STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A264	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Pacifica Center	3674 Pacific Avenue Jurupa Valley, CA 92509

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, facility failed to ensure the resident was treated with dignity and respect for one of three sampled residents (Resident 1), when Mental Health Worker (MHW 1) did not assist the resident after he fell from his wheelchair and failed to provide support when the resident dropped his cigarette. This failure resulted in Resident 1 becoming angry and agitated with staff member. Findings: A review of Resident 1's record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (mental health condition with symptoms of schizophrenia [thoughts or experiences that seem out of touch with reality, disorganized speech or behavior] and a mood disorder [intense and persistent changes in mood, energy, and behavior]) and osteoarthritis (tissues in the joint break down over time) of knee. A review of Resident 1's Progress Notes, dated February 15, 2025, indicated, .Incident Note .Approximately at 1950 (7:50 p.m.), res (Resident 1) was at the patio for smoke break, then res (resident) was noted arguing with a male staff .res accidentally dropped his cigarette on the floor then the male staff that the res doesn't want to touch his cigarette was seen pulling res wheelchair backward and res fell on his knees and hands, then the male staff left res on the floor and walked away, so, another staff helped res to get back on his wheelchair, the res turn around and attempted to pick another cigarette that was on the floor, so the same male staff then kicked the cigarette out of the way . On February 27, 2025, at 10:50 a.m., an interview was conducted with the Administrator (Admin) who stated, on February 15, 2025, at approximately 7:55 p.m., Resident 1 was on the patio during a smoke break with MHW 1. The Admin stated, Resident 1 dropped a cigarette and reached for it when MHW 1 kicked it out of reach, causing Resident 1 to fall from his wheelchair. The Admin stated, MHW 1 did not assist Resident 1 back into the wheelchair or offer another cigarette. The Admin stated, the staff were expected to help residents with tasks they could not perform themselves. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, at 3:01 p.m., an interview was conducted with MHW 2. MHW 2 stated, on February 15, 2025, at approximately 7:55 p.m., he was inside the facility when he heard Resident 1 outside on the patio, cursing and yelling at MHW 1. MHW 2 stated, he went outside, Resident 1 argued that the cigarette MHW 1 offered was not his. MHW 2 stated, MHW 1 insisted it was and did not attempt to calm the resident. MHW 2 stated, he retrieved the cigarette, which settled the issue. MHW 2 stated, after returning inside, he saw Resident 1 on the ground in front of his wheelchair. MHW 2 stated, MHW 1 stood behind the wheelchair, watching but not assisting. MHW 2 stated, he went outside and helped Resident 1 back into his wheelchair. MHW 2 stated, as the smoke break ended, Resident 1 leaned forward to grab a cigarette from the ground, MHW 1 kicked it away. MHW 2 stated, Resident 1 became upset, stood up, raised his fists. MHW 2 stated, he stepped in between them to prevent a confrontation and escorted Resident 1 inside to calm down. MHW 2 stated, MHW 1 was unprofessional and did not assist Resident 1. MHW 2 stated, he reported the incident to Licensed Vocational Nurse (LVN) 1 immediately. On February 27, 2025, at 3:23 p.m., an interview was conducted with LVN 1, who stated, on February 15, 2025, at approximately 8:00 p.m., MHW 2 told her to review the security cameras due to an incident between MHW 1 and Resident 1 on the patio. LVN 1 stated, she reviewed the footage and saw MHW 1 appearing to antagonize Resident 1 by holding a cigarette in his hand but not giving it to the resident. LVN 1 stated, she saw MHW 2 come outside and hand Resident 1 a cigarette. LVN 1 stated, she then saw Resident 1 drop his cigarette on the ground and reached for it, MHW 1 then Stomped, on the cigarette and swept it out of resident's reach with his foot, resulting in Resident 1 falling out of his wheelchair while reaching for the cigarette. LVN 1 stated, after resident fell out of his wheelchair, MHW 1 was observed walking away from resident, and did not assist resident back into his wheelchair. LVN 1 stated, MHW 2 came out to the patio and assisted Resident 1 back into his wheelchair. LVN 1 further stated, MHW 1 did not treat Resident 1 with respect and dignity, as MHW 1 did not assist resident with his needs. LVN 1 stated, she reported the incident immediately to the Director of Nursing (DON), who instructed her to send MHW 1 home pending investigation. On February 27, 2025, at 5:52 p.m., an interview was conducted with the DON, who stated, she expected staff to treat residents with dignity and respect. The DON stated, on February 15, 2025, at approximately 8:40 p.m., LVN 1 reported, an incident had occurred between Resident 1 and MHW 1 on the patio at approximately 7:55 p.m. The DON stated, she reviewed the cameras and observed Resident 1 dropped his cigarette on the ground, at which time, MHW 1, Kicked and Kicked the cigarette out of resident's reach, causing Resident 1 to slide out of his wheelchair, on to the ground, his hands and knees. The DON stated, when resident slid out of his wheelchair, his pants had partially fallen, exposing half of his buttocks in the presence of other residents. The DON stated, this incident appeared to violate Resident 1's rights as he was not being treated with dignity and respect by MHW 1. The DON stated, the situation (on the patio) was not handled appropriately by MHW 1. The DON stated, she would expect MHW 1 to have handed Resident 1 another cigarette and help resident back into his wheelchair. The DON stated she instructed LVN 1 to send MHW 1 home immediately pending investigation. The DON verified, MHW 1's employment was terminated on February 18, 2025 due to unacceptable conduct and behavior. