

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Sierra Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on interview and record review, the facility failed to ensure staff treated residents with dignity and respect when a Certified Nursing Assistant 1 (CNA 1) verbally abused one of three sampled residents (Resident 1) by calling Resident 1 a derogatory term and inappropriately discussed details of Resident 1's personal sex life with fellow staff members. This failure resulted in Resident 1 feeling humiliated, dehumanized, embarrassed and to experience emotional distress. Findings: During a review of Resident 1's admission Record (contains medical and demographic information), the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a serious mental disorder characterized by distortions in thinking, perception, emotions, sense of self and behavior), history of traumatic brain injury (past traumatic brain injury) , and congestive heart failure (a condition in which the heart cannot pump blood effectively enough to meet the body's needs). During a review of Resident 1's Minimum Data Set Assessment (MDS assessment - an electronic medical assessment) dated February 19, 2026, the MDS assessment section C (section for cognitive patterns) indicated Resident 1 had a Brief Interview for Mental Status score (BIMS score - a screening tool used to assess a resident's cognitive status, including memory and orientation) of 15 out of 15 (cognitively intact). During a review of Resident 1's Electronic Health Record (EHR - computer based medical record), a progress note dated March 26, 2026 indicated, On 3/26/26 [March 26, 2026] Resident submitted a grievance stating that on 3/25/26 [March 25, 2026] staff reportedly stated He a damn snitch, he went and got the RN. Per resident; Resident reported I went to go get the RN and she called me a damn snitch because I went and got the RN [registered nurse]. During a review of Resident 1's grievance report titled, Concern/Grievance Form, dated March 25, 2026, the Concern/Grievance Form, indicated, At about 9 PM [9:00 PM] I asked [Name of Licensed Psychiatric Technician 1 [LPT 1] for a [medication] prn [prn - medication administered as needed]. He [LPT 1] refused I went and got the RN. As I walked back to the nurses station, [Name of CNA 1] said and [I] quote, He a damn snitch, went and got the RN. During a review of a documented witness interview titled, Witness Interview Record, dated March 26, 2026, signed by Primary Counselor 2 [PC 2], the witness interview record indicated, I [PC 2] was in the activities room around 9:15 PM. I [PC 2] was hearing yelling, I got up and I went and stood by the T [a podium in the hallway]. I heard [name of CNA 1] say, I don't give a fuck. I said what I said. [Name of Resident 1] was walking towards the T and sat at the table. During a review of a documented witness interview titled, Witness Interview Record, dated March 26, 2026, signed by Behavioral Specialist 3 [BS 3], the witness interview record indicated, I [BS 3] heard yelling, I came out the activities room and I heard her say, you ain't nothing but a god damn snitch and I said what I said. He [Resident 1].was standing by the phone and talking to another staff about [Name of CNA 1] telling him stuff about sleeping with another resident and how she [name of another resident] is sleeping with other people. During an interview on May 28, 2026, at 3:15 PM, with BS 3, BS 3's signed, Witness Interview Record, dated and signed March 26, 2026, was read. BS 3 stated the record was her recollection of the incident and stated on March 26, 2026, she came out of the activities room and heard CNA 1 say, You ain't nothing (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 05A027	Facility ID: 05A027 If continuation sheet Page 1 of 2

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but a god damn snitch and I said what I said, BS 3 stated CNA 1 was talking directly to Resident 1 and they were by the T podium at the end of the hallway. BS 3 stated Resident 1 then complained to her about how CNA 1 was taunting him about [name of another resident] sleeping with other residents. During a review of a documented witness interview titled, Witness Interview Record, dated March 26, 2026, signed by PC 4, the witness interview record indicated, I heard commotion. I heard [name of CNA 1]'s voice when I was coming out of the locker room. I heard her [CNA 1] yelling. I walked up to the T and asked them what was going on. They said [Name of CNA 1] was down the hall cussing [Name of Resident 1] out. I hear [sic] [Name of Resident 1] screaming too. I walked towards [Resident 1] at the activity tables writing a grievance. I asked him what was going on. He told me, I'm tired of [Name of CNA 1] and the way she talks to me and any of the residents. She is very disrespectful and rude and I don't have to take her shit. She was taunting me about [name of another resident] and telling me about how [name of another resident] is sleeping with other residents but she doesn't know what she's talking about. We have an open relationship. During an interview on May 28, 2026, at 3:10 PM, with PC 4, PC 4's signed, Witness Interview Record, dated and signed March 26, 2026, was read. PC 4 stated the record was her recollection of the incident and stated on March 26, 2026, she heard CNA 1 yelling and she asked other staff members by the T what was going on, and other staff members told her [name of CNA 1] was down the hall cursing [name of Resident 1] out. PC 4 further stated she also heard Resident 1 screaming and Resident 1 informed her how disrespectful and rude CNA 1 was and how CNA 1 was telling him about [name of another resident] sleeping with other residents. PC 4 stated Resident 1 was visibly upset, his face was red and he was visibly flustered. PC 4 stated in the past, she had also heard CNA 1 tell other residents they were snitches and other discouraging words. During a review of the facility's investigative summary of the incident titled, Event Summary Report, dated April 1, 2026, the report indicated, Date and time of incident: 3/26/26. Resident [Name of Resident 1]. Staff: [Name of CNA 1]. Alleged Verbal Abuse. Summary of investigation - Regarding grievance submitted by resident, in which he alleges staff stated He a damn snitch, he went and got the RN, investigation is complete and substantiates resident's account. Facility determined staff violated facility policy. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition, dated February 23, 2021, the P&P indicated, Sierra vista prohibits abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Federal Definitions: . Verbal abuse - is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Mental Abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. 5. Actions to prevent abuse, neglect exploitation, or mistreatment. will include: . 5.2. Establishing a safe environment that supports to the extent possible, a patient's consensual sexual relationship.		