged abuse or any follow-up by Social Services (SS) or ADM. CRN 1 stated that after reporting the alleged abuse to the abuse coordinator, she would expect him to report to proper authorities and conduct an investigation. CRN 1 stated she would expect they would separate the residents involved. CRN 1 stated a possible outcome of not reporting or investigating the alleged abuse it that the abuse can keep happening to the victim.Record review of Nurse's Note for Resident 4, dated 1/13/26 at 2:26 P.M., indicated Res(ident 4) was verbally aggressive and displayed threatening behavior to CNA who informed him he is not allowed to have coffee in stainless mug due to potential risk of burns from hot beverages. Staff observed stainless mugs were full of hot coffee. Educated on risks of keeping hot beverages and conduct with staff.Record review of nursing note for Resident 2, dated 1/15/26 at 3:22 P.M., indicated Resident [2] claims that someone threw water on him but cannot recall the face upon assessment resident gown is wet.Record review of Nurse's Note for Resident 4, dated 1/26/26 at 2 P.M., indicated CNA reported that [Resident 4] may become upset if roommate is assisted back to bed at this time. CNA was informed that writer would speak with resident to provide explanation.Writer was also informed by staff that Resident 4 had previously expressed agitation related to noise and there is concern he may throw water or potentially harm his roommate if the roommate becomes noisy.Staff were advised to continue monitoring interaction closely and to report any escalation in behavior immediately. DON.,and Administrator.were informed.On 1/27/26 at 12:50 P.M., an interview with the Quality Nurse (QN) and review of EMR for Resident 2 was conducted. The QN stated that she found out about Resident 2 getting water thrown on him, during the IDT team meeting. The QN stated she spoke to the DON who stated she was going to talk to Social Services about investigating the alleged abuse on 1/26/26. The QN stated the ADM was the abuse coordinator. The QN stated that typical process for resident-to-resident abuse was to:1. separate the residents and make sure they are safe, 2. do head-to-toe assessment on each resident, 3. report to the ADM, and he should initiate investigation and report to the following authorities: a. Physician (MD), b. Responsible Party (RP- is the person or entity legally and financially accountable for paying a patient's medical bills and invoices), c. Police Department (PD), d. Ombudsman (an independent, neutral advocate who helps patients), and e. California Department of Public Health (CDPH), 4. Document alleged abuse and findings in Change in Condition (CIC) note, progress note, and Care plan. The QN stated alleged abuse should be reported to the ADM, and he should (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056330	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report to the appropriate authorities and investigate the incident. The QN stated the importance of reporting immediately is for patient safety and preventing further abuse. The QN stated that she could not find any notes regarding the investigation or followup of the alleged abuse in the EMR. On 1/27/26 at 2:30 P.M., an interview with the Assistant Director of Nursing (ADON) was conducted. The DON was currently out of state. The ADON stated that she was unaware of any recent alleged abuse cases that were being investigated at the facility, including the incident involving Resident 1 and Resident 11, and the incident involving Resident 2 and Resident 4. The ADON stated the Abuse Coordinator was the ADM. The ADON stated if an alleged abuse incident was reported to her, she would immediately report it to the ADM. The ADON stated it was important to report the alleged abuse immediately so they can conduct and investigation and do the appropriate reporting to: 1. MD, 2. RP, 3. PD, 4. Ombudsman, & 5. CDPH. The ADON stated there should be documentation of investigation and follow-up in the EMR. The ADON stated the importance of timely reporting and investigation was for patient safety, preventing emotional distress, and self-isolation of the victim.On 1/27/26 at 2:45 P.M., an interview with the ADM was conducted. The ADM stated he was the abuse coordinator. The ADM stated he investigated the alleged abuse for Resident 2 versus Resident 4 but didn't report it because Resident 2 did not complain about water being thrown on him when he interviewed him. The ADM stated that Resident 2 and Resident 4 were offered room changes but both refused so they did not pursue the incident as alleged abuse and did not further investigate. The ADM stated that the investigation was not documented in the EMR and he was unsure why. The ADM stated he was not sure if the abuse had occurred and was unsure if he should have reported it. The ADM stated that not reporting the abuse immediately and properly investigating the alleged abuse could have .the abuse repeated, escalated, and put the victims at further risk.On 1/28/26 at 7:43 A.M., a phone interview was conducted with the DON. The DON stated that Resident 2 getting a cup of water thrown on him by another resident was resident-to-resident abuse. The DON stated that the ADM conducted an investigation of this incident. The DON stated that QA nurse was supposed to be the one starting the investigation, and she (the DON) would follow up. The DON stated that she could not follow up on the investigation. The DON stated that the ADM did talk to both residents involved and both refused room change. The DON stated for alleged abuse, they should report to the appropriate authorities per policy and procedure within 2 hours of the allegation of abuse. The DON stated the facility did not report this alleged abuse to the appropriate authorities because She believed that the incident did not happen. The DON stated that not reporting and investigating alleged abuse in a timely manner could put the residents at risk for more abuse. On 2/13/26 at 8:39 A.M., an attempt to contact ombudsman for interview was made. A message was left with the ombudsman service as ombudsman was on vacation until 2/17/26. On 2/13/26 at 10 A.M., a follow-up interview was conducted with the ADM. The ADM confirmed that he did not do full investigations, 5-day investigation summaries, or report to the ombudsman for either incident of alleged abuse.A record review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, indicated Reporting Allegations to the Administrator and Authorities.1. If the resident abuse.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law, 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility, b. The local/state ombudsman, c. The resident's representative, e. law enforcement officials, f. the resident's physician.3.Immediatedly is defined as: a. within two hours of an allegation involving abuse or serious bodily injury, 4. Verbal/written notices to agencies are submitted via.fax, email, or by (continued on next page)

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