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	11/27/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents and/or responsible parties for two of of 12 sampled residents (Resident 2 and 4). This deficient practice violated the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. Findings: A review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). A review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/10/2024, indicated the resident had severe cognitive impairment (problems with a person's ability to remember, concentrate, and make decisions that affect daily life) and had the inability to make decisions. A review of Resident 2's Advance Directive Acknowledgment form dated 1/30/2024, indicated the resident was unable to sign because they did not have the capacity to understand and make decisions. The form did not indicate a signature from Resident 2's responsible party to acknowledge receipt of written information regarding the resident's right to formulate an advance directive. A review of Resident 4's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including senile degeneration of the brain (a progressive decline in cognitive function that can lead to memory loss, impaired thinking, and a loss of independence) and schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 4's MDS dated [DATE], indicated the resident had severe cognitive impairment and did not have the ability to make decisions. (continued on next page)

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

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	11/27/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's Advance Directive Acknowledgment form dated 2/1/2021, indicated the resident was unable to sign because they did not have the capacity to understand and make decisions. The form did not indicate a signature from Resident 4's responsible party to acknowledge receipt of written information regarding the resident's right to formulate an advance directive. During a concurrent interview and record review with the Social Services Director (SSD) on 11/26/2024 at 8:42 AM, the Advance Directive Acknowledgement form for Resident 2 and 4 was reviewed. The SSD stated and confirmed written information regarding the resident's right to formulate an advance directive was not provided to the responsible parties for Resident 2 or 4. A review of the facility's policy titled, Advance Directive, revised 2024, indicated that if a resident was incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative.

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	11/27/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 18's and Resident 25's) Minimum Data Set (MDS- a federally mandated resident assessment tool) accurately reflected the resident's diagnosis of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and support the administration of psychotropic medications (drugs that affect the brain and mind, altering a person's thoughts, emotions, feelings, awareness, and perceptions). This deficient practice had the potential to result in a delay of the continuity of care such as monitoring signs and symptoms of adverse reactions and had the potential to negatively affect the resident's delivery of care and services. Findings: a. A review of Resident 18's Admission Record indicated the resident was originally admitted to the facility on [DATE]. A review of Resident 18's History and Physical dated 2/20/2023 indicated the resident had a diagnosis of COPD and had capacity to understand and make decisions. A review of Resident 18's MDS dated [DATE], under active diagnoses, did not include the diagnosis of COPD (inaccurate assessment). A review of Resident 18's care plan revised on 11/2024 indicated the resident was at risk for respiratory distress related to COPD. During an interview on 11/26/2024 at 2:20 PM, the Minimum Data Set Nurse (MDSN) stated Resident 18 had a history of COPD and the diagnosis of COPD was not included in the latest MDS dated [DATE] under the section of active diagnoses. The MDSN stated it was important to reflect all the resident's diagnosis for accuracy of care and there was a risk of delayed treatment when a diagnosis was not included. During an interview on 11/27/2024 at 2:20 PM, the Director of Nursing (DON) stated all active diagnoses should be included in the residents MDS. The DON stated it was important the MDS reflected the accurate diagnoses of residents because there was a risk of missing a diagnosis and delaying treatment. A review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised 2024, indicated all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 50296 (continued on next page)

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	11/27/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of Resident 25's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorders the slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks), and dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning). A review of the Physician's Orders dated 8/1/24, indicated Resident 25 received Lexapro for depression (a mental health condition that causes low mood and loss of interest), Depakote for bipolar disorder (mood swings that range from the low feelings to elevated periods of emotional highs), and Risperidone for schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 25's MDS dated [DATE], indicated the resident was not oriented to time, and did not exhibit feeling down, depressed, or hopeless. The MDS indicated under Section I - Active Diagnoses, subsection psychiatric / mood disorders, indicated the diagnoses of depression, bipolar disorder, and schizophrenia remained blank. During concurrent interview and record review on 11/26/24 at 9:30 AM with the MDSN, Resident 25's MDS and Active Diagnoses, dated 10/16/24 were reviewed. In Resident 25's MDS under Section I - Active Diagnoses subsection psychiatric/mood disorder indicated, none of the diagnoses were triggered. The MDSN stated Resident 25 had a diagnoses of bipolar and psychosis in the MDS Section I - Active Diagnosis, dated on 4/8/22. The MDSN stated Resident 25 was transferred to the General Acute Care Hospital (GACH) often and each visit, all diagnoses follow the resident to the GACH from the facility. The MDSN stated when Resident 25 returned to the facility, the psychiatric diagnoses were not in the admission paperwork and the admitting nurse at the facility did not continue all the resident's current diagnoses. The MDSN stated not continuing all the diagnoses could be the reason the diagnoses of bipolar, depression and schizophrenia were missed. The MDSN stated all diagnoses should be continued when the residents returned to the facility. The MDSN stated the result to the resident would be a delay of care for continuity of care for psychotropic medications. During concurrent interview and record review on 11/27/24 at 9:45 AM with Licensed Vocational Nurse (LVN) 2, Resident 25's electronic chart was reviewed. LVN 2 stated Resident 25 was taking antipsychotic medications, and that It is important that the diagnoses and medication match, because if you're giving psych meds there must be a reason. LVN 2 stated when the resident went to the hospital, the discharge medical record was included. LVN 2 stated once the resident was readmitted to the facility, the same diagnoses from the hospital should be continued. LVN 2 stated the effect to the resident would be psychotropic medications were given without proper diagnoses. During an interview on 11/27/24 at 12 PM, the DON stated, the facility takes the admission information for the residents from the history and physical from the GACH which includes the diagnoses from the facility. The DON stated all diagnoses should be in the history and physical from the GACH. The DON stated that the admitting nurse performed the re-admission including the assessment, checking the orders, labs, and informed the physician that the resident arrived. The physician would write orders with the admitting diagnoses but not all diagnoses. The DON stated the physician would write the orders out, but the admitting nurse was the one to check all orders, diagnoses. The DON stated the LVNs admit the residents, the RN supervisor or Assistant Director of Nursing assist by performing the assessments. The DON stated the result to the resident by not transposing all diagnoses during admission would be a delay of proper care, medication signs and symptoms and proper monitoring could be missed. (continued on next page)

