

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Bonnie Brae Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide skin and pressure ulcer (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin) care consistent with professional standards of practice and per physician's orders for two out of five sampled residents (Resident 8 and Resident 12) on Low Air Loss Mattresses (LAL M- a pressure-relieving mattress used to prevent and treat pressure injuries). By failing to:Ensure Resident 8's physician's order for LALM dated 12/19/2025 indicated a specific setting for the LALM.Ensure Resident 8's physician's order for LALM dated 1/1/2026 indicated a specific setting for the LALM.This deficient practice placed Resident 8 and Resident 12 at risk for developing pressure injuries and complications from pressure injuries which could result in systemic infections that could lead to death.Findings: During a review of Resident 8's admission Record, the admission record indicated the facility admitted Resident 8 on 8/1/2022, with diagnoses that included respiratory failure with hypoxia (a severe condition where the lungs can't get enough oxygen into the blood), muscle weakness (a loss of strength in one or more muscles, making it hard to move them normally), and osteoporosis (a bone disease causing bones to become weak, thin, and fragile). During a review of Resident 8's Care Plan Report dated 12/20/25, the Care Plan Report indicated Resident 8 was at risk for developing pressure sores, bruising, and other skin breakdown. The care plan indicated an intervention to use pressure relieving devices as needed. During a review of Resident 8's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 12/24/2025, the MDS indicated Resident 8 had a memory problem and was severely impaired with decision making. The MDS indicated the resident was at risk for pressure injuries and had a pressure-reducing device for the bed. During a concurrent observation and record review on 1/5/2026 at 9:45 AM in Resident 8's room, Resident 8's physician order and weights were reviewed. Resident 8 was observed lying on the bed with closed eyes. Resident 8 was lying on a LAL mattress; the setting was set at a little under 120lbs on normal pressure. Resident 8's physician order dated 12/19/2025 indicated may use low air loss mattress. Resident 8's weight indicated the resident weighed 91lbs on 1/1/2026. During a concurrent interview and record review on 1/6/2026 at 11:10 AM with Licensed Vocational Nurse (LVN) 2, Resident 8's physician order for LALM dated 12/19/2025 was reviewed. LVN 2 reviewed Resident 8's LALM setting and LVN 2 stated the LALM was set between 80 to 120 pounds (lbs.). LVN 2 stated Resident 8's weight ranged between upper 80s to lower 90s. LVN 2 reviewed Resident 8's physician's order for LALM which indicated they may use the LALM, but no instructions were given. LVN 2 stated the physician's order should have indicated a specific setting for the LALM. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated Resident 8 was bed bound, and the LALM was to prevent pressure injuries. LVN 2 stated Resident 8 was at risk for developing pressure ulcers/injuries without orders for LALM settings. During a concurrent interview and record review on 1/6/2026 at 11:18 AM with the Director of Nursing (DON), Resident 8's physician order dated 12/19/2025, the facility's policy and procedures titled, Pressure Injuries Prevention dated 12/2025, and facility policy and procedures titled, Low Air Loss Mattress dated 12/2025. The DON stated the order for LAL mattress should have had specific instructions for the settings. The DON reviewed the facility's policies for weight settings. The DON stated the facility should have followed the policy, which indicated to adjust the LALM setting by weight. The DON stated Resident 8's physician order should have had instructions for setting the LALM settings. The DON stated Resident 8 would be at risk of a pressure ulcer without proper weight setting. During a review of the facility's policy and procedure titled, Pressure Injuries Prevention dated 12/2025, indicated, for prevention measures associated with specific devices, consult current clinical practice guidelines. During a review of the facility's policy and procedure titled, Low Air Loss Mattress dated 12/2025, indicated, adjust weight setting for patient comfort/pressure relief. During a review of Resident 12's admission Record, the admission Record indicated the facility initially admitted the resident on 5/23/2013 and readmitted on [DATE] ,with diagnoses that included Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), hypertensive disease(high blood pressure) with heart failure(a long-term condition in which your heart can't pump blood well enough to meet your body's needs), partial(not complete) intestinal obstruction(a blockage in the gut), muscle weakness (generalized), cerebral infarction(a stroke caused by a blocked blood vessel in the brain), cerebrovascular disease (problems with the blood vessels in the brain) affecting the right non-dominant(less used) side, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis(weakness on one side of the body) following unspecified cerebrovascular disease. During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 12/22/2025, the MDS indicated the resident had moderate cognitive impairment (impaired ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 12 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 12 was dependent (helper does all of the effort) from the staff for toileting, personal hygiene, shower/bathe self, lower body dressing, sit to lying, lying to sitting on the side of the bed, putting on and/or taking off footwear and chair/bed to chair transfer. During a review of Resident 12's Dietary Profile dated 9/23/2025, the Dietary Profile indicated the resident weighed 157 lbs. on 9/23/2025. During a review of Resident 12's Order Summary Report dated 1/1/2026, the Order Summary Report indicated an order for LALM with no specific parameters for settings. During a review of Resident 12's Care Plan Report titled High Risk of Developing Pressure Sore, Bruising, and Other Types of Skin Breakdown dated 12/23/2025, indicated the resident was to have a (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Specialized Mattress as Ordered on Low Air Mattress. During an observation on 1/5/2026 at 10:25 AM Resident 12 was observed in bed with a LALM turned on and set to 180 pounds. During a concurrent interview and record review on 1/6/2026 at 11:18 AM with the Director of Nursing (DON), Resident 12's Order Summary Report dated 1/1/2026 was reviewed, the Order Summary Report indicated LAL Mattress. The DON stated the LALM needed specific instructions and the setting was usually placed based on a resident's weight. The DON stated there were no specific instructions on Resident 12's orders for LALM and the order should have had specific instructions. The DON stated there was no weight recorded for Resident 12 for the month of December 2025 or January 2026 in the resident's medical record. The DON stated if the facility did not have a weight for Resident 12, facility staff would not know what setting to set for the resident's LALM. The DON stated LALMs were to be set based on the physician orders. The DON stated a resident could get a pressure ulcer if the LALM was too soft or hard for the