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	06/17/2026

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 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 protect the resident's right to be free from physical abuse by another resident, for one of seven residents reviewed for abuse (Resident 1), when Resident 2 struck Resident 1 a second time following an earlier physical altercation. The facility failed to ensure Resident 2 was adequately separated from Resident 1 following the initial incident to prevent further incidents. This failure resulted in Resident 1 being subjected to second physical assault and had the potential to negatively affect the resident's physical, emotional, and psychosocial well-being. Findings: On June 2, 2026, at 11:41 a.m., an interview was conducted with Resident 1. Resident 1 stated, on May 25, 2026, Resident 2 struck him in the back of the head while they were in the TV room. Resident 1 stated he ran away to avoid further confrontation and staff intervened. Resident 1 stated that approximately 30 minutes later, Resident 2 struck him again on the side of the head while he was walking in the hallway. Resident 1 stated he had no prior disagreements with Resident 2 and did not retaliate. On June 2, 2026, at 1:25 a.m., an interview was conducted with Mental Health Worker (MHW 2). MW 2 stated after the initial altercation, Resident 2 was placed on 1:1 supervision and escorted to the smoking patio by two staff members. MHW 2 stated after the smoke break, staff escorted Resident 2 back through the hallway and Resident 2 struck Resident 1 near the nursing station. MHW 2 stated she failed to ensure the hallway was clear and that established protocols to prevent further altercations were not followed. On June 2, 2026, at 2:13 p.m., an interview was conducted with the Mental Health Counselor MHC. MHC stated 1:1 supervision was implemented to prevent further incidents and that staff should have ensured Resident 1 was not in the area before escorting Resident 2 through the hallway. MHC stated a 1:1 protocol meant staff should ensure a minimized activity while monitoring behaviors to ensure further incidents would not occur during a ?cool down' process, which was a process of attempting to calm the resident after an altercation. MHC stated the purpose of having 1:1 intervention in place were to prevent retaliation. MHC stated staff should have made sure the hallways were clear of all residents, including Resident 1, and should not have escorted Resident 2 within a close proximity of Resident 1 after the smoke break. On June 2, 2026, at 3:19 p.m., an interview was conducted with Licensed Vocational Nurse (LVN 1). LVN 1 stated the protocol for escorting a resident on 1:1 supervision requires clearing the hallway by announcing the need for clearance and ensuring safety before escorting a resident into the area. LVN 1 stated staff assigned to the 1:1 supervision should have ensured the hallway was clear and avoided bringing Resident 2 into close proximity to Resident 1 following the earlier altercation. LVN 1 stressed the importance of all staff maintaining vigilance during 1:1 supervision and monitoring nearby residents to prevent similar incidents, which was not done in this case. On June 2, 2026, Resident 1 and Resident 2's records were reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosis which included, schizoaffective disorder bipolar type (mental health condition that combines hallucinations or delusions with severe mood swings). The Minimum Data Set (MDS - an assessment tool, dated February 27, 2026, indicated, .Brief Interview for Mental Status (BIMS - screening test used for mental and cognitive status) score of 15 (intact cognitive status). A review of Resident 1's progress (continued on next page)

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

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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	notes dated May 26, 2026, at 12:08 p.m., indicated, .program note. PC met with resident to discuss the incident noted regarding this resident being the victim in two resident to resident altercations. A review of the care plan dated May 25, 2026, indicated, .resident to resident altercation as non-aggressor.resident will have no complications through the review date.interventions.give resident space to express fears and apprehension. Resident 2 was admitted to the facility on [DATE], with diagnosis which included Schizophrenia (mental health condition that combines hallucination or delusions with severe mood swings). The Minimum Data Set (MDS - an assessment tool, dated May 6, 2026, indicated, .Brief Interview for Mental Status (BIMS - screening test used for mental and cognitive status) score of 15 (intact cognitive status). A review of Resident 2's progress notes indicated the following:-Dated May 25, 2026, at 11:33 a.m., .at approximately 11 am on 5/25 the residents were sitting in the TV room with this resident seated in the back row and his peer in the row in front of him, without provocation this resident stuck his peer one time with a closed fist on the right side of his head. The resident attempted to strike his peer again; however his peer got out of his seat and ran. This resident began chasing his peer when staff intervened. Code amber (all staff response) was called and the resident was escorted to his room using proper NCI (nonviolent crisis intervention). Resident was placed on 1:1 supervision. When asked about the incident the resident stated, I don't know want to talk about it. No injuries were reported for either resident. -Dated May 25, 2026, at 3:48 p.m. indicated, .At approximately 12 p.m., resident was being escorted to room from smoke break. Peer was turning away from nursing station after receiving medication. Resident broke away from escort and struck peer on left lower jaw x1.Resident immediate separated from peer and escorted to room using proper NCI. Resident and per assessed for injury none. The care plan, revised on May 28, 2026, indicated, .resident to resident aggressor.will have no further behavior through the review date.will monitor and assist to identify the causative factor or trigger effect.will monitor and supervise resident for every shift. On June 2, 2026, at 3:58 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated staff failed to effectively communicate and assess the risk when escorting Resident 2 after the smoke break, resulting in Resident 2 being brought near Resident 1 and creating the opportunity for a second physical altercation. The DON stated staff were required to maintain a safe environment by clearing the area and escorting residents carefully to prevent additional altercations. A review of the facility policy and procedure titled, Resident to Resident Abuse undated, indicated, .should the resident be observed/accused of seriously abusing another resident, our facility will.remove the aggressor from the situation if the aggressor is still in the area in which the incident occurred.temporarily separate the resident from other residents as a therapeutic intervention to help lower the agitation.prevent recurrence of such incident.