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	11/27/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Resident Assessment, dated 2024 indicated, all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of the information. A review of the facility's P&P titled, Psychotropic Medications, dated 2024, indicated psychotropic medication management includes: indication of use, dose, duration, adequate monitoring for efficacy and adverse consequences, and preventing, identifying, and responding to adverse consequences. The P&P indicated situations that may prompt an evaluation or re-evaluation of the resident included admission or re-admission. A review of the facility's P&P titled, Abstract of Medical Records, dated 12/2006, indicated specific data concerning a resident's medical condition may be released when the resident was transferred to the hospital, the abstract included current diagnosis and current resident assessment or MDS.

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	11/27/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50391 Based on interview and record review, the facility failed to ensure residents with limited range of motion (ROM movement of joints) receive quarterly joint mobility assessments for one of three sampled residents (Resident 11). This deficient practice caused an increased risk in the prevention and maintenance of mobility for Resident 11, with potential for contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: A review of Resident 11's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including muscle weakness. A review of Resident 11's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/19/2024, indicated the resident had intact cognitive skills for daily decision-making and was dependent on staff with bed mobility, transfer, toilet use, personal hygiene, and bathing. A review of the Joint Mobility Assessment form dated 7/24/2024 indicated Resident 11 was not within normal limits. There were no other joint mobility assessments found completed after this date in Resident 11's medical record. During an interview on 11/27/2024, at 11 AM, the Director of Nursing was asked about the facility's policy on the timing of assessments. The DON stated the facility did not have any policies that focus on time frame for joint mobility assessments, however the facility had a policy on resident assessment, resident mobility / ROM, and comprehensive assessment. The DON stated any quarterly assessment should be completed within three months and that the Physical therapist was responsible for completing joint mobility assessments. The DON was not able to locate a recent joint mobility assessment after the date of admission for Resident 11 and explained that the resident should have a quarterly assessment completed. The DON stated if assessments were not completed then, We have no measurement to show if the resident is doing better or worst. On 11/27/2024, at 11:57 AM, during an interview, the PT stated there should be a quarterly evaluation done every three months after the initial assessment at admission. The PT stated the workload at the facility was low but remained very demanding for one therapist. The PT stated there were many residents that have yet to be reassessed, but he could only get to them when he can. The PT stated Resident 11's joint mobility evaluation should have been completed and there was no measurement of progress. (continued on next page)

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	11/27/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Resident Mobility and Range of Motion, dated 2024 indicated residents would not experience an avoidable reduction in range of motion. Residents with limited mobility would receive appropriate services, and assistance to maintain or improve mobility unless reduction in mobility was unavoidable. The policy indicated documentation of the resident's progress toward the goals and objectives would include attempts to address any changes in decline in the resident's condition or needs. Interventions may include therapies and / or exercises and would be based on professional standards of practice and be consistent with the state laws and practice acts.