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy & Procedure, titled, Resident Rights, undated, indicated, . Employees shall treat all residents with kindness, respect and dignity . 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, the facility failed to report the neglect for one of three sampled residents (Resident 1) to the California Department of Public Health (CDPH) within 2-hours. Resident 1 was denied a cigarette and left without assistance back into his wheelchair by Mental Health Worker (MHW) 1. This failure had the potential to result in Resident 1 to remain at risk of further harm and emotional distress. Findings: On February 27, 2025, at 10:50 a.m., an interview was conducted with the Administrator (Admin), who stated, he was the facility's abuse coordinator and that staff were expected to report all witnessed or suspected abuse or neglect within two hours to CDPH and other agencies. A review of Resident 1's record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (mental health condition with symptoms of schizophrenia [thoughts or experiences that seem out of touch with reality, disorganized speech or behavior] and a mood disorder [intense and persistent changes in mood, energy, and behavior]) and osteoarthritis (tissues in the joint break down over time) of knee. A review of Resident 1's Progress Notes, dated February 15, 2025, indicated, .Incident Note .Approximately at 1950 (7:50 p.m.), res (Resident 1) was at the patio for smoke break, then res (resident) was noted arguing with a male staff .res accidentally dropped his cigarette on the floor then the male staff that the res doesn't want to touch his cigarette was seen pulling res wheelchair backward and res fell on his knees and hands, then the male staff left res on the floor and walked away, so, another staff helped res to get back on his wheelchair, the res turn around and attempted to pick another cigarette that was on the floor, so the same male staff then kicked the cigarette out of the way . On February 27, 2025, at 3:23 p.m., an interview with Licensed Vocational Nurse (LVN) 1, was conducted. LVN 1 stated, that facility policy required reporting neglect to CDPH and other agencies within two hours. LVN 1 stated, on February 15, 2025, at approximately 8:05 p.m., while reviewing security footage, she observed MHW 1 and Resident 1 on the patio during a smoke break at approximately 7:55 p.m. LVN 1 stated, she saw MHW 1 antagonizing Resident 1 by withholding a cigarette and later sweeping a cigarette away with his foot when Resident 1 reached for it, causing Resident 1 to fall out of his wheelchair. LVN 1 stated, MHW 1 walked away, leaving Resident 1 on the ground, while MHW 2 assisted the resident back into his wheelchair. LVN 1 further stated, she reported the incident to the Director of Nursing (DON) at approximately 8:50 p.m. LVN 1 stated, the DON instructed her to send MHW 1 home pending and investigation, which she did immediately. LVN 1 stated, she informed the Director of Staff Development (DSD) and asked for assistance in reporting the incident to CDPH and other agencies. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, at 4:04 p.m., a concurrent interview with the DSD and review of CDPH and other agency reporting times was conducted. The DSD stated, per facility policy , abuse or neglect must be reported to CDPH and other agencies within two hours. The DSD stated, on February 15, 2025, at approximately 9:30 p.m., LVN 1 reported that MHW 1 left Resident 1 on the ground after he slid from his wheelchair and did not assist him. The DSD stated, MHW 2 helped Resident 1 back into his wheelchair . The DSD stated, it was neglect and basic care was not provided. The DSD stated, she was informed of the incident at 9:30 p.m. and knew it had occurred at 7:55 p.m. The DSD stated, she did not report it to CDPH and other agencies until 11:20 p.m. (3 hours later). The DSD stated, she had completed paperwork before making the report making the report and stated I should have called first and then done the paperwork. On February 27, 2025, at 5:52 p.m., a concurrent interview with the DON and review of intake reporting times was conducted. The DON stated, facility policy required staff to report suspected neglect to CDPH and other authorities within two hours. The DON stated, an incident of neglect involving Resident 1 and MHW 1 had occurred on the smoking patio at 7:55 p.m. but was not reported to CDPH via telephone until 11:20 p.m. The DON stated the report had not been made within the required two-hour timeframe. A facility Policy & Procedure, titled, Reporting Abuse & Unlawful conduct to State Agencies and Other Entities/Individuals, undated, indicated, . All suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. Allegations of abuse, including injuries of unknown source or causing serious bodily injury must be reported as soon as possible or no later than 2 hours from the time the facility is made aware . 3. The Administrator or his designee will notify the State Licensing/Certification agency of any injuries of unknown injury or incidents of abuse that result in serious bodily injury as soon as possible and no later than 2 hours .