resident. During a concurrent interview and record review on 1/6/26 at 12:26 PM with Licensed Vocational Nurse (LVN)1, Resident 12's Order Summary Report dated 1/1/2026 was reviewed. LVN 1 stated LALM required an order from the physician and the setting was based on a resident's weight. LVN 1 confirmed by stating there was no specific order for Resident 12's LALM. LVN 1 stated facility staff should have clarified Resident 12's order for LALM with the doctor. LVN 1 stated Resident 12 could have developed a pressure injury if the LALM was not at the correct setting. During a review of the undated operational manual titled Proactive medical products Operation Manual for Protekt Aire 4000DX/5000DX, the operational manual indicated Product Function .Press up or down buttons to select the correct patient weight. The operational manual indicated Press the up/down buttons on panel to adjust the weight/pressure level to the patient's specific requirements. The operational manual indicated Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion of the health care professional. During a review of the facility's policy and procedure (P&P) titled, Pressure Injuries Prevention revised 12/2/2025, the P&P indicated, Review and select medical devices with consideration to the ability to minimize tissue damage The P&P indicated Monitor regularly for comfort and signs of pressure related injury. For prevention measures associated with specific devices, consult current clinical practice guidelines.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and record reviews the facility failed to honor a resident's right to dignity (a person's worth as a human being, deserving of respect, honor, and fair treatment, regardless of their situation, status, or abilities) for one out of one sampled residents (Resident 17) when Certified Nursing Assistant 1 (CNA 1) stood over Resident 17 while assisting Resident 17 with his lunch on 1/5/2025. This failure had the potential to cause emotional distress, affect Resident 17's self-esteem (your overall opinion of yourself-how much you like, value, and respect yourself as a person), cause loss of dignity, and a decline in psychosocial wellbeing (feeling good and functioning well in your life, covering your mental, emotional, and social health). Findings: During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 6/10/2019 and readmitted Resident 17 on 11/24/2025 with diagnoses that included pneumonitis (swelling of lung tissue) due to inhalation of food and vomit, chronic obstructive pulmonary disease (COPD- progressive condition that affects lung function), Diabetes Mellitus type II (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), muscle weakness, dysphagia (difficulty swallowing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 17's Minimum Data Set (MDS - a standardized resident assessment tool) dated 12/31/2025, the MDS indicated Resident 17 sometimes had the ability to understand others and sometimes had the ability to make himself understood. The MDS indicated Resident 17 needed substantial/maximal assistance (helper does more than half the effort and helper lifts or holds chest or arms) for eating. During a review of Resident 17's Care Plan titled Resident has self-care deficits (unable to fully care for self) related to generalized weakness, reduced mobility (ability to move around), cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment dated 11/25/2025, indicated Resident 17 needed moderate assistance with eating. The care plan indicated an intervention (a specific action the nursing staff takes to help a resident meet their health goals, like giving medication, repositioning them, or providing education, all detailed in their personalized care plan to ensure consistent, effective care) of encourage resident to do as much as possible for himself as much as possible to increase independence. During a review of Resident 17's Order Summary Report, dated 12/31/2025, the Order Summary Report indicated Resident 17 had an order for a regular diet pureed-4 (all food is blended, ground, or strained into a smooth, lump-free, pudding-like consistency, requiring no chewing and making it easier to swallow), moderately thick-3 consistency. During a review of Resident 17's PT (Physical therapy - focused on restoring, maintaining, and improving movement and physical function)/OT (Occupational Therapy - focused on helping residents participate in activities of daily living [ADL's: activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating]), notes dated 1/5/2026, indicated Resident 17 was receiving OT for ADL retraining. During a concurrent observation and interview on 1/5/2026 at 11:46 AM with CNA 1 and Licensed Vocational Nurse 1 (LVN 1) in Resident 17's room, CNA 1 was observed standing over Resident 17 while assisting Resident 17 with his meal. CNA 1 stated he (CNA 1) was standing over Resident 17 because the occupational therapist told CNA 1 to assist Resident 17 with eating/feeding himself (Resident 17). LVN 1 stated CNA 1 should have been sitting while helping Resident 17 with his (Resident 17) meal and not standing over Resident 17 to provide Resident 17 with dignity. During an interview on 1/5/2026 at 11:54 AM with the Assistant Director of Nursing (ADON), the ADON stated CNAs (general) had to assist residents with their meals and had to be at the same eye level as the residents, to monitor residents for choking. The ADON stated CNAs needed to be on the same level as the residents when assisting the residents with their meals to provide the residents with dignity. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/2026 at 12:03 PM with the Director of Nursing (DON), the DON stated CNA 1 should have been at the same eye level as Resident 17 when assisting with the lunch meal on 1/5/2026, to provide Resident 17 with dignity. The DON stated when CNA 1 stood over Resident 17, Resident 17 could have felt overpowered (something is too strong, intense, or dominant) by CNA 1. During a concurrent interview and record review on 1/8/2026 at 9:22 AM with the DON, the facility's policy and procedures (P&P) titled, Assistance with Meals, dated 12/2025 and P&P titled Dignity, dated 12/2025, were reviewed. The DON stated CNA 1 should have sat down with Resident 17 when CNA 1 was assisting Resident 17 with his lunch on 1/5/2026 to provide Resident 17 with a dignified dining experience. During a review of the facility's P&P titled Assistance with Meals, dated 12/2025, the policy indicated 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals During a review of the facility's P&P titled Dignity, dated 12/2025, the policy indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their rights. For example, residents are: d. provided with a dignified dining experience.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of five sampled residents (Resident 5) was free from chemical restraints (a form of medical restraint in which a drug is used to restrict the freedom of movement of a patient or in some cases to sedate the patient) by failing to: -Ensure Resident 5's Medical Doctor obtained an informed consent (a process where someone voluntarily agrees after fully understanding the details, including its benefits, risks, and alternatives, ensuring they can make a free and educated decision) and to include the indication of the use of Seroquel (an antipsychotic [medications work by altering brain chemistry] used to treat mental health conditions) to Resident 5 or Resident 5's responsible party. This failure had the potential to restrict Resident 5's mobility (movement). Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the Resident 5 on 6/4/2022 and readmitted Resident 5 on 5/16/2025 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance (acting out, agitated, aggressive or mood/personality changes), psychotic disturbance (hallucinations or strong delusions), mood disturbance (disruptive sadness, irritability), and anxiety disorder (excessive worry, fear, and nervousness), unspecified. During a review of Resident 5's Order Summary Report, the Order Summary Report dated 8/11/2025, indicated Resident 5 had an order for Seroquel 25 milligrams (mg-unit of measurement), one tablet via gastrostomy tube (G-Tube is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) two times a day (BID) related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. During a review of Resident's 5 History and Physical (H&P), dated 8/13/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Order Summary Report dated 11/14/2025, the Order Summary Report indicated to monitor Resident 5's behavior of unconsolable screaming/yelling every shift tally (simple way of counting) by hash (strokes or lines) mark. During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 5 was rarely/never understood had short-term and long-term memory problems and had no recall ability. The MDS indicated Resident 5 was dependent on staff for oral and personal hygiene, bathing, rolling left and right, and dressing. The MDS indicated Resident 5 had no potential indicators of psychosis and had no verbal symptoms directed toward others (threatening others, screaming at others, cursing at others). During a review of Resident 5's Facility Verification of Resident Informed Consent dated 8/11/2025, the Facility Verification of Resident Informed Consent indicated Resident 5, resident's representative or legal empowered representative (a person who has the legal authority to act on someone else's behalf) did not receive an informed consent for the use of Seroquel. The Facility Verification of Resident Informed Consent indicated there was no medical symptom (any feeling or change in your body that tells you something is wrong) indicated for the use of the chemical restraint (using medication like sedatives or antipsychotics to control a person's behavior, making them calmer, quieter or less mobile) and the medical doctor had not verbally indicated informed consent had been obtained. The Facility Verification of Resident Informed Consent indicated the signature of the medical doctor who obtained informed consent was signed on 1/26/2026. During a review of Resident 5's Resident Care Plan Psychotropics dated 8/11/2025m the Care Plan indicated Resident 5 had episodes of agitation manifested (shown) by yelling/screaming calling out names of others, and the nursing interventions was to administer medication as per physician order. During a review of Resident 5's Note to Attending Physician/Prescriber dated 9/7/2025 from the facility's pharmacist indicated the use of this class of medications (antipsychotic) for dementia-related behaviors is non(not) Food and Drug administration (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(FDA-a US government agency that protects public health by ensuring the safety, and effectiveness of drugs) approved. The Note to Attending Physician/Prescriber indicated for the physician to review the therapeutic (treating sickness) benefits versus (vs-as opposed to) potential risks for Resident 5's having received Seroquel 25mg BID and to have provided a brief statement that the benefit on continued therapy outweighed (more important) the potential risks. The Note to Attending Physician/Prescriber indicated the prescriber had disagreed with the pharmacist indicating Resident 5 had episodes of agitation and signed on 12/27/2025. During a review of Resident 5's Interdisciplinary Team Conference Record (IDT - a group of experts with different specialties who work together to solve a problem or help someone) dated 9/8/2025, the IDT indicated Resident 5 was on psychotherapeutic drug Seroquel and did not indicate a gradual dose reduction(GDR-slowly lowering the amount of medicine you take over time, instead of stopping suddenly, to see if still needed) had been attempted, and if the medication continued to be appropriate or necessary. The Interdisciplinary Team Conference Record indicated family, responsible party, or resident had not acknowledged that indications for psychotherapeutic drugs were obtained from the physician and informed consent was not given for use of psychotherapeutic drugs. The IDT Conference Record indicated to have continued Resident's plan of care. During a review of Resident 5's Monthly Behavioral Summary dated 11/14/2025 indicated all fields were left blank. During a review of Resident 5's Nursing Administration Report dated 11/1/2025 through 11/30/2025 indicated Resident 5 did not have any behavior of unconsolable screaming or yelling. During a review of Resident 5's Nursing Administration Report dated 12/1/2025 through 12/31/2025 indicated Resident 5 had one episode on 12/6/2025 during the night shift of unconsolable screaming or yelling. During a review of Resident 5's Psychiatrist Note dated 12/27/2025 indicated Resident 5 had dementia and was on Seroquel 25 mg BID. The Psychiatrist Note did not indicate a medication dose(amount) reduction was clinically contraindicated (anything that is a reason for a person to not receive a particular treatment because it may be harmful and did not indicate the current dosage of Seroquel was the lowest effective dose for Resident 5. During a review of Resident 5's Nursing Administration Report dated 1/1/2026 through 1/7/2026 indicated Resident 5 did not have any behavior of unconsolable screaming or yelling. During an observation on 1/5/2026 at 10:23 AM in Resident 5's room, Resident 5 was lying in bed, the bed rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed. Resident 5 would open his eyes when voice prompted. During an interview on 1/7/2026 at 12:02 PM with Certified Nurse Assistant (CNA)1, CNA 1 stated Resident 5 was calm and was not restless. During a concurrent interview and record review on 1/7/2026 at 1:21PM with Registered Nurse (RN) 2, Resident 5's Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drug or [Prolonged Use of a Device] and Note to Attending Physician/Prescriber from PH and was reviewed. RN 2 stated Resident 5 had returned from the general acute care hospital (GACH) on 8/11/2025, and Seroquel was ordered from GACH. RN 2 stated Resident 5 was on Seroquel due to his behavior at GACH. RN 2 did not specify what Resident 5's behavior was. RN 2 stated a GDR for Seroquel was not done for Resident 5 and there was not an IDT done for Resident 5's psychotropic medication Seroquel upon return from GACH on 8/11/2025. RN 2 stated Resident 5's Psychiatrist signed the Note to attending Physician/Prescriber on 12/27/2025 from the facility's PH dated 9/7/2025 for Seroquel 25mg BID that indicated provide a brief statement that benefits on continuing therapy outweigh the potential risk. RN 2 stated the box on the form was checked off disagrees due to note indicating Resident 5 had episodes of agitation. RN 2 stated