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	11/27/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of two sampled residents (Resident 18 and 34). Resident 18 and Resident 34 with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), did not have a label or date on the resident's oxygen humidifier bottle (a device used to make supplemental oxygen moist). This deficient practice caused an increased risk in infection control when handling oxygen equipment, leading to resident discomfort and/or infection. Findings: a. A review of Resident 18's Admission Record indicated the resident was originally admitted to the facility on [DATE]. A review of Resident 18's History and Physical dated 2/20/2023 indicated the resident had a diagnosis of COPD and had capacity to understand and make decisions. A review of the Physician's Order dated 2/13/2023, indicated Resident 18 received oxygen at two liters per minute via nasal cannula as needed for shortness of breath. A review of Resident 18's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 11/1/2024 under special treatments, procedures, and programs indicated the resident received zero days of respiratory therapy for at least 15 minutes in the past seven days. A review of Resident 18's care plan revised on 11/2024 indicated the resident was at risk for respiratory distress related to COPD. The intervention included giving medication as ordered. During a concurrent observation and interview on 11/25/2024 at 10:05 AM in Resident 18's room, with Licensed Vocation Nurse 1 (LVN 1), LVN 1 confirmed the resident's oxygen humidifier bottle was not labeled nor dated. LVN 1 stated it was important the oxygen humidifier bottle was dated so staff were aware of when the bottle was last changed. During an interview with the Director of Nursing (DON) on 11/27/2024 at 9:58 AM, the DON stated respiratory equipment like the oxygen humidifier bottle should be labeled with a date, time, and staff initials. The DON stated it was important the oxygen humidifier bottle was labeled so staff know how long it had been there and if it was time to change it. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 2024, indicated the purpose was to provide guidelines for safe oxygen administration. The policy indicated the humidifier bottle should be labeled with date, time, and signature. b. A review of Resident 34's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including COPD. A review of the Physician's Order dated 2/13/2023, indicated Resident 34 was to receive oxygen administerion at two liters per minute via nasal cannula as needed for shortness of breath and oxygen less than 90%. (continued on next page)

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	11/27/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 34's At risk for respiratory distress related to COPD care plan revised on 9/2024, indicated the intervention included giving medication as ordered. A review of Resident 34's MDS dated [DATE], indicated the resident was cognitively intact and under special treatments, procedures, and programs indicated Resident 34 received zero days of respiratory therapy for at least 15 minutes in the past seven days. During a concurrent observation and interview on 11/25/2024 at 10:35 AM in Resident 34's room with LVN 1, LVN 1 confirmed the resident's oxygen humidifier bottle and nasal cannula were not labeled nor dated. LVN 1 stated it was important the oxygen humidifier bottle and nasal cannula were labeled with a date so staff were aware of when the equipment was last changed. During an interview with the Director of Nursing (DON) on 11/27/2024 at 9:58 AM, the DON stated respiratory equipment like the oxygen humidifier bottle and nasal cannula should be labeled with a date, time, and staff initials. The DON stated it was important the oxygen humidifier bottle and nasal cannula were labeled so staff know how long it had been there and if it was time to change it.

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	11/27/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49836 Based on interview and record review, the facility failed to ensure two Certified Nursing Assistants (CNA 1 and 2), three Licensed Vocational Nurses (LVN 3, 4 and 5) and Registered Nurse (RN) 2 had a completed annual competency and annual performance evaluation. This deficient practice violated the facility's Competency and Performance Evaluations policy and had the potential for residents to not receive appropriate services. Findings: A review of CNA 1's employee file indicated the date of hire was 4/23/2016 and the competency evaluation was last completed on 8/16/2023. A review of CNA 2's employee file indicated the date of hire was 8/13/2020 and the competency evaluation was last completed on 10/23/2021. A review of LVN 3's employee file indicated the date of hire was 3/3/2014 and there was no competency nor performance evaluations noted in file. A review of LVN 4's employee file indicated the date of hire was 5/19/2017 and the performance evaluation was last completed on 12/12/2023. There was no competency evaluation noted in file. A review of LVN 5's employee file indicated the date of hire was on 3/24/2017 and the performance evaluation was last completed on 9/10/2023. The competency evaluation was last completed on 4/23/2021. A review of RN 2's employee file indicated the date of hire was 10/23/2012 and there was no competency nor performance evaluation noted in file. During an interview and record review on 11/27/2024 at 12:24 PM, the Administrator (ADM) stated that all competency and performance evaluations should be done annually for all licensed staff. The ADM stated the Director of Staff Development (DSD) was responsible for ensuring the evaluations were completed on time and updated in the employee files. After review with the ADM of the employee files for CNA 1 and 2, LVN 3, 4, and 5, and RN 2, the ADM confirmed there were no updated annual competency or performance evaluations for CNA 1 and 2, LVN 3, 4, and 5 and RN 2. The ADM stated the potential risk for not completing the evaluations timely would be that the quality of care to the resident could be compromised. A review of the facility's policy and procedure (P&P) titled, Performance Evaluations, revised 2024, indicated the job performance of each employee shall be reviewed and evaluated at least annually. A review of the facility's P&P titled, Competency of Nursing Staff, and revised 2024, indicated that facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.

