STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055622	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonita Hills Post Acute	1233 West LA Habra Boulevard LA Habra, CA 90631

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 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview, medical record review, and facility P&P review, the facility failed to offer a copy of the inventory of the resident's personal belonging and follow up with the resident's family regarding the personal belongings for Resident 4. This failure had the potential to affect the ability of the resident or resident's responsible party to be informed of their belonging. Findings Review of the facility's P&P titled Resident Personal Belonging dated [DATE], showed the inventories of all the items are to be reviewed and examined by social services designee and the resident's representative. Recipients of such personal items at the time of discharge or death shall sign off their legal signature acknowledging receipt of all personal belonging presented. Notification of deceased resident's family or responsible agent will be accomplished by means of a certified letter-Return Receipt requested which shall be sent as soon as possible after the death, indicating, and containing: a copy of the resident belonging inventory and disposition offering alternative methods of disposing of all the resident's personal possessions pick up, mail, documentation, donation, and destruction. Closed medical record review of Resident 4 was initiated on [DATE]. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's closed medical record showed the resident's inventory list to be provided to the resident's representative or family member was still in the resident's medical record. There was no documented evidence the resident's family member was notified how the resident's belongings would be disposed or offered methods of disposing per the facility's P&P, since the resident had expired. On [DATE] at 1200 hours, an interview and concurrent medical record review was conducted with the Social Worker. The Social Worker was asked if he had followed up with Resident 4's family member regarding the resident's personal belonging. The Social Worker stated he had not followed up with them. On [DATE] at 0900 hours, an interview and concurrent medical record review was conducted with the Director of Medical Record. The Director of Medical Record acknowledged one copy of the inventory list should be given to the resident or resident's responsible party. The Director of Medical Record verified the findings.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation and interview, the facility failed to maintain a clean, safe, and homelike environment for one nonsampled residents (Resident C). This failure posed the negatively effects on Resident C's well-being. Findings: Medical record review of Resident C was initiated on 9/18/24. Resident C was admitted to the facility on [DATE], and readmitted on [DATE]. On 9/18/24 at 1545 hours, the frame of Resident C's bedside commode was observed rusty and corrosive. Resident C stated she felt gross to see her bedside commode rusty and had informed the staff, but it had not been replaced yet. On 9/18/24 at 1600 hours, an interview was conducted with DON. The DON was informed regarding the bedside commode of Resident C. The DON stated she would inform the maintenance to replace it. On 9/23/24 at 1200 hours, an interview was conducted with Resident C. Resident C stated they had not replaced the bedside commode. The DSD was summoned to the room, the bedside commode of resident C was observed rusty and corrosive. The DSD verified the findings.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure an allegation of staff to resident abuse was reported to the State Agency and failed to investigate an allegation of staff to resident abuse for one of five sampled residents (Resident 1). * The facility was informed by Resident 1's family that Resident 1 allegedly felt intimidated by the care a CNA provided to Resident 1. However, the facility failed to report the allegation to the State Agency, failed to investigate the allegation, and failed to report the results of the investigation to the State Agency within 5 working days of the alleged incident, in accordance with the facility's Abuse, Neglect and Exploitation P&P. This failure resulted in the State Agency not being notified of the resident's allegation of abuse, which posed the risk for inhibiting the State Agency from determining whether resident abuse occurred and thus ensuring the safety of the residents. Additionally, the facility's failure to investigate an allegation of staff to resident abuse posed the risk for actual incidents of resident abuse not being identified. This had the potential for further actual incidents of resident abuse to occur. Findings: Review of the facility's P&P titled Abuse, Neglect and Exploitation revised 12/19/22, showed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident, by developing and implementing written policies and procedures that prohibit and prevent abuse. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Possible indicators of abuse include family report of abuse. An immediate investigation is warranted when reports of abuse occur. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation. Providing complete and thorough documentation of the investigation. Reporting of all alleged violations to the stage agency within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. The Administrator will follow up with government agencies to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Closed medical record review for Resident 1 was initiated on 9/17/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/31/24, showed Resident 1 had the capacity to understand and make decisions. On 9/16/24 at 1456 hours, an interview was conducted with Family Member 2. Family Member 2 stated Resident 1 informed her that she (Resident 1) felt threatened, scared, and intimidated by CNA 1. Family Member 2 stated Resident 1 informed her of the allegation in early August 2024. Family Member 2 stated she informed the DON of Resident 1's allegation. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 1344 hours, an interview was conducted with the DON. The DON was asked if she was aware of a staff to resident abuse allegation involving CNA 1 and Resident 1. The DON stated on 8/8/24, Resident 1 sustained a witnessed fall. The DON stated a day or two after the fall, Family Member 2 informed the DON that Resident 1 felt intimidated by the care CNA 1 provided to Resident 1. The DON was asked if Resident 1 having felt intimidated by the care CNA 1 provided, was considered an allegation of abuse, in accordance with the facility's abuse P&P. The DON stated no. On 9/17/24 at 1523 hours, a concurrent interview and facility P&P review was conducted with Administrator 1. Administrator 1 stated she was aware Family Member 2 had informed the DON Resident 1 felt intimidated by the care CNA 1 provided to Resident 1. Administrator 1 stated she was aware of this allegation on 8/8/24. Administrator 1 was asked if the facility reported to the State Agency the allegation Resident 1 felt intimidated by the care CNA 1 provided to Resident 1, in accordance with the facility's Abuse, Neglect and Exploitation P&P. Administrator 1 stated the facility failed to report the allegation to the State Agency. Administrator 1 was asked if the facility conducted an investigation specific to the allegation, Resident 1 felt intimidated by the care CNA 1 provided to Resident 1, in accordance with the facility's Abuse, Neglect and Exploitation P&P. Administrator 1 stated the facility failed to conduct an investigation. Administrator 1 reviewed the facility's Abuse, Neglect and Exploitation P&P revised 12/19/22, and stated the facility should have reported the allegation to the State Agency, conducted an investigation, and reported the results of the investigation to the State Agency within 5 working days of the alleged incident, in accordance with the facility's Abuse, Neglect and Exploitation P&P.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident's right to remain in the facility was permitted. The facility initiated a transfer/discharge of the resident without having first met the regulatory requirements, specific to a facility-initiated transfer/discharge for one of five sampled residents (Resident 1). * After Resident 1 exceeded her ordered out-on-pass time and missed her scheduled medications, the facility obtained a discharge against medical advice order. However, Resident 1 returned to the facility and wanted to enter the facility, at which time the facility did not allow Resident 1 to enter the facility. The facility failed to notify Resident 1's physician that Resident 1 had returned to the facility. The facility failed to conduct an assessment of Resident 1 upon her return to the facility. The facility failed to coordinate transition of care with a receiving facility. The facility failed to provide Resident 1 or her family with necessary information (advance directive information, list of Resident 1's current medications, comprehensive care plans, a copy of the Resident's 1's discharge summary, and contact information of the practitioner responsible for the care of Resident 1) to ensure a safe transition of care to the receiving facility. The facility's refusal to allow Resident 1 to enter the facility resulted in Resident 1's Family Member 1 having to transport Resident 1 to the acute care hospital emergency department to be assessed by the health care professionals and attempt to attain Resident 1's medications she had missed while out on pass (which included the blood pressure and blood thinner medications). These failures resulted in Resident 1 having to wait in the acute care hospital emergency room for hours. Resident 1's spouse stated while waiting in the emergency room , Resident 1 complained of a headache, was nervous, and wanted to go back to the facility. Resident 1's Family Member 1 stated Resident 1 was crying and thought she did something wrong because she could not return to the facility. Upon assessment by the acute care hospital physician Resident 1's blood pressure was 174/90 mmHg (normal range: 120/80 mmHg) and her oxygen saturation level was 74% (normal range: 95-100%). Resident 1 was also noted with some mild abdominal pain. Findings: (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, showed it is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. Facility-initiated transfer or discharge is a transfer or discharge which the resident objects to or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: (1) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. (2) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. (3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. (4) The health of individuals in the facility would otherwise be endangered. (5) The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. (6) The facility ceases to operate. When a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving Against Medical Advice (AMA). The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Notify Adult Protective Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly. Closed medical record review for Resident 1 was initiated on 9/17/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/31/24, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's physician's order dated 8/19/24, showed Resident 1 may have out on pass for four hours. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 1615 hours, an interview was conducted with Resident 1's spouse (Family Member 1). Family Member 1 stated on 8/21/24, he took his wife out on pass to a medical appointment and after the appointment, he took Resident 1 to their home. Family Member 1 stated he received a phone call from the facility instructing him to return Resident 1 to the facility. Family Member 1 stated he then drove Resident 1 back to the facility at approximately 1400 hours. Family Member 1 stated he arrived at the facility and parked his car in the facility parking lot. Family Member 1 stated he was in the process of assisting Resident 1 out of the car and onto her wheelchair when he was approached by the facility's Social Worker. Family Member 1 stated the Social Worker told him and Resident 1 that Resident 1 could not enter the facility and Family Member 1 had to take Resident 1 to the emergency department. Family Member 1 stated he told the Social Worker if the facility would not allow the resident to return to her bed inside the facility, Resident 1 needed her medications, a printout of Resident 1's current medications, and Resident 1's personal property. Family Member 1 stated the Social Worker told him no and instructed Family Member 1 to have the emergency department doctor contact the facility for Resident 1's current medications. Family Member 1 stated the facility did not provide him with any paperwork and did not inform him which hospital to take Resident 1 to. Family Member 1 stated he drove Resident 1 to Acute Care Hospital 2. Family Member 1 stated he and Resident 1 had to wait in the Acute Care Hospital 2 emergency room for hours. Family Member 1 stated Resident 1 needed her blood pressure and blood thinner medications. Family Member 1 stated Resident 1 complained of a headache, was nervous, and wanted to go back to the facility. Family Member 1 stated Acute Care Hospital 2 provided Resident 1 with a four-day supply of medications. Family Member 1 stated he then hurried to obtain a doctor's appointment to obtain Resident 1's prescriptions to ensure Resident 1 had her medications after the four-day supply ran out. Family Member 1 stated he and Resident 1 were not informed previously that Resident 1 would not be allowed to return to the facility. Family Member 1 stated he was extremely upset and asked why the facility did not tell him they would not allow Resident 1 to enter the facility before he drove Resident 1 back to the facility. Family Member 1 stated at least the facility could have provided him with a list of Resident 1's medications to allow her to obtain refills. Review of Resident 1's Acute Care Hospital 2 Emergency Department Provider Notes dated 8/24/24 at 1450 hours, showed Physician 2 documented Resident 1's Family Member 1 took her to a doctor's appointment, but when he was taking Resident 1 back to the facility, they were refusing to take her back and would not give the medications or medication list to Resident 1. Resident 1 needed the medication refills for all her medications. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician 2 documented he spoke with the facility Social Worker who expressed Resident 1 was picked up by her family members at 0730 hours yesterday and was not brought back within the four-hour period and reportedly brought back at 2030 hours. Given Resident 1 missed her medications and apparently ate food that fell outside of her dietary restrictions, decision was made to label Resident 1 as AMA and have her be evaluated in the emergency department to receive her medications. The Social Worker at this facility said they destroyed the medications, and Resident 1 would not be allowed to access back into the facility. Resident 1 did not know which medications she took. Per speaking with the facility, family, and Resident 1, the stories were corroborated by one another. Having multiple conversations with the family and informing them that they would not be able to return to the facility, the decision was made to prescribe Resident 1 very short course of select antihypertensive, anticoagulant, and seizure medications. Physician 2 reviewed prior facility medication list note that was remarkable for the medication list. Upon assessment by Physician 2, Resident 1's blood pressure was 174/90 mmHg and her oxygen saturation level was 74%. Resident 1 was also noted with some mild abdominal pain. Review of Resident 1's Social Services Progress Note dated 8/21/24 at 1523 hours, showed Resident 1 went out on pass at 0730 hours. Resident 1 had an order for four-hours out on pass, there had been multiple occasions that Resident 1 had surpassed the out on pass order of six hours as well. Resident 1 had missed all her morning medications today, the family stated when it was brought to their attention, they did not care nor think it was a big deal. Also, while speaking to the family, they stated Resident 1 had not eaten lunch. This information was mentioned by Family Member 2 at 1415 hours in a care plan meeting. After Family Member 2's response, Resident 1's physician was made aware of the risks and noncompliance of family/Resident 1. AMA order was given. Family Member 2 was provided with the Ombudsman's number. The Social Worker informed Family Member 2 that he would be involving the Adult Protective Services. Resident 1's Family Member 1 and Resident 1 showed