the form does not indicate specifically when Resident 5 had episodes of agitation. RN 2 stated Resident 5 had not received informed consent for Seroquel as indicated on Resident 5's Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drug or [Prolonged Use of a Device]. RN 2 stated the nurse received the order for Seroquel on 8/11/2025 and the physician signed the informed consent on 1/6/2026. During a concurrent interview and record review on 1/7/2026 at 2:50 PM with the Director of Nursing (DON) and RN 2 Resident 5's orders for medication Seroquel (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	25mg BID and the California Department of Public Health All Facilities Letter (AFL) dated 2/28/2024 were reviewed. The DON stated Seroquel for Resident 5 was ordered on 8/11/2025 and Resident 5 was currently on Seroquel. The DON stated according to AFL 24-07 indicated written informed consent and disclosure (telling someone important information they need to know to make a good decision). The DON [NAME] stated we could not get the signature from Resident 5 or their representative. RN 2 stated to have given informed consent the risks and benefits of medication needed to be given by the doctor. The DON stated if Resident 5 could not have given informed consent and did not have any family or representative, the facility would have involved the ombudsman and would have done an IDT meeting for psychotropic medication. The DON stated she did not know who the doctor received informed consent from or had given informed consent to for Resident 5. The DON and RN2 confirmed Resident 5 was getting psychotropic medication without informed consent. The DON and RN 2 stated they were advocates for the residents (in general). During a telephone interview on 1/7/2026 at 3:17PM T with the medical doctor (MD) for Resident 5 with the DON, RN 2 present, the MD stated Resident 5 was discharged from GACH back to the facility on Seroquel. The MD stated Seroquel was given to Resident 5 at the GACH in August 2025. The MD stated Resident 5 was given Seroquel because he was fighting and there was concern about pulling out his G tube. The MD stated Resident 5 was discharged from the GACH with Seroquel, and it would not have been appropriate to stop the medication upon being discharged because we were unable to get informed consent. The MD stated Resident 5 could not give informed consent I agree with you but it's the best, it's in the best of his interest and after discussion with the staff we did this after discussion with the staff is it's not only the physician we've decided this is the best for the patient given the current situation. The MD stated he did not receive consent upon admission for Resident 5's Seroquel. The MD stated, The informed consent for psychotropic medication that it's signed by me yesterday (1/6/2026). The MD stated he's 90 something years old and there was concern from the team and pulling out the G-tube right and you know sometimes the behavior may not have been too much of concern but it was If he pulls out the g-tube he is going to end up in going back to the hospital OK that's the issue we are discussing. The MD stated yesterday 1/6/2026 I signed the informed consent myself to carry out the order from the hospital but now we can decide whether it would be appropriate to discontinue the medication. The MD stated the informed consent form was given to him on 1/6/2026 and Seroquel was given to Resident 5 upon his admission to the facility from GACH. The MD stated he could not explain why he did not sign the informed consent form until 1/6/2026. During a concurrent interview and record review on 1/7/2026 at 3:35 PM with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Policy and Procedure Informed Consent, dated 7/10/2025 was reviewed. The DON stated we should have advised the doctor we needed to have gotten informed consent first from someone for Resident 5's Seroquel. The DON stated the doctor could not explain why he signed the informed consent form on 1/6/2026. The DON stated it was the facility's responsibility to obtain informed consent. The DON stated, the policy indicates If the resident is adjudicated incompetent, informed consent could be given by a legal guardian. The [NAME] stated the policy indicates If the resident was confused with no decision maker, legal guardian or no one with Durable Power of Attorney for health Care Purposes, then the facility IDT team will review and make the necessary decision. During a telephone interview on 1/8/2026 at 1:14 PM with the facility's pharmacist (PH) stated the medication region review (MRR - a thorough check up of all medicines to make sure they are safe) for Resident's 5's Seroquel 25mg BID was done on 9/7/2025 when Resident 5 was admitted to the facility with the medication on 8/12/2025. The PH stated I had noticed that Seroquel 25mg BID was indicated for mood disturbance, anxiety and dementia. The PH stated I questioned that and left a note for the psychiatrist on 9/7/2025 to address the use of the medication since it was not FDA approved for dementia and had a black box warning (BBW- a most serious warning for prescription drugs to alert doctors and patients about the potential life-threatening or permanently disabling risks). The PH stated Seroquel for the use of Alzheimer's dementia was not indicated by the FDA. The PH (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated on 9/7/2025 I had addressed to have clarified Resident 5's behavior. The PH stated on 12/1/2025, he had left a note for the psychologist for a GDR, and the reason Resident 5 was on Seroquel 25mg BID from 8/12/2025. The PH stated the DON would have my monthly review of medication. During a telephone interview on 1/8/2026 at 1:41 PM with Medical Director (MDIR) stated he was the new medical director. The MDIR stated in his professional history for residents receiving psychotherapeutic medication (drugs that help managemental health conditions) GDRs were done and made sure the psychiatrist came frequently and routinely reviewed medications to see if residents had meet their dose reduction, and had a chance to review the psychotherapeutic medications to have seen what was the lowest dose that could be given to prevent side effects(unwanted reaction to a medication). The MDIR stated the best thing to have done, the most appropriate for residents (in general) to have received psychotherapeutic medications was to have the psychiatric team provide informed consent rather than the primary care physician. The MDIR stated medical doctors (in general) were not trained in psychiatry and one of the purposes of the informed consent was to explain the side effects to the residents. The MDIR stated the whole idea is the word informed, we needed to place emphasis on informed, not just the residents, the doctor needs to be informed of what they were giving. The MDIR stated it would have been ideal for the psychiatrist to have been the person to have prescribed Seroquel instead of the primary care physician. The MDIR stated for Resident 5, it would have been ideal for the physician to have consulted the psychiatrist, prescribed the medication, and have obtained informed consent if the law allowed. The MDIR stated if Resident 5 did not have capacity(ability) to have given informed consent the facility should have brought it up in Utilization Review(a quality check on medical care