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	11/27/2024

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49836 Based on interview and record review, the facility failed to ensure two Certified Nursing Assistants (CNA 1 and 2) had a completed annual performance evaluation. This deficient practice caused an increased risk in identifying the staffs areas of weakness with the potential for residents to not receive appropriate services. Findings: A review of CNA 1's employee file indicated that their date of hire was 4/23/2016 and there was no performance evaluation was noted in file. A review of CNA 2's employee file indicated the date of hire was 8/13/2020 and there was no performance evaluation was noted in file. During a concurrent interview and record review with the Administrator (ADM) on 11/27/2024 at 12:24 PM, the employee files of CNA 1 and 2 were reviewed with the ADM. The ADM stated that all performance evaluations should be done annually for the CNA's. The ADM stated the Director of Staff Development (DSD) was responsible for ensuring the performance evaluations were completed on time and updated in the employee files. The ADM confirmed that there were no updated performance evaluations for CNA 1 and 2 and that the potential risk for not completing the evaluations timely would be that the quality of care to the residents could be compromised. A review of the facility's policy and procedure (P&P) titled, Performance Evaluations, revised 2024, indicated the job performance of each employee shall be reviewed and evaluated at least annually.

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	11/27/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five (5) percent (%) or lower by having three medication errors out of 35 opportunities contributing to an overall error rate of 12% for two of four sampled residents (Resident 34 and 36) observed during Medication Administration. The medication errors were as follows: -Resident 34 was not instructed to seal their mouth over the mouthpiece of Qvar (a medication used for Chronic Obstructive Pulmonary Disease [COPD -a disease that blocks air flow and makes breathing difficult]) oral inhaler (a device containing the medication that is orally inhaled,) according to manufacturer instructions. -Resident 36 received pantoprazole (medication used to treat acid in the stomach) oral packet at a different time and received a form of ferrous sulfate (a medication used to produce a protein in red blood cells that carries oxygen throughout the body) that was different than the Physician's Order. These failures had the potential to result in Resident 34 and 36 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 34's and 36's health and well-being to be negatively impacted. Findings: a. A review of Resident 36's Admission Record dated 11/25/24, indicated the resident was originally admitted to the facility on [DATE] with diagnoses including Gastro-Esophageal Reflux Disease ([GERD] - a condition where there is a backward flow of stomach acid into the tube that connects the mouth to the stomach) and anemia (a condition where the body does not have enough healthy red blood cells, and iron deficiency anemia was the most common type of anemia), chronic obstructive pulmonary disease (a condition that makes it difficult to breathe). A review of Resident 36's Order Summary Report, for November 2024, indicated Resident 36 was prescribed ferrous sulfate oral solution 220 mg per 5 ml to give 7.5 ml via G-tube two times a day for supplement, starting 6/2/24, and was prescribed pantoprazole 40 mg oral packet to give one packet via G-tube before meals for GERD, starting 10/14/24. A review of Resident 36's Medication Administration Record (MAR), dated November 2024, indicated Resident 36 was prescribed ferrous sulfate oral solution 220 mg per 5 ml to give 7.5 ml via G-tube two times a day for supplement, at 9 a.m. and 5 p.m., and was prescribed pantoprazole 40 mg oral packet to give one packet via G-tube before meals for GERD, at 11:30 a.m. During an observation on 11/25/24 at 9:45 a.m., in Medication Cart Station 1, Licensed Vocational Nurse (LVN) 2 was observed administering ferrous sulfate 325 milligram ([mg]-a unit of measure of mass) tablet that was crushed (pressed very hard so that the shape is destroyed and formed into a soft powder) and pantoprazole 40 mg oral packet via gastrostomy tube ([G-tube] - a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 36. (continued on next page)