up to the facility and was aggressive after the situation was explained. On 9/18/24 at 1053 hours, a concurrent interview and closed medical record review was conducted with the Social Worker. The Social Worker was asked if he informed Resident 1 and Family Member 1, upon having arrived at the facility on 8/21/24, that Resident 1 was not allowed to enter the facility. The Social Worker stated on 8/21/24, Family Member 1 picked up Resident 1 from the facility and took Resident 1 to an appointment. After the appointment Resident 1 was brought home instead of back to the facility. The Social Worker stated after Resident 1 had exceeded the four-hours out on pass order, the facility contacted Family Member 2 and informed Family Member 2 that the facility was concerned about Resident 1 having missed her morning medications and Resident 1 needed to be evaluated at an acute care hospital emergency department. The Social Worker stated Family Member 2 was not agreeable to the four-hours out on pass order and Family Member 2 refused to take Resident 1 to the acute care hospital. Family Member 2 stated Resident 1 would return to the facility at 2000 hours. The Social Worker stated the facility had contacted Resident 1's physician (Physician 1) and informed Physician 1 that Resident 1 had missed her morning medications (which included antihypertensive, anticoagulant, and antiseizure medications) and had exceeded her four-hours out on pass order. Additionally, Resident 1's family wanted to return Resident 1 to the facility at 2000 hours. The Social Worker stated Physician 1 gave a DC AMA (Discharge Against Medical Advice) order and for Resident 1 to go to an acute care hospital emergency department for evaluation. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Order Summary Report showed a physician's order dated 8/21/24, for DC AMA. The Social Worker was asked to describe his understanding of the physician's order to DC AMA. The Social Worker stated the physician's DC AMA order indicated Against Medical Advice; Resident 1 missed her prescribed medications and exceeded her four-hours out on pass order. The Social Worker stated Family Member 1 and Resident 1 arrived back at the facility on 8/21/24 (sometime before 1523 hours). Family Member 1 had driven Resident 1 back to the facility. The Social Worker stated he alone without any other staff contacted Resident 1 and Family Member 1. The Social Worker stated he observed Resident 1 sitting in the car. Social Worker 1 stated Family Member 1 told him he wanted his wife to return to the facility. The Social Worker stated he spoke with Resident 1 and Family Member 1 and advised them Resident 1 could not come back inside the facility and explained there was a DC AMA order, and Physician 1 wanted Resident 1 brought to the acute care hospital emergency department to be evaluated for having missed her prescribed medications. The Social Worker was asked if Physician 1 had ordered for Resident 1 not to be allowed to enter the facility if she returned to the facility, to which the Social Worker replied no. The Social Worker was asked if he notified Physician 1 that Resident 1 had returned to the facility, to which he replied he had not. The Social Worker was asked if Resident 1 no longer desired to reside in and receive care at the facility. The Social Worker stated Resident 1 wished to return to the facility. The Social Worker was asked if the licensed nursing staff assessed Resident 1 upon Resident 1 having returned to the facility, to which the Social Worker replied they had not. The Social Worker was asked if he provided Resident 1 or Family Member 1 with the following information: a written transfer/discharge notice containing Resident 1's appeal rights; the location to which Resident 1 was to be discharged ; information to be provided to the receiving provider (contact information of the practitioner responsible for the care of Resident 1, advance directive information; list of Resident 1's current medications, comprehensive care plans, a copy of the Resident's 1's discharge summary) to ensure a safe transition of care. The Social Worker stated the facility did not provide Resident 1 or Family Member 1 with any paperwork. The Social worker stated Resident 1 and Family Member 1 were not informed what acute care hospital emergency department Resident 1 was to be transferred or discharged to. The Social Worker stated the facility did not coordinate Resident 1's transfer or discharge with a receiving provider or transportation company. The Social Worker stated he contacted APS to report neglect as evidenced by Resident 1 having missed her scheduled medications, Resident 1 having exceeded her ordered out on pass time, and Family Member 2 having refused to take Resident 1 to the acute care hospital emergency department to be evaluated. The Social Worker was asked upon Resident 1's return to the facility if he felt it was safe to allow Resident 1 to remain with the individuals he reported to the APS for alleged neglect versus taking custody of Resident 1 and allowing her to return to the facility. The Social Worker stated yes, it was safe because he reported the individuals to the APS and they were under investigation. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 1346 hours, an interview was conducted with Resident 1's physician (Physician 1). Physician 1 stated he was informed by the facility that Resident 1 had exceeded her out on pass time with increased frequency. Physician 1 stated the facility expressed concerns specific to noncompliance with scheduled medications, missed meals, and participation in care. Physician 1 stated on 8/21/24, he was contacted by the facility and informed that Resident 1 had exceeded her out on pass time, had not returned to the facility, had not received her scheduled medications, and may have missed meals, and the facility subsequently obtained a DC AMA order. Physician 1 was asked if the facility informed him that Resident 1 had returned to the facility after having obtained the DC AMA order on 8/21/24. Physician 1 stated he was not informed when Resident 1 had returned to the facility. Physician 1 was asked if he ordered or informed the facility not to allow Resident 1 to enter the facility, if she was to return to the facility, to which Physician 1 replied, no. Physician 1 stated Resident 1 had the right to be cared for by the facility staff when Resident 1 returned to the facility. Physician 1 stated when Resident 1 returned to the facility, his expectation would be for the nursing staff to perform an assessment of Resident 1 to determine Resident 1's condition and then inform him of Resident 1's condition. Physician 1 stated if Resident 1 required care at the acute care hospital, the facility would then coordinate the transfer to the acute care hospital. On 9/23/24 at 1503 hours, an interview was conducted with LVN 1. LVN 1 stated she was assigned to care for Resident 1 on 8/21/24. LVN 1 stated Resident 1 had an out on pass order for four hours on 8/21/24. LVN 1 stated Resident 1 was picked up by her family at approximately 0730 hours. LVN 1 stated Resident 1's family brought Resident 1 to an appointment scheduled the morning of 8/21/24. LVN 1 stated after four hours had passed, Resident 1 had not returned to the facility and missed her scheduled morning medications. LVN 1 stated the Social Worker contacted Resident 1's family and re-educated Resident 1's family that the allotted out on pass time was four hours. LVN 1 stated Resident 1's family indicated they would bring Resident 1 back to the facility at 2030 hours. LVN 1 stated Resident 1 having exceeded her ordered out on pass time and having not received her scheduled medications constituted Against Medical Advice, specific to the out on pass order and ordered medications. LVN 1 stated if she had been aware Resident 1 had returned to the facility, she would have performed an assessment of Resident 1 and obtained Resident 1's vital signs to determine Resident 1's clinical status. LVN 1 stated she would have then contacted Resident 1's physician and informed him of her assessment findings and inquired as to whether to administer the mediations that Resident 1 missed or to administer Resident 1's medications at the next scheduled time. LVN 1 stated she had no knowledge that Resident 1 desired to be discharged from the facility without the authority of and against the advice of her physician (Physician 1) and therefore, Resident 1 would still be a resident of the facility when she returned to the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bonita Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 West LA Habra Boulevard LA Habra, CA 90631	

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 1059 hours, an interview was conducted with RN 1. RN 1 verified she was assigned to care for Resident 1 on 8/21/24. RN 1 stated Resident 1's family picked up Resident 1 from the facility early in the morning to transport Resident 1 to her appointment. RN 1 stated she was not informed Resident 1 had returned to the facility on [DATE], after having gone out on pass. RN 1 was asked if Resident 1 had returned to the facility late from being out on pass and had missed her scheduled medications, what her actions would have consisted of. RN 1 stated she would have conducted a physical assessment and obtained Resident 1's vital signs to determine Resident 1's clinical status. RN 1 stated she would also have notified the physician Resident 1 had returned to the facility and informed the physician of Resident 1's clinical status. RN 1 stated she would have asked the physician if Resident 1 was to receive her missed medications and if needed to coordinate a transfer to the acute care hospital. On 9/18/24 at 1536 hours, a concurrent interview, closed medical record review, and facility P&P review was conducted with Administrator 1. Administrator 1 stated Family Member 1 picked up Resident 1 from the facility on 8/21/24, at approximately 0730 hours. Family Member 1 then drove Resident 1 to an appointment. Administrator 1 stated Resident 1 had an out on pass order for 4 hours. Administrator 1 stated after Resident 1 had exceeded four hours out on pass, an IDT meeting was conducted with Resident 1's family (Family Member 2) via phone. Administrator 1 explained to Family Member 2 that Resident 1 had missed her medications and exceeded the out on pass order time. Administrator 1 stated Physician 1 was contacted and informed Resident 1 had exceeded her ordered out on pass time and missed her scheduled morning medications. Administrator 1 stated Physician 1 recommended Resident 1's family to take Resident 1 to an acute care hospital emergency department to be evaluated, being Resident 1 missed her scheduled medications and exceeded the ordered time allowed out of the facility. Administrator 1 stated the Social Worker contacted Family Member 2 and informed her to take Resident 1 to an acute care hospital emergency department to be evaluated. Administrator 1 stated Family member 2 stated she would not bring Resident 1 to the emergency department. Administrator 1 stated Family Member 1 then drove Resident 1 back to the facility sometime before 1530 hours. Administrator 1 stated when they arrived, the Social Worker informed Family Member 