to ensure treatments, tests and hospital tests your doctor recommends are necessary) would have been the first step, or an IDT to have had two physicians, preferably two psychiatrists if the benefits of the medication outweighed(more important than another) the risks. The MDIR stated If the benefit outweighed the risk, two psychiatrists could sign the informed consent, and the medical director could have be one of the doctors. The MDIR stated it had to be two signatures on the informed consent. The MDIR stated the proper thing to have done would have been to have brought Resident 5's informed consent and medication Seroquel through the bioethics committee (a diverse group of experts navigate through tough moral questions in medicine). The MDIR stated he was willing to put aside his time and could do an in -service (training to improve skills) for the staff since he was new to the facility and could do a policy and procedures implementation or add an addendum (an addition or supplement to an existing document). During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure Informed Consent, dated 7/10/2025, the P&P indicated This facility shall comply with the requirements as established concerning informed consent for all of its residents. The P&P indicated It is the policy that the physician has the responsibility to actually obtain consent, and it is additionally established that the patient's rights to be free from .chemical restraints be observed to the fullest The P&P indicated It is additionally established that the patient's rights to provide informed consent be accepted from the patient's representative when the patient lacks the ability to understand. The P&P indicated If the Resident is adjudicated incompetent, informed consent can be given by a legal guardian. If the resident is confused with no decision maker Legal Guardian or no one with Durable Power of Attorney for Health Care purposes, then the facility interdisciplinary team will review and make the necessary decision.During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 12/2025, the P&P indicated Residents on psychotropic medications receive gradual dose reductions.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview, and record review the facility failed to ensure to implement the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, dated 7/2025 for one of one sampled resident (Resident 18) by failing to: -Ensure the Administrator (ADM) reported Resident 18's allegation of financial abuse to the local police timely and suspended Certified Nurse Assistant 2 (CNA2) on 1/5/2026. Resident 18 alleged that CNA2 took \$500.00 dollars from Resident 18 (unidentified date) and the ADM was aware on 1/5/2026. The ADM reported Resident 18's allegation of financial abuse to the local police and suspended CNA2 on 1/6/2025. This failure had the potential for delays in the investigation process of Resident 18's allegation of financial abuse. Findings: During a review of Resident 18's admission Record, the admission Record indicated the facility admitted Resident 18 on 4/9/2025 with a diagnoses of schizoaffective disorder bipolar type (a mental illness that blends symptoms of hallucinations, delusions, disorganized thinking with symptoms of extreme mood swings between manic highs and depressive lows), major depressive disorder (a serious mood condition causing persistent sadness, loss of interest, and affecting how you feel, think, and act), and anxiety disorder (mental health conditions causing excessive fear, worry, and dread that significantly interfere with daily life). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 4/22/2025, the MDS indicated Resident 18 had good recall but not oriented to the day of the week. During an observation and interview on 1/5/2026 at 12:08 PM with Resident 18 inside Resident 18's room, Resident 18 stated CNA 2 owed the resident (Resident 18) \$500.00 dollars. Resident 18 stated CNA 2's wife (unidentified) gave CNA 2 the money. Resident 18 stated CNA 2's wife worked at the facility, but Resident 18 did not know the name of CNA 2's wife. Resident 18 stated the money was given to CNA 2 in December (unidentified year). During an interview on 1/5/2026 at 12:42 PM with the ADM, the ADM stated the allegation of money taken from Resident 18 by CNA 2 was reported to the ADM. The ADM stated Resident 18 had accused others (unidentified) of taking money and other items (unidentified) in the past. The ADM stated the amount of money changed every time. The ADM stated the facility did not report the allegations in the past due to Resident 18's mental capacity. During a review of Resident 18's Social Services Note dated 1/5/2026, the Social Services Note indicated the Social Services Designee (SSD) sent an SOC 341(a form used in California to report suspected abuse of dependent adults) to the Ombudsman (an official appointed to investigate individuals' complaints against maladministration) and to the Department. The SSD note indicated Resident 18 reported to one of the surveyors (during annual survey) that a facility staff (unidentified) took Resident 18's \$500.00 dollars. The SSD note indicated that the facility started an investigation on 1/5/2026. During an interview on 1/6/2026 at 12:55 PM with the Social Worker (SW), the SW stated that monitoring for Resident 18 for 72 hours had not begun since the allegation was reported on 1/5/2026. The SW stated she (SW) could not recall when the facility conducted the last abuse in-service. During a concurrent interview and record review on 1/6/2026 at 1:35 PM with the ADM and Registered Nurse1 (RN 1), the Abuse/Neglect policy dated 12/2025 was reviewed. The ADM proceeded to describe the process of reporting and investigating an abuse allegation. The ADM stated the facility would report the allegation to the ombudsman and the California Department of Public Health (CDPH). The ADM stated that the police would get involved when there was an altercation or physical injury and a resident was sent out to the hospital. The ADM stated the police would get involved at the resident's (unspecified) request. RN 1 stated on 1/5/26, Resident 18 reported that CNA 2 took \$500.00 dollars in cash in December 2025. RN 1 stated that CNA 2 obtained the money from the safe (the computer), and that CNA 2's wife gave CNA 2 the money. RN 1 stated the police were not notified. RN 1 stated that Resident 18 should be monitored for 72 hours. RN 1 stated that abuse training was conducted in the facility in December of 2025. The ADM stated that if an abuse allegation involved an employee, that the employee would be told to not have any contact with the (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident (unidentified) in question. The ADM stated CNA 2 was told not to have any contact with Resident 18. The ADM stated CNA 2 had not been suspended and was currently working in the facility. The ADM stated that there had not been an Interdisciplinary Team Meeting (IDT, group of diverse health care professionals from different fields) scheduled for the abuse allegation for Resident 18. The ADM and RN 1 were both unsure if a psychological consultation had been scheduled for Resident 18. The ADM reviewed the Abuse/Neglect policy. The ADM stated that the policy did not mention that a staff member involved in an allegation of abuse should be placed on suspension. The ADM stated that the