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	11/27/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/24 at 10:01 a.m., LVN 2 stated that LVN 2 administered ferrous sulfate 325 mg crushed tablet and pantoprazole 40 mg oral packet via G-tube at 9:45 a.m. to Resident 36. LVN 2 acknowledged the physician's order specified to administer ferrous sulfate 7.5 milliliter ([ml] - a unit of measure of volume) oral liquid containing 220 mg per 5 ml at 9 a.m., and to administer pantoprazole 40 mg oral packet at 11:30 a.m. LVN 2 stated that LVN 2 administered ferrous sulfate 325 mg by crushing the tablet instead of administering ferrous sulfate 7.5 ml liquid and that per facility policy, there was a 60-minute window for medication administration before and after the specified time. LVN 2 administered the pantoprazole 40 mg oral packet sooner than that timeframe to Resident 36. LVN 2 stated these were considered medication errors and that LVN 2 did not follow the physician's orders. b. A review of Resident 34's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including COPD with exacerbation. A review of Resident 34's Order Summary Report, for November 2024, indicated Resident 34 was prescribed Qvar to give one puff inhaled orally once a day related to COPD with exacerbation, starting 6/19/24. A review of Resident 34's MAR dated November 2024, indicated Resident 34 was prescribed Qvar to give one puff inhaled orally once a day related to COPD with exacerbation, at 9 a.m. During an observation on 11/26/24 at 9:04 a.m., in Medication Cart Station 2, Registered Nurse (RN) 3 was observed administering QVAR one puff orally to Resident 34. Resident 34 was observed orally inhaling one puff of QVAR without fully closing lips around the mouthpiece and with open gaps on both sides of his mouth. During an interview on 11/26/24 at 9:11 a.m., RN 3 stated that RN 3 administered QVAR one puff orally at 9:04 a.m. to Resident 34 and failed to instruct Resident 34 to fully close lips around the mouthpiece of the inhaler to get a good seal. RN 3 stated Resident 34 had gaps on the side of the mouth when inhaling the medication, and as a result some medication had escaped into the air and not fully inhaled. RN 3 stated QVAR manufacturer instructions indicated to fully seal lips around the mouthpiece to prevent medication from escaping. RN 3 stated that not administering medication according to manufacturer instructions was considered a medication error and that not receiving the full dose Resident 34 was not being fully treated and at risk for COPD exacerbation (the process of making a problem or situation worse,) potentially resulting in hospitalization . During an interview on 11/26/24 at 12:10 p.m., the Director of Nursing (DON) stated that LVN 2 failed to administer the correct form of ferrous sulfate and failed to administer pantoprazole at the indicated time on 11/25/24 to Resident 34, as ordered by the physician. The DON also stated RN 3 failed to instruct Resident 34 to fully seal lips around the QVAR inhaler while administering the dose, as instructed by the manufacturer. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician's orders were followed and the right medications were administered at the right times to residents, and to follow manufacturer instructions to ensure medications were administered correctly to prevent potential harm to residents such COPD exacerbation for Resident 34. (continued on next page)

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	11/27/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P&P) titled, Administering Medications, [undated], indicated that Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required timeframe. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. A review of the facility's P&P titled, Administering Medications through a Metered Dose Inhaler, revised 2024, indicated the purpose was to provide guidelines for the safe administration of inhaled medications. The following equipment and supplies will be necessary when performing this procedure. -Place the mouthpiece in the mouth and instruct resident to close his or her lips to form a seal around the mouthpiece. A review of the facility's P&P titled, Adverse Consequences and Medication Errors, revised 2024, indicated Adverse Consequences -An adverse consequence refers to an unwanted, uncomfortable, or dangerous effect that a drug may have . -The staff and practitioner shall strive to minimize adverse consequences by: -Following relevant clinical guideline and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. Medication Errors -A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. manufacturer specifications or accepted professional standards and principles of the profession(s) providing services. -Examples of medication errors include: -Wrong drug (e.g. liquid ordered, capsule given) -Wrong time -Failure to follow manufacturer instructions and/or accepted professional standards. A review of a facility provided manufacturer's guideline on QVAR, last revised 1/21, indicated Place the mouthpiece in your mouth and close your lips around it so you form a good seal.

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	11/27/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for one sampled residents (Resident 14) investigated for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use, by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin administration sites. This deficient practice increased the risk of adverse effects (unwanted, unintended result) from same site administration such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: A review of Resident 14's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus (DM II - [a condition where there are high blood sugar levels]). A review of the Physician's Order Summary Report, dated 11/1/24, indicated Resident 14 was prescribed Humulin 70/30 (intermediate-acting insulin combined with the more rapid onset regular insulin) to 35 units ([un] - measure of insulin dose) subcutaneously ([SQ] - under the skin) once a day, and 15 un SQ in the evening, related to DM II, starting 8/1/24. A review of Resident 14's Medication Administration Record (MAR) for November 2024, indicated Resident 14 was prescribed Humulin 70/30 to 35 un SQ once a day at 9 a.m., and 15 un SQ in the evening at 5 p.m., related to DM II. Further review of the MAR indicated Humulin 70/30 35 un was administered at 9 a.m. by the following licensed nurses, on the following days, and sites: 11/2/24 on Right Arm (RA) by Licensed Vocational Nurse (LVN) 2 11/3/24 on RA by LVN 2 11/5/24 on RA by LVN 6 11/6/24 on RA by LVN 2 11/7/24 on RA by LVN 2 11/8/24 on RA by LVN 6 11/9/24 on RA by LVN 2 11/10/24 on RA by LVN 2. (continued on next page)

