STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A264	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VISTA PACIFICA CENTER	**3674 PACIFIC AVENUE RIVERSIDE, 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 observation, interview, and record review the facility failed to ensure and maintain an environment free from abuse when Resident 1 was hit by Resident 2. This failure resulted in Resident 2 sustaining a bruise to the right side of his abdomen. Findings: On March 11, 2020, at 9:54 a.m., an unannounced visit was conducted at the facility for the investigation of a facility reported incident. On March 11, 2020, at 10:28 a.m., during a tour with the Assistant Program Director (APD), Resident 1 was observed outside sitting in a chair. In a concurrent interview, Resident 1 stated on March 8, 2020, he was outside the TV room when Resident 2 came up and hit him in the left side of his rib area. He stated he hit Resident 2 back. On March 11, 2020, at 10:36 a.m., during a tour conducted with the APD, Resident 2 was observed lying on his bed, in his room. In a concurrent interview, he stated Resident 1 hit him first and he retaliated by hitting him back. He stated he was hit to the right side of his abdomen. He was observed to lift his shirt. An area of purplish discoloration, approximately two by four inches with yellowish-green edges, was observed on the right side of his abdomen. He stated he was unsure of how he got the bruise. The APD was observed to look at the discoloration on Resident 2's abdomen. The APD was concurrently interviewed, and stated he was unsure if the bruise was assessed and documented in Resident 2's record. On March 11, 2020, at 10:43 a.m., an interview was conducted with the primary counselor (PC). The PC stated Residents' 1 and 2 had an on and off relationship. She stated sometimes they were friendly to each other and at other times would not get along. On March 11, 2020, at 11:07 a.m., an interview was conducted with the Director of Nursing (DON). She stated Resident 2 hit Resident 1 outside the TV room. She stated Resident 1 retaliated by hitting Resident 2. On March 11, 2020, Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Progress Notes, dated March 8, 2020, at 4:46 p.m., indicated, .Incident Note .@ (at) approximately 1520 (3:20 p.m.) .both residents were outside of the TV room talking when being unprovoked resident punched his peer with a closed fist to his stomach and back two times, resident's peer did retaliate and hit resident to his side resident . On March 11, 2020, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Progress Notes, dated March 8, 2020, at 5:03 p.m., indicated .Incident Note .resident was hit by his peer .to his stomach and his back with a closed fist, resident did retaliate and hit his peer to his side with a closed fist . On March 12, 2020, at 3:40 p.m., a telephone interview was conducted with the Registered Nurse (RN). She stated both residents were outside the TV room in the hall when Resident 2 hit Resident 1 twice to his back and stomach area. She stated Resident 1 retaliated and hit Resident 2 in the stomach. The undated facility policy and procedure titled, Preventing Resident Abuse, was reviewed. The policy indicated, .Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing abuse .Preventing abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the bruise on Resident 2's abdomen, was identified, assessed, and monitored. In addition, the facility failed to ensure Resident 2's physician was notified timely. These failures had the potential to result in the delay of the necessary care and treatment for [REDACTED]. On March 11, 2020, at 10:36 a.m., an observation of Resident 2 was conducted with the Assistant Progress Director (APD). Resident 2 was observed lying on his bed, in his room. In a concurrent interview, Resident 2 stated Resident 1 hit him first and he retaliated by hitting him back. He stated he was hit to the right side of his abdomen. He was observed to lift his shirt. An area of purplish discoloration, approximately two by four inches, with yellowish-green edges was observed on the right side of his abdomen. He stated he was unsure of how he got the bruise. The APD was concurrently observed to look at the discoloration on Resident 2's abdomen. In an concurrent interview the APD stated he was unsure if the 'bruise was assessed and documented in Resident 2's record. On March 11, 2020, at 11:15 a.m., a record review and concurrent interview were conducted with the DON. The DON stated there was no documentation of Resident 2's bruise on his record. She stated staff should have documented Resident 2's bruise on the 72-hour charting. She further stated staff should not rely on asking residents about injuries, but should assess the residents themselves. On March 11, 2020, at 12:15 p.m., a follow-up interview was conducted with the DON. She stated staff should visualize the resident's skin for injuries and document the findings. She stated by the licensed staff asking Resident 2 and not actually lifting his shirt to observe his skin, staff were not able to assess for the bruise. On March 11, 2020, Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Progress Notes, dated March 8, 2020, at 4:46 p.m., indicated, .Incident Note .@ (at) approximately 1520 (3:20 p.m.) .both residents were outside of the TV room talking when being unprovoked resident punched his peer with a closed fist to his stomach and back two times, resident's peer did retaliate and hit resident to his side resident was assessed and no swelling, bruising or skin tear is observed at this time. resident (sic) sustained no injuries during the incident . There was no documented evidence the bruise on Resident 2's abdomen was identified, assessed, and monitored. There was no documented evidence the physician was notified about the bruise on Resident 2's abdomen. On March 12, 2020, at 3:40 p.m., a telephone interview was conducted with the Registered Nurse (RN). She stated staff were to assess the resident every shift and document their findings. She stated if residents refused the skin assessment staff were to document the refusal and attempt again later in the shift. She stated Resident 2's bruise should have been documented and reported to the physician. She stated the bruise should have been included in the 72-hour charting so staff could monitor and assess the injury. She further stated the bruise was not identified until March 11, 2020, three days after the altercation. On March 17, 2020 at 9:20 a.m., a telephone interview was conducted with the DON. She stated the bruise resulting from the resident to resident altercation would be considered a change of condition. She stated there was no documentation the physician had been notified of Resident 2's bruise. She stated the physician should have been notified of Resident 2's bruise. The DON stated the facility did not have a policy on identification, assessment, and monitoring of a resident's skin. The facility policy and procedure titled, Reporting a Change in Condition, revised March 3, 1999 was reviewed. The policy indicated, .A Change of condition in a resident can adversely affect his/her medical and psychological status, therefore all significant changes in condition are to immediately be reported to the attending physician .so that proper follow up (i.e., .Physician appointment, Lab, X-ray,

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

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Education, Treatment Planning including Emergency evaluation of need be) will be accomplished in a timely manner to insure the health and safety to all residents .to complete the Change of Condition .do a complete assessment, mental status as well as physical status .Notify physician promptly .