facility in an allegation of abuse would do an incident report then report to the ombudsman, CDPH but not necessarily to the police. RN 1 stated Resident 18 would be at risk for the allegation not to be investigated correctly. During an interview on 1/7/2026 at 9:29 AM with the Director of Staff Development (DSD), the DSD stated that abuse training was conducted every six months and as needed. The DSD stated during abuse training staff (unidentified) were asked about the different types of abuse, reporting and investigating. The DSD stated that reporting of abuse should occur immediately and should be to the supervisor, charge nurse, or to the ADM. The DSD stated the ADM should report to CDPH, the ombudsman, and in certain circumstances to the police. The DSD stated the police should be involved when the abuse involved physical altercation and if financial abuse can be proven. The DSD stated if a staff member (in general) was accused of abuse, the staff member would be suspended. During a concurrent interview and record review on 1/7/2026 at 9:57 AM with the ADM, the Abuse, Neglect, exploitation, or Misappropriation - Reporting and Investigating policy dated 7/2025 was reviewed. The ADM stated that CNA 2 was suspended on 1/6/2026 and was not in the building. The ADM stated CNA 2 received a verbal notification of suspension. The ADM provided the abuse policy, which was reviewed, the ADM stated that on 1/6/2026 when the policy Abuse/Neglect was given to the surveyor, the ADM did not recognize the policy. The ADM stated the Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating was the policy the facility recognized. The ADM stated she (ADM) agreed that regardless of which policy was recognized, the facility was not following their policies on abuse. During an interview on 1/7/2026 at 9:58 AM with the Director of Nursing (DON), the DON stated the facility would notify the abuse coordinator, family members of the residents, MD, CDPH, Ombudsman, and law enforcement (in general). The DON stated the facility would start the investigation, and the abuse coordinator would designate who would perform the investigation and reporting was done immediately. The DON stated that for an allegation of abuse involving a staff member (unspecified) and a resident (unspecified) the facility would report to the abuse coordinator, CDPH, law enforcement, family members, Ombudsman, and MD. The DON stated the staff would be put on leave till the investigation was complete. The DON stated the residents were monitored for at least 72 hours (in general). The DON stated nursing would provide documented monitoring. The DON stated the SSD would be involved with reporting to the entities and documenting monitoring. The DON stated a psychological consult would be provided for the resident (in general). The DON stated the residents were monitored for at least 72 hours. DON stated nursing would provide documented monitoring. The DON stated the SW would be involved with reporting to the entities and documenting monitoring. The DON stated a psychological consult would be provided for the resident. The DON stated that Resident 18 would be at risk for improper investigation of the abuse without following the policy. During a review of the facility's policy and procedures (P&P) titled, Abuse/Neglect, dated 12/2025, indicated, that verbal abuse is any use of oral, written or gestured language that willfully include disparaging and derogatory terms to resident or to their families, or within their hearing distance, regardless of their age ability to comprehend or disability. The P&P indicated abuse included, but was not limited to physical, mental, verbal, sexual, or financial abuse or misappropriation of resident property. The P&P indicated the company takes all allegations seriously. The P&P indicated all staff will be in-serviced at least quarterly on abuse prevention, detection of abuse and reporting requirements. The P&P indicated that the facility would report all allegations and substantiated occurrences of abuse, neglect and misappropriation of (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	property to the state agency and law enforcement officials as designated by state law. During a review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, dated 7/2025, indicated, the administrator immediately reports his or her suspicion to the following persons or agencies: state licensing/certification agency, local state ombudsman, and law enforcement officials. The P&P indicated that any employee who has been accused of resident abuse would be placed on leave with no resident contact until the investigation was completed.		

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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** Based on interview and record review the facility failed to provide an accurate Minimum Data Set (MDS - a resident assessment tool) Assessment for one out of three sampled residents (Resident 1) as indicated in the facility's policy and procedures titled Resident Assessments, dated 7/31/2025. This failure resulted in the facility not accurately identifying Resident 1's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) and delivery of services. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 4/1/2022 and readmitted Resident 1 on 12/2/2025 with diagnoses that included chronic combined systolic and diastolic congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, hypertension (HTN-high blood pressure), atherosclerotic heart disease (thickening or hardening of the arteries), schizoaffective disorder, bipolar type (a serious mental illness where someone experiences symptoms of schizophrenia [like hearing voices or having strange beliefs] mixed with the mood swings of bipolar disorder, meaning they have intense highs [mania] and often lows [depression], making it hard to tell reality from fantasy during mood shifts), functional quadriplegia (someone can't move their arms and legs due to severe illness, frailty, or conditions like advanced dementia not from a direct spinal cord injury), dementia (a progressive state of decline in mental abilities), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's History and Physical (H&P - formal and complete assessment of the patient and the problem) dated 11/26/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a concurrent interview and record review on 1/6/2026 at 2:37 PM with the MDS Licensed Vocational Nurse (MDSLVN), Resident 1's MDS dated [DATE] was reviewed. The MDS indicated Resident 1's BIMS score was 99 (a BIMS score of 99 indicated the BIMS was unable to be completed). The MDS indicated the following: C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? - YesC0200. Repetition of Three Words - NoneC0300. Temporal Orientation (orientation to year, month, and day)A. Able to report correct years - Missed by >5 years or no answerB. Able to report correct month - Missed by >1 month or no answerC. Able to report correct day of the week - Incorrect or no answerC0400. RecallA. Able to recall sock - not assessedB. Able to recall blue - not assessedC. Able to recall bed - not assessed. The MDSLVN stated Resident 1's MDS assessment was not accurate because she (MDSLVN) asked Resident 1 to recall the words sock, blue, and bed and Resident 1 was not able to recall the words. The MDSLVN stated she pressed override (to disregard) on the assessment