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	11/27/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/26/24 at 11:08 a.m., Registered Nurse (RN) 3 reviewed Resident 14's MAR for November 2024. RN 3 stated several licensed nurses failed to rotate the insulin administration sites and that failure to rotate sites could harm Resident 14 by damaging the skin, causing bruises and lumps. During a concurrent interview and record review on 11/26/24 at 12:10 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 14's MAR for November 2024. The DON stated that for Resident 14 the MAR indicated there were instances where the insulin administration sites were not rotated for the Humulin 70/30 by several licensed nurses, as expected by facility policy, standard of practice and manufacturer guidelines. The DON stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 14 by causing lipodystrophy (skin abnormalities such as lumps in the skin or thickened skin) at the repeated administration sites. A review of the facility's Policy & Procedures (P&P) titled, Adverse consequences and Medication Errors, revised 2024 indicated an 'adverse consequence' refers to an unwanted, uncomfortable or dangerous effect that a drug may have. The staff and practitioner shall strive to minimize adverse consequences by following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. An adverse drug reaction (ADR), a form of adverse consequences, was defined as a secondary and usually undesirable effect of a drug. A review of facility's P&P titled, Subcutaneous Injections/Insulin Administration, revised 2024, indicated the purpose was to provide guidelines for the safe administration of medication by subcutaneous / insulin injection and to select an appropriate injection site. A review of a facility provided manufacturer's guide titled, Highlights of Prescribing Information, for Humulin 7030, dated June 2022, indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis (skin with lumps).

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	11/27/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure medications were labeled, properly stored or discarded in accordance with current accepted professional standards of practice for insulin (medication used to regulate blood sugar levels), Aplisol (also known as Tubersol - medication used to diagnose tuberculosis [infection in the lungs]), and Pneumovax 23 (a vaccine that helps protect against serious infections of the ears, sinuses, lungs, blood and brain, especially in person's with high risk conditions and over the age of 65, such as pneumonia). In addition, the expired emergency medication kit (storage container for emergency use medications) in Medication room [ROOM NUMBER] was not removed or discarded. These deficient practices increased the risk that residents in the facility could receive medication that had become ineffective or toxic. Findings: During an observation on 11/25/24 10:42 a.m., in Medication Cart 1, in the presence of Licensed Vocational Nurse (LVN) 2, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: -One open insulin Humulin R vial for Resident 21 was found stored at room temperature, without a date indicating when storage or use at room temperature began. According to the manufacturer's product labeling, opened Humulin R vials should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 31 days of opening or once storage at room temperature began. -One open insulin Humulin R vial for Resident 26 was found stored at room temperature with a label indicating that use at room temperature began on 8/25/24 and the vial expired on 9/22/24. According to the manufacturer's product labeling, opened Humulin R vials should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 31 days of opening or once storage at room temperature began. During an interview on 11/25/24 10:43 a.m., LVN 2 stated the insulin Humulin R multi-dose (containing more than one dose) vial for Resident 21 was opened, used, stored at room temperature, and not labeled with a date when use at room temperature began, and the insulin Humulin R multi-dose vial for Resident 26 was open and labeled with a date indicating that use began on 8/25/24 and expired on 9/22/24. LVN 2 stated that LVN 2 was unaware when the insulin Humulin R vial for Resident 21 was stored at room temperature therefore unknown when it would expire and need to be discarded. (continued on next page)

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	11/27/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated that most insulin vials expire within 28 days of opening the vial, and that the Humulin R vials for Resident 21 and 26 needed to be removed from the medication cart to ensure expired insulin was not administered in error to Resident 21 and 26. LVN 2 stated administering expired insulin would not be effective in keeping the blood sugar stable and can harm Resident 21 and 26 by causing high or low blood sugar levels, leading to coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. LVN 2 stated the insulin Humulin R vials needed to be immediately replaced with new ones from pharmacy for Resident 21 and 26. During an observation, on 11/25/24 at 11:05 a.m., with LVN 2, in Medication room [ROOM NUMBER], the following medication was found either stored and not labeled with an open date as required by their respective manufacturer's specifications, expired and not discarded, or stored contrary to facility policies: -Two open Aplisol multi-dose vials for facility stock were found stored in the refrigerator with a label indicating use began on 10/19/24 and 10/20/24, respectively. According to the manufacturer's product storage and labeling, Aplisol vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 30 days of opening the vial. -One unopened Pneumovax 23 prefilled syringe for facility stock was found stored at room temperature with a manufacturer label indicating an expiration date on 11/24/24. According to the manufacturer's product storage, unopened Pneumovax 23 vials should be stored under refrigeration from 36 to 46 degrees Fahrenheit and used until the manufacturer indicated expiration date. -One expired emergency medication kit labeled with an expiration date of 8/24. According to pharmacy label and facility policy, expired emergency medication kits should not be used and discarded by the indicated expiration date. During a concurrent interview, LVN 2 stated two Aplisol vials stored in the refrigerator in Medication room [ROOM NUMBER] were opened on 10/19/24 and 10/20/24, respectively. LVN 2 stated the Pneumovax syringe expired on 11/24/24. LVN 2 stated the emergency kit was open and expired on 8/24. LVN 2 stated both Aplisol vials and Pneumovax syringe were expired and needed to be removed from the refrigerator and placed in the expired medication bin to be disposed of and not accidentally used for residents, and the emergency kit needed to be replaced with a new one from pharmacy before August 2024. LVN 2 stated administering expired Aplisol to residents may result in inaccurate results (either false negative or false positive) and therefore lead to providing the incorrect treatment to the residents, and administering expired Pneumovax may not provide protection against pneumonia for residents. LVN 2 stated emergency medications were needed in emergency situations and used from the emergency kits. LVN 2 stated giving residents expired medications from the emergency kits during emergency situations would only make the emergent situation worse for residents. (continued on next page)

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	11/27/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 11/26/24 at 12:10 p.m., with the Director of Nursing (DON,) the DON stated that the emergency medication kit in the medication room had expired August of 2024 and should have been replaced with a new one from pharmacy. The DON stated the medication storage areas should have been checked daily for expired medications and any expired medication removed from those areas. The DON stated the facility failed to remove the expired emergency medication kit from the medication room. During the same interview, the DON stated that two Aplisol vials were opened on 10/19/24 and 10/20/24, respectively, and stored in the medication refrigerator for facility stock use. The DON stated multi-dose vials usually expire 28 days after opening the vials and should be discarded beyond that date to prevent accidental use. The DON stated expired multi-dose vials were no longer sterile (free from contaminants) and not effective. The DON stated using Aplisol vials beyond the expiration date in error may potentially provide inaccurate results for tuberculosis (a contagious bacterial disease that's usually spread through the air when someone with tuberculosis coughs, sneezes, or spits) leading to inaccurate treatment for residents. The DON stated both Aplisol vials were expired and needed to be removed from the medication room and be discarded to prevent accidental use. During the same interview, the DON stated that the Pneumovax vaccine was expired on 11/24/24, and the facility failed to remove it from the medication room refrigerator. The DON stated using expired Pneumovax would not be effective in providing protection against pneumonia to residents. During the same interview the DON stated that the insulin Humulin R vial for Residents 21 and 26 were considered expired and should have been removed from the medication cart. The DON stated several LVN's failed to label an open vial of Humulin R and failed to remove an expired vial of Humulin R from the medication cart, which can lead to the administration of expired insulin to Resident 21 and 26, resulting in significant medication error. The DON stated the Humulin R vials needed to be replaced with new ones from pharmacy because one vial had an unknown expiration date due to lack of labeling, and one vial was expired. The DON stated that expired insulins lost potency (the strength of medication) and effectiveness and when administered would not be effective in controlling blood sugar levels leading to hyperglycemia (high blood sugar levels) and adverse effects for Resident 21 and 26, potentially resulting in hospitalization . A review of the facility's Policy & Procedures (P&P) titled, Medication Labeling and Storage, revised 2024, the P&P indicated If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying the items. -Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. -Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date. A review of the facility's P&P titled, Storage of Medications, [undated,] indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. (continued on next page)

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	11/27/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. A review of the facility's P&P titled, Procedure for Disposal, [undated,] indicated Discontinued or outdated non-controlled drugs are to be stored in a secured area designated for that purpose until picked up by the pharmaceutical waste disposal service or the pharmacy personnel. A review of the facility's P&P titled, Administering Medications, [undated,] indicated When opening a multi-dose container, the date opened is recorded on the container. A review of the facility's P&P titled, Medications Requiring Notation of Date Opened, [undated,] indicated All medications requiting an open date will be dated immediately upon opening. Date will be applied using a Date Open label or written directly on the packaging by the charge nurse. The following expiration periods are based on currently accepted standards of practice and/or the manufacturer's recommendations. -Expires 28 days after opening: All insulins except . -Expires one month after opening (refrigerate after opening) PPD (e.g.Tubersol) solutions. -Expires one (1) month after opening; -Multi-dose injectables not noted above.

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	11/27/2024

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure necessary care was provided consistently for one of three sampled residents (Resident 4), who was receiving hospice service (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease and offers physical, emotional, social, and spiritual support for residents and their families). For Resident 4, there was no coordination of personal care and nursing needs with the hospice staff. This deficient practice had the potential to result in a delay of care and delivery of hospice care and services to Resident 4. Findings: A review of Resident 4's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including senile degeneration of the brain (a progressive decline in cognitive function that can lead to memory loss, impaired thinking, and a loss of independence) and schizophrenia (a mental illness that is characterized by disturbances in thought). A review of the Physician's Orders dated 7/9/2024, indicated to admit Resident 4 for hospice care and treatment. A review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/11/2024, indicated the resident had severe cognitive impairment (problems with thinking, reasoning) and had the inability to make decisions. The MDS indicated Resident 4 received hospice services while a resident at the facility and had a condition or chronic disease that could result in a life expectancy of less than six months. A review of Resident 4's hospice records sign in sheets did not indicate visits from a skilled nurse (care provided by a registered nurse or licensed vocational nurse) or home health aide (person who assists clients in their daily personal tasks, such as bathing or dressing). During a concurrent interview and record review with the Registered Nurse (RN) 1 on 11/26/2024 at 8:52 AM, Resident 4's hospice records were reviewed. RN 1 stated that a hospice skilled nurse visited once a week and a home health aide visited twice per week for Resident 4. RN 1 reviewed Resident 4's hospice records and confirmed there were no signatures from the skilled nurse or home health aide on the sign in sheets and that there was no hospice care plan for Resident 4. RN 1 stated that it was important to ensure the hospice staff was visiting Resident 4 as ordered and that there should be a hospice plan of care for the staff to know the specific needs of the resident. During an interview with the Director of Nursing (DON) on 11/27/2024 at 9:02 AM, the DON stated that all hospice staff should be signing in the hospice sign in sheet and should also have a hospice care plan. The DON stated the facility staff should be communicating with the hospice staff during their visits and by not having a record of hospice visits from the hospice staff and no hospice care plan, it could potentially compromise Resident 4's care. (continued on next page)

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	11/27/2024

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled, Hospice Program, revised 2024, indicated it was the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure the level of care provided was appropriately based on the individual resident's needs.

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	11/27/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 34) was provided a safe and sanitary environment, when the resident's oxygen nasal cannula (a device used to deliver supplemental oxygen placed directly on a resident's nostrils) was observed on the floor. This deficient practice resulted in contamination of Resident 34's oxygen nasal cannula and placed the resident at risk for infection. Findings: A review of Resident 34's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD). A review of the Physician's Order dated 2/13/2023, indicated Resident 34 received oxygen at two liters per minute via nasal cannula as needed for shortness of breath and oxygen saturation less than 90%. A review of Resident 34's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 10/26/2024, indicated the resident was cognitively intact (no problems with ability to think, reason or make decisions). The MDS under special treatments, procedures, and programs indicated Resident 34 received zero days of respiratory therapy for at least 15 minutes in the past seven days. This was a discrepancy. During a concurrent observation and interview on 11/25/2024 at 10:36 AM in Resident 34's room with LVN 1, LVN 1 stated and confirmed the resident's nasal cannula was on the floor. LVN 1 stated the nasal cannula should not be on the floor because it was a concern for infection control and there was a risk for infection. During an interview with the Director of Nursing (DON) on 11/27/2024 at 10 AM, the DON stated if the nasal cannula was not in use, the nasal cannula should be covered in a plastic bag for infection control purposes. The DON stated it was important the nasal cannula did not touch the floor because the floor was considered a dirty surface and there was a risk for infection. A review of the facility's policy and procedure titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised 2024, indicated infection control consideration related to oxygen administration included keeping the oxygen cannulae and tubing used in a plastic bag when not in use.

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	11/27/2024

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on observation and interview, the facility failed to ensure 10 of 22 (Rooms 1, 3, 4, 5, 6, 12, 15, 18, 13, and 24) met the required 80 square feet per resident and failed to ensure of two rooms (room [ROOM NUMBER]) met the required 100 square feet per resident. This deficient practice had the potential to result in inadequate space necessary to provide safe nursing care and privacy for residents. Findings: During an observation on 11/27/2024 at 8:39 AM, the Maintenance Supervisor (MS) measured Rooms 1, 3, 4, 5, 6, 9, 12, 15, 18, 23, and 24. The rooms measured as follows: Room No. Room Sq. Footage. Resident Capacity. Square Ft. Per 1 11'6x12'9 2 149.64 3 11'7x13'0 2 152.1 4 16'8x18'7 4 314.16 5 11'6x13'0 2 150.8 6 16'8x18'7 4 314.16 9 9'7x10'0 1 97 12 19'3x11'5 3 221.95. 15 19'4x11'5 3 223.1 18 24'9x112'6 4 313.74 23 13'4x10'7 2 143.38 24 13'4x11'4 2 152.76 The measurements were compared to the client accommodation analysis dated 11/25/2024 and all measurements matched taken by the MS on 11/27/2024 at 8:39 AM. During an interview with Resident 3 on 11/27/2024 at 9:25 AM in room [ROOM NUMBER], Resident 3 stated she had a wheelchair that she kept outside of her room. Resident 3 stated she was able to get around her room with no issues. (continued on next page)

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	11/27/2024

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview with Resident 12 on 11/27/2024 at 9:33 AM in room [ROOM NUMBER], Resident 12 stated she has been at the facility for [AGE] years and had no complaints about her room size. Resident 12 stated the room was spacious. During an interview with the Certified Nurse Assistant 3 (CNA 3) on 11/27/2024 at 10:20 AM, CNA 3 stated she was assigned to provide care in room [ROOM NUMBER]. CNA 3 stated she was able to do her work and had no concerns with the size of the room. A review of the facility's undated policy and procedures titled, Bedrooms, indicated bedrooms were to measure at least 80 square feet of space per resident in double rooms and at least 100 square feet of space in single rooms.