1 and Resident 1 that Resident 1 could not come into the facility due to an AMA order even though Resident 1 desired to return to the facility. Administrator 1 reviewed the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, and verified in accordance with the P&P, a facility-initiated transfer/discharge of Resident 1 could only occur if Resident 1 met one of the following exemptions: (1) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. (2) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. (3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. (4) The health of individuals in the facility would otherwise be endangered. (5) The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. (6) The facility ceases to operate. After reviewing the exemptions, Administrator 1 stated Resident 1 had not met any of the exemptions to allow the facility to initiate a transfer or discharge. (continued on next page)

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Bonita Hills Post Acute	1233 West LA Habra Boulevard LA Habra, CA 90631

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furthermore, Administrator 1 stated Resident 1's physician (Physician 1) should have been notified of Resident 1's return to the facility. Administrator 1 stated Resident 1 should have been assessed by the licensed nursing staff to determine Resident 1's clinical condition, and based on the assessment findings, a determination could be made as to whether Resident 1 needed to be transferred to the acute care hospital for further evaluation. Administrator 1 stated if Resident 1 needed to be transferred to the acute care hospital (after having arrived at the facility), the facility should have coordinated the transfer and provided the necessary information (advance directive information, list of Resident 1's current medications, comprehensive care plans, a copy of the Resident's 1's discharge summary, and contact information of the practitioner responsible for the care of Resident 1) to ensure a safe transition of care to the receiving facility. Administrator 1 reviewed Resident 1's medical record and stated there was no documentation Resident 1's Physician (Physician 1) had ordered that Resident 1 would not be allowed inside the facility, if Resident 1 had returned to the facility, after exceeding her ordered out on pass time. Administrator 1 further reviewed Resident 1 medical record and stated there was no documentation Resident 1 wished to be discharged from the facility Against Medical Advice of her physician(s).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to provide a notice of transfer/discharge to the resident and resident's representative, before the facility initiated a transfer/discharge for one of five sampled residents (Resident 1). This failure posed the risk for Resident 1 and Resident 1's representative not being aware of their appeal rights and potentially jeopardizing the appeal process in the event Resident 1 and/or Resident 1's representative felt the facility-initiated transfer or discharge from the facility was inappropriate and involuntary. Findings: Review of the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, showed the facility's transfer/discharge notice will be provided to the resident and the residents representative in a language and manner in which they can understand. The notice will include all of the following (information) at the time it is provided: the specific reason and basis for the transfer or discharge. The effective date of transfer or discharge. The specific location (such as the name of the new provider) to which the resident is to be transferred or discharged . An explanation of the right to appeal the transfer or discharge to the State. The name, address and telephone number of the State entity which receives such appeal hearing requests. Information on how to obtain an appeal form. Information on obtaining assistance in completing and submitting the appeal hearing request. The name, address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman. When a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals at the facility. Generally, the notice must be provided at least 30 days prior to a facility-initiated transfer of discharge of the resident. Closed medical record review for Resident 1 was initiated on 9/17/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/31/24, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's physician's order dated 8/19/24, showed Resident 1 may have out on pass for four hours. On 9/18/24 at 1053 hours, a concurrent interview and closed medical record review was conducted with the Social Worker. Review of Resident 1's Order Summary Report showed a physician's order dated 8/21/24, to DC AMA (Discharge Against Medical Advice). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Worker stated Family Member 1 and Resident 1 arrived back at the facility (after having exceeded the ordered out on pass allotted time) on 8/21/24. Family Member 1 had driven Resident 1 back to the facility. The Social Worker stated he alone without any other staff contacted Resident 1 and Family Member 1. The Social Worker stated he observed Resident 1 sitting in the car. Social Worker 1 stated Family Member 1 told him that he wanted his wife to return to the facility. The Social Worker stated he spoke with Resident 1 and Family Member 1 and advised them that Resident 1 could not come back inside the facility and explained there was a DC AMA order, and Physician 1 wanted Resident 1 brought to the hospital emergency room to be evaluated for having missed her prescribed medications. The Social worker stated Resident 1 and Family