instead of answering the questions correctly. The MDSLVN stated when she pressed override the questions for recalling sock, blue, and bed automatically changed the answers to not assessed. The MDSLVN stated Resident 1's BIMS score of 99 was not correct because the MDSLVN stated she completed Resident 1's BIMS assessment. The MDSLVN stated she should have marked the form correctly and answered Resident 1 could not recall the word sock, blue, and bed instead of pressing override. The MDSLVN stated Resident 1's BIMS score should have been 0. The MDSLVN stated the MDS Assessment needed to be accurate for the facility to correctly care for Resident 1's needs. During a concurrent interview and record review on 1/6/2026 at 2:48 PM with Registered Nurse 1 (RN1), Resident 1's MDS dated [DATE] was reviewed. RN 1 stated Resident 1's MDS was not accurate. RN 1 stated the MDS had to be accurate for the facility's staff to know how to appropriately care for Resident 1. During a concurrent interview and record review on 1/7/2-26 at 9:35 AM with the facility's Director of Nursing (DON), Resident 1's MDS dated [DATE] was reviewed. The DON stated the MDSLVN should not have pressed override on the recall questions (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the BIMS assessment section of the MDS assessment. The DON stated when the MDSLVN pressed override the answers to the recall questions defaulted to not assessed, rendering the assessment (MDS) inaccurate. During a concurrent interview and record review on 1/7/2-26 at 9:35 AM with the facility's Director of Nursing (DON), P&P titled Resident Assessments, dated 7/31/2025 was reviewed. The DON stated the MDSLVN did not perform the MDS assessment accurately. The DON stated the MDSLVN should have performed the MDS assessment accurately because the MDS assessment was used to develop, review, and revise the resident's (in general) comprehensive care plan per the P&P titled Resident Assessments, dated 7/31/2025. During a review of the facility's P&P titled Resident Assessments, dated 7/31/2025, the P&P indicated the following: 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. The P&P indicated 9. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan (a detailed, personalized roadmap for someone's health, written down to guide everyone involved [doctors, nurses, family] on all their needs to ensure consistent, coordinated, and goal-oriented care, covering everything from medications and treatments to personal routines and emergency steps).		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to provide medically related social services, by failing to: Advocate for and obtain a public guardian (a court-appointed, government-funded helper or manager for adults who can't care for themselves because of severe mental or physical disabilities, often when no family or friends are available) when the one of three sampled residents (Resident 5) was assessed to not have the capacity to make or understand medical decisions on [DATE]. Ensure the ombudsman (a neutral, independent advocate to find fair resolutions) was notified prior to updating a Physician Order for Life-Sustaining Treatment (POLST: a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) as per the facility's policy and procedures (P&P) titled POLST, updated 12/2025. This failure had the potential not to follow Resident 5's wishes for medical care and end-of-life. Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), persistent atrial fibrillation (an irregular heart beat), ventricular tachycardia (the heart's lower chambers [ventricles] beat too fast to pump enough blood to the body), blindness in bilateral (both) eyes, metabolic encephalopathy (a condition where brain dysfunction occurs due to a chemical imbalance in the body), bilateral hearing loss, adult failure to thrive (a severe, rapid decline in physical and mental health), unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, anxiety disorder (excessive worry, fear, and nervousness), unspecified. During a review of Resident's 5 History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings), dated [DATE], the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS- a standardized resident assessment tool), dated [DATE], the MDS indicated Resident 5 was rarely/never understood had short-term and long-term memory problems and had no recall ability. The MDS indicated Resident 5 was dependent on staff for oral and personal hygiene, bathing, rolling left and right, and dressing. During an observation on [DATE] at 10:23 AM in Resident 5's room, Resident 5 was observed lying in bed, the bed rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed. Resident 5 opened his eyes when voice prompted but did not respond verbally. During an interview on [DATE] at 8:01 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated an advance directive was a document signed by the resident for medical care and if the resident was unable to make decisions for health care the document would let facility staff know the next steps to take for the resident. LVN 1 stated the advanced directive would speak for the residents if the residents could not speak for themselves. LVN 1 did not know if a POLST was the same as an advanced directive. LVN 1 stated a referral would have to be made to social services if a resident did not have an advanced directive. During a review of Resident 5's Resident Care Conference Record, dated [DATE], the Resident Care Conference Record indicated an interdisciplinary team meeting (IDT, a collaborative group of diverse health care professionals who work together) conference was conducted secondary to (resulting from) a Change of Condition (COC- change in a resident's health or functioning). The Resident Care Conference Record indicated Resident 5 did not attend or participated and the stated reason was cognitive impairment. The record indicated Resident 5 was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) and was not to receive CPR (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Bonnie Brae Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(cardiopulmonary resuscitation. It is an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped). The record indicated the agent (person) responsible portion section was blank and the IDT was attended by nursing (unspecified) and the social services director. The Resident Care Conference Record indicated Discussed with Medical Director resident's current condition and he concurs with IDT recommendations to discontinue hospice care. During a concurrent interview and record review on [DATE] at 8:16 AM with the Social Worker (SW) Resident 5's POLST dated [DATE] was reviewed. The POLST indicated a POLST was to compliment (Support) an Advanced Directive and was not intended to replace the Advanced Directive. The SW stated a POLST was not the same as an advanced directive. The SW stated Resident 5's POLST indicated Resident 5 was unable to sign due to cognitive impairment as indicated on the signature portion of patient or legally recognized decisionmaker. The SW stated if a resident was unable to sign the POLST, two doctors were supposed to sign the POLST. The SW confirmed by stating there was only one doctor that signed the POLST on [DATE] for Resident 5. The SW stated if a resident was incapacitated (unable to function, make decisions, or care for oneself due to illness, injury