STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A027	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista	3455 East Highland Ave Highland, CA 92346

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for one resident (Resident 1), when a Certified Nursing Assistant (CNA 1) threw water on Resident 1's face and kicked his right leg. This failure placed Resident 1 at risk for physical and psychological harm. Findings: During a review of Resident 1's Admission Record (clinical record with demographic information), it indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included paranoid schizophrenia (a mental disorder that affects a person's thoughts, feelings, and behavior). A review of the MDS (Minimum Data Set, and assessment tool), dated November 14, 2024, indicated Resident 1 had cognitive function with a score of 15/15 on the BIMS assessment (Brief Interview for Mental Status) which indicated Resident 1 is likely to have normal cognition and may require the least amount of cognitive aid and memory support from staff. During a telephone interview with Primary Counselor (PC 1) on December 3, 2024, at 1:42 PM, PC 1 stated she witnessed the incident that occurred on December 2, 2024, at approximately 7:45 AM. PC 1 stated after Resident 1 took his medication, he stood in line to get his meal ticket. PC 1 stated she saw CNA 1 requested Resident 1 to drink water, but Resident 1 refused. PC 1 further stated that Resident 1 lunged [to move forward suddenly] at CNA 1, CNA 1 reacted by kicking Resident 1 on his right leg and poured the water on his face before Resident 1 moved back into line. During an interview with Resident 1, on December 3, 2024, at 1:59 PM, Resident 1 stated on December 2, 2024, CNA 1 kicked him and threw water on his face because he refused to drink water after taking his medication. Resident 1 indicated his right lower leg when asked where he had been kicked. During an interview with the Quality Assurance (QA 1), on December 3, 2024, at 2:17 PM, she stated the CNA 1's actions of kicking and throwing water at Resident 1, constituted abuse. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A027	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista	3455 East Highland Ave Highland, CA 92346

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent interview and record review with QA 1 on December 3, 2024, at 2:35 PM, facility Policy & Procedure (P&P) titled Abuse Prohibition dated February 23, 2021, was reviewed. The P&P indicated, . Federal Definitions; .Physical Abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment . Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for one resident (Resident 1), when a Certified Nursing Assistant (CNA 1) threw water on Resident 1's face and kicked his right leg. This failure placed Resident 1 at risk for physical and psychological harm. Findings: During a review of Resident 1's Admission Record (clinical record with demographic information), it indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included paranoid schizophrenia (a mental disorder that affects a person's thoughts, feelings, and behavior). A review of the MDS (Minimum Data Set, and assessment tool), dated November 14, 2024, indicated Resident 1 had cognitive function with a score of 15/15 on the BIMS assessment (Brief Interview for Mental Status) which indicated Resident 1 is likely to have normal cognition and may require the least amount of cognitive aid and memory support from staff. During a telephone interview with Primary Counselor (PC 1) on December 3, 2024, at 1:42 PM, PC 1 stated she witnessed the incident that occurred on December 2, 2024, at approximately 7:45 AM. PC 1 stated after Resident 1 took his medication, he stood in line to get his meal ticket. PC 1 stated she saw CNA 1 requested Resident 1 to drink water, but Resident 1 refused. PC 1 further stated that Resident 1 lunged [to move forward suddenly] at CNA 1, CNA 1 reacted by kicking Resident 1 on his right leg and poured the water on his face before Resident 1 moved back into line. During an interview with Resident 1, on December 3, 2024, at 1:59 PM, Resident 1 stated on December 2, 2024, CNA 1 kicked him and threw water on his face because he refused to drink water after taking his medication. Resident 1 indicated his right lower leg when asked where he had been kicked. During an interview with the Quality Assurance (QA 1), on December 3, 2024, at 2:17 PM, she stated the CNA 1's actions of kicking and throwing water at Resident 1, constituted abuse. During concurrent interview and record review with QA 1 on December 3, 2024, at 2:35 PM, facility Policy & Procedure (P&P) titled Abuse Prohibition dated February 23, 2021, was reviewed. The P&P indicated, . Federal Definitions; .Physical Abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment .