STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055538	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonnie Brae Skilled Nursing	420 South Bonnie Brae St. Los Angeles, CA 90057

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** 49571 Based on Observation, Interview, and record review the facility failed to protect the resident ' s right to be free from resident-to-resident verbal and physical abuse for two of two sampled residents (Resident 1 and Resident 2) by failing to: 1. Provide necessary behavioral health assessment monitoring and ordered psychiatrist/psychology referrals when Resident 1 was exhibiting behavioral health symptoms of entering other resident ' s rooms without their permission to shout at other residents. 2. Protect Resident 2 from Resident 1 ' s verbal abuse, when on 11/28/24 at 9:30 AM Resident 1 to yell and Resident 2 (roommate), leading a resident-to-resident physical altercation (fight). This deficient practice resulted in Resident 2 hitting Resident 1 with his phone on the right side of the face on 11/28/24 at 9:30 AM. Resident 1 exhibited redness and bruising (bluish discoloration mark) on the right side of the face and above the right eye, complained blurry vision. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 8/30/2024 with diagnoses that included combined forms of age-related bilateral cataract (a condition in which the lens of an eye becomes cloudy and affects vision) and other unspecified peripheral vascular diseases (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 9/12/24 indicated, assessment for verbal behavioral symptoms directed toward others (e.g. Threatening others, screaming at others, cursing at others) indicated; behavior not exhibited. Overall present of behavioral symptoms assessment indicated; behavior not exhibited. A review of Resident 1 ' s History and Physical (H&P) record dated 9/26/24, indicated the resident had a history of drug and alcohol use and had been homeless for 2 years. The H&P indicated the resident had the capacity to make and understand decisions. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Care Plan for Behavioral Symptoms initiated on 11/16/24 indicated, the resident had behavioral problems related to socially inappropriate/disruptive symptoms: talking harshly and loudly. The goal for Resident 1 included but was not limited to, not making disruptive noises, behaviors, and to interact peacefully in social situations. The care plan intervention indicated, not argue with the resident, allow control and decision making as able, redirect behavior, provide diversional activities, monitor behavior, and refer to Interdisciplinary Team (IDT, a team of health care professions, which include the facility ' s medical director, Director of Nursing (DON), social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents), psychiatry/psychology consult as needed. A review of Resident 1 ' s Order Summary Report with order date 11/16/24 indicated, Monitor inappropriate behavior m/b (manifested by) talking harsh and loud often disruptive every shift, order date 11/30/24 indicated, Refer to Psych d/t (due to) behavior of constantly yelling. A review of Resident 1 ' s psych notes from 11/16/24 to 11/28/24 did not indicate Resident 1 was seen by a psychiatrist or psychologist. A review of Resident 1 ' s Situation, Background, Assessment, and Recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) dated 11/28/24 at 9:30 AM indicated, the resident had an altercation with his roommate (Resident 2). The SBAR indicated a change in skin or wound status to redness to right side of face, scratch to upper forehead, monitor and refer to ophthalmologist (an eye doctor who specializes in diagnosing and treating eye and vision conditions) consult for evaluation. A review of Resident 1 ' s Progress Note dated 11/28/24 at 9:30 AM, indicated, Resident 1 noted yelling [NAME], [NAME], [NAME] irritating roommate (Resident 2) who was stationary behind him, stood face to face imitating roommate. Resident 1 was struck with cellphone to right side of face. On assessment, noted redness to right side of face with a small scratch. Resident 1 stated Vision blurry. A review of Resident 1 ' s Nursing Progress Note dated 11/29/24 at 10:12 AM indicated, the resident noted in front of room [ROOM NUMBER], yelling [NAME], [NAME], [NAME] and irritating roommate who was standing behind him. Resident stood face to face with roommate irritating him when he was struck with cellphone to right side of face. First aid rendered, ophthalmologist consult for evaluation and continue to monitor. A review of Resident 1 ' s Physician ' s Order record dated 12/2/24 indicated, Psychiatry evaluation, history of past mood disorder, history of anxiety. A review of Resident 2 ' s admission record indicated the facility admitted the resident on 4/1/24 with diagnoses that included generalized muscle weakness, aphasia (difficulty speaking) following a cerebral infarction (a serious medical condition when a blood flow to the brain is blocked due to problems with blood vessels leading to brain cell death). A review of Resident 2 ' s H&P dated 4/5/24 indicated the resident had the capacity to make and understand decisions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Review of Resident 2 ' s Progress note dated 11/28/24 at 9:30 AM, indicated Resident 2 was noted to be standing behind roommate (Resident 1), when roommate turned around and started to imitate resident face to face, Resident 2 then struck roommate with cellphone. A review of Resident 2 ' s care plan for communication deficit related to aphasia (no date) indicated, the goal for the care plan was for the resident ' s needs to be met and anticipated daily. The care plan interventions indicated for staff to allow ample time for the resident to respond, speak slowly and clearly, and to allow ample time for the resident to respond. A review of Resident 2 ' s SBAR dated 11/28/24 at 9:30 AM, indicated the resident had an altercation with his roommate (Resident 1). The SBAR indicated facility staff was to monitor the resident for outbursts and the resident was to have a psych consult. During an interview on 12/16/24 at 3:15 PM, Resident 2 stated Resident 1 (roommate) was yelling in front of their room in the hallway irritating him and Resident 1 would get aggressive at times. Resident 1 was pacing in and around their room. Resident 2 stated Resident 1 came in the room and raised his fist, there was no verbal cue, Resident 1 is taller than me, when he raised a fist, I felt threatened and raised my hand for defense holding my phone and hit him on the right side of the face. (Unable to recall date and time of incident, stated it happened few days ago). During an interview on 12/16/24 at 3:55 PM with Resident 1 in room [ROOM NUMBER], Resident 1 stated, I had an eye surgery and was admitted to the facility for rehab in August. Stated, on thanksgiving morning I was up walking around making turkey jokes saying [NAME] to entertain other people, my roommate (Resident 2) came up to me and mumbled because he can ' t speak well then cracked me with his phone on my face. I did not try to attack him, I did not raise my hand, I did not make a fist. He hit me on the right side of my face, when he brought down his hand he scratched my eyes with his finger. My vision is blurry, an ophthalmologist came to see me and told me the surgery looks good and no problems. Stated, before coming to the facility I used to be in a residential facility and taking antidepressant medications. I stopped all the medications when I became a homeless since January 2024. During an interview on 12/16/24 at 3:40 PM with Social Services Director (SSD), SSD Stated, Resident 1 was known to be very loud, when that happens, the resident was reminded to lower his voice. The SSD stated the resident required a lower-level care and the SSD was working for placement. The SSD stated it was appropriate to have Resident 1 referred for psychological consult prior to the altercation between Resident 1 and Resident 2. During an interview and record review on 12/17/24 at 10:02 AM with minimum data set coordinator (MDS), Resident ' s 1 ' s care plan was reviewed. The MDS stated when a resident did not come to the facility with a psychiatry/psychological diagnosis, the facility conducted ongoing observations and ordered psychiatry/psychological consults when symptoms were exhibited. The MDS stated Resident 1 did not come to the facility with a psych diagnosis. Thee MDS stated Resident 1liked to go to other resident ' s rooms, but the MDS did not see the resident as a threat. The MDS reviewed Resident 1 ' s care plan and stated based on the residents ' behavior since admissions and according to the care plan interventions, Resident 1 was supposed to be referred for psychology consult and evaluated on 11/16/24 and was not. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 11:38 AM with Certified Nursing Assistant (CNA 1), CNA 1 stated, Resident 1 liked to go around other resident ' s rooms and nursing stations, spoke very loudly, and was in a hallway most of the time. During an interview on 12/17/2024 at 11:38 AM with the Director of Nursing (DON), DON stated, the altercation between Resident 1 and Resident 2 took place in a hallway in front of Resident 1 and Resident 2 ' s room, Resident 1 was in Resident 2 ' s face irritating him, Resident 1 was raising his voice. The DON stated Resident 1 was loud and liked going around rooms usually in the evenings. The DON stated Resident 1 was not referred for psychology evaluation because he was not a threat, there was no safety concerns or complaints from other residents. The DON agreed the behavioral assessments did not reflect Resident 1 ' s behavior, based on care plan goals and interventions. The DON stated Resident 1 was supposed to be referred for psychology evaluations and was not. During an interview on 12/17/2024 at 12:50 PM with the facility ' s Administrator (ADM), the ADM stated, I oversee abuse coordination and investigations. Received a call from the DON on Thanksgiving Day after the incident between Residents 1 and 2 took place. Stated, Resident 1 likes to be in a hallway, I have observed him to be naturally loud, he was not a threat to anyone, Resident 1 could have benefited from psychology consult. A review of the facility ' s policy and procedures titled Resident Assessment revised November 2024, indicated A comprehensive assessment includes completion of MDS, completion of the care area assessment process and development of comprehensive care plan. A review of the facility ' s policy and procedures titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised November 2024, indicated Residents have the right to be free from abuse, neglect. Including but not limited to protect residents from abuse, neglect from other residents. Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents and neglect of residents. A review of the facility ' s policy and procedures titled Care Plans, Comprehensive Person-Centered revised November 2024, indicated, the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident ' s condition, when the desired outcome is not met.