or disability) the SSD had to find a public guardian. The SW stated, I filled out the POLST form on [DATE] and I wrote unable to sign due to cognitive impairment and then I left the doctor to sign the form. During a concurrent interview and record review on [DATE] at 9:01 with Registered Nurse (RN)1, Resident 5's POLST dated [DATE] was reviewed. RN 1 stated an advanced directive and POLST were two separate documents. RN 1 stated there was only one physician signature on the POLST and indicated Resident 5 could not sign the form for himself due to impaired cognition. RN 1 stated Resident 5 could not communicate and had no family members and no advanced directive. RN 1 did not know if the facility had an ethics committee (a group of diverse people [nurses, doctors, social workers, clergy, families] who help sort out tough moral problems or disagreements about resident care, making sure choices respect the resident's rights, dignity, and best interests, acting as advisors, not bosses, to guide fair and compassionate decisions, especially for things like end-of-life care or consent). During an interview and record review on [DATE] at 11:51 AM with the SW, the SW could not provide an answer and remained silent on how the facility determined Resident 5's code status (medical instructions for facility staff about what to do if a resident's heart or breathing stops). During an interview on [DATE] at 1:25 PM with RN 1 stated the facility did have a bioethics committee. RN 1 stated the IDT and the bioethics committee were the same and had the same members. RN 1 stated there was no IDT done for Resident 5 for not having an advanced directive and for his POLST being updated on 1/18/ 2024. RN 1 stated the facility did not have a policy for conservatorship (court appointed person[conservator]to make important decisions for another adult[conservatee]). RN 1 stated the ombudsman should have been included in the decision to change the POLST for Resident 5. During a concurrent interview and record review on [DATE] at 12:46 PM with the Director of Nursing (DON), Resident 5's POLST and the facility policy and procedures (P&P) titled, POLST, updated 12/2025 was reviewed. The DON stated if a resident did not have any family or elected representative, the facility would have an IDT meeting and discuss the diagnosis and the plan. The DON stated if a resident did not have a family member, a friend, or designated representative the facility was to contact a public guardian or another conservatorship. The DON stated a new POLST was signed for Resident 5 on [DATE] for CPR and full treatment. The DON stated the facility should have tried to obtain a public guardian or conservatorship for Resident 5. The DON stated the facility should have also invited the ombudsman to join and discussed the advanced directive during the care conference. The DON stated the facility policy on POLST indicated The Physicians Orders for Life-Sustaining Treatment (POLST) is a physician order form that complements an advanced directive by converting an individual's wishes regarding life- sustaining treatment and resuscitation into physician orders. The DON stated Resident 5 did not have a legally recognized healthcare decision maker and policy and procedure was not followed. During a review of the facility's (P&P) titled, POLST, updated 12/2025, indicated The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order form that complements (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Bonnie Brae Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. The P&P indicated A qualified healthcare provider , preferably a social service director, will conduct an initial review of the POLST with the resident, or if the resident lacks decision making capacity the legally recognized healthcare decisionmaker (Ombudsman or Public Guardian's Office), within the first required 14-day assessment period as part of the comprehensive assessment and care planning process.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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** Based on observation and interviews, the facility failed to ensure 10 out of 18 (room [ROOM NUMBER], 3, 4, 5, 6, 12, 15, 18, 23, and 24) resident rooms met the required 80 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 a review of the facility's room waiver letter dated 1/5/2026, the letter indicated the facility was requesting a room variance (room size different from required amount) for 11 out of 18 resident rooms (room [ROOM NUMBER], 3, 4, 5, 6, 9, 12, 15, 18, 23, and 24). The room waiver letter indicated the following rooms had less than 80 square feet per bed: Room Number Floor Area Capacity room [ROOM NUMBER].64 room [ROOM NUMBER].12 room [ROOM NUMBER].164 room [ROOM NUMBER].82 room [ROOM NUMBER].164 room [ROOM NUMBER] room [ROOM NUMBER].953 room [ROOM NUMBER].13 room [ROOM NUMBER].744 room [ROOM NUMBER].382 room [ROOM NUMBER].762 The room waiver request letter indicated the rooms were in accordance with the special needs of the residents and would not inhibit residents from getting in and out of wheelchairs and affording sufficient freedom of movement. The space of each room would not have adverse effect on the residents' health and safety; and would not impede the ability of any resident in the rooms to attain his/her highest practicable well-being. The room waiver letter indicated all measures would be taken to ensure the comfort of each resident, staff, and visitor and would not be compromised by the facility's existing room square footage. During an observation on 1/8/2026 at 12:40PM, the Maintenance supervisor (MS) measured rooms [ROOM NUMBERS]. The rooms measured as follows: room [ROOM NUMBER].62 room [ROOM NUMBER].12 During multiple observations of nursing care conducted on 1/8/2026 in rooms [ROOM NUMBERS], nursing staff were observed with adequate space to provide care to the residents in each resident room [ROOM NUMBER] and room [ROOM NUMBER]. Each resident was observed to have privacy curtains, working call-lights, storage, and a bedside table with personal belongings stored in each resident's choice of location. During an interview on 1/8/2026 at 9:51am with Resident 90 in room [ROOM NUMBER] bed A, Resident 90 stated the room was big enough to accommodate him (Resident 90) and his wife. The Resident stated the size of the room has never stopped care of services from being completed. During a concurrent observation and interview on 1/8/2026 at 9:34am, the surveyor and occupational therapist (OT) toured the resident rooms listed with room waivers (1,3,5,9,10,11,14,16,17,23, and 24). The OT stated that she had sufficient space within the rooms that had room waivers to give care and complete the residents' plan of care. During an interview on 1/8/2026 at 10:00am with Resident 10 in room [ROOM NUMBER] the resident stated that she had not noticed that the room was smaller than other rooms. The resident states that the room is big enough, and nursing care has never been compromised. A review of the facility's policy and procedures (P&P) titled Resident bedrooms revised on 8/2024, the policy indicated resident bedrooms had to be designed and equipped for adequate nursing care, comfort and privacy of resident and would measure at least 80 square feet per resident in multiple resident bedrooms. The Department is recommending continuation of the room waiver request.		