Member 1 were not informed what hospital emergency room Resident 1 was to be transferred or discharged to. The Social Worker stated the facility did not coordinate Resident 1's transfer or discharge with a receiving provider or transportation company. The Social Worker was asked if he provided Resident 1 or Family Member 1 with a written transfer/discharge notice containing Resident 1's appeal rights. The Social Worker stated the facility did not provide Resident 1 or Family Member 1 with any paperwork. On 9/18/24 at 1536 hours, a concurrent interview and facility P&P review was conducted with Administrator 1. Administrator 1 reviewed Resident 1's medical record and verified the facility failed to provide Resident 1 and/or Resident 1's family with the facility's transfer/discharge notice, in accordance with the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22. Administrator 1 verified the notice would have provided the following information to Resident 1 and Resident 1's family: The specific reason and basis for the transfer or discharge. The effective date of transfer or discharge. The specific location (such as the name of the new provider) to which the resident is to be transferred or discharge. An explanation of the right to appeal the transfer or discharge to the State. The name, address and telephone number of the State entity which receives such appeal hearing requests. Information on how to obtain an appeal form. Information on obtaining assistance in completing and submitting the appeal hearing request. The name, address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman. Administrator 1 verified the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, showed when a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals at the facility. Cross reference to F622.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Residents 4) received care and services to address their pain and skin condition. * Resident 4 complained of pain; however, the resident's pain was not comprehensively assessed for location, timing, frequency, duration of pain, pattern, radiation of pain. There were no nonpharmacological interventions offered before the pain medication administration. Resident 4 complained of moderate pain but was given a pain medication prescribed for severe pain. In addition, the physician was not informed of the resident's moderate pain. * Resident 4 was admitted with multiple skin issues; however, the resident's skin was not comprehensively assessed for description of size, location, drainage, pain, odor, type of tissue in wound bed, the extend of redness, and skin discoloration. These failures had the potential for not providing necessary care and services to meet the care needs for this resident. Findings: 1. Review of the facility's P&P titled Pain Management dated 12/19/22, showed in part, identifying key characteristics of the pain: duration of pain, frequency, location, timing, pattern (e.g. constant or intermittent), radiation of pain; and obtaining descriptors of the pain (e.g. stabbing, aching, pressure, spasms). Pain Management and Treatment: non-pharmacological interventions will include but are not limited to: environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning), loosening any constrictive bandage, clothing or device, applying splinting (e.g., pillow or folded blanket), physical modalities (e.g., cold compress, warm shower/bath, massage, turning and repositioning), exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility, cognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain). Closed medical record review of Resident 4 was initiated on 9/18/24. Resident 4 was admitted to the facility on [DATE]. Review of the Order Summary Report dated 9/18/24, showed the following physician's orders: - acetaminophen oral tablet 325 mg (acetaminophen) two tablets by mouth every four hours as needed for mild pain (for pain levels of 1-3, on a 0-10 pain scale, 0 = no pain and 10 = worst), not to exceed 3 grams/24 hours. - hydromorphone hydrochloride 4 mg one tablet orally every four hours as needed for severe pain (for pain levels of 8-10). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for September 2024 showed the entry for hydromorphone hydrochloride 4 mg one tablet orally every four hours as needed for severe pain (for pain levels of 8-10). On 9/12/24 at 0458 hours and 9/13/24 at 0240 hours, the pain level was documented 7 and hydromorphone hydrochloride was given. On 9/19/24 at 0850 hours, an interview and concurrent closed medical record review was conducted with the Quality Assurance staff. The Quality Assurance staff was asked if the nurse informed the physician regarding the resident's pain level of 7 on 9/12 and 9/13/24. The Quality Assurance staff acknowledged the nurse should have called the physician to get an order for pain medication for moderate pain since the hydromorphone hydrochloride oral one tablet 4 mg was ordered for severe pain. The Quality Assurance staff verified the findings. On 9/24/24 at 1000 hours, an interview was conducted with RN 2. RN 2 was asked if Resident 4 had complained of pain upon admission on 9/6/24. RN 2 stated the resident did complain of pain level of 7 around the resident's penis area. RN 2 stated she informed the LVN about it. RN 2 was asked if there is any documentation regarding the resident's pain. RN 2 stated she did not document it. On 9/24/24 at 1115 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 was asked if Resident 4 had complained of pain during the admission. LVN 2 stated she remembered Resident 4 had complained of pain. LVN 2 stated Resident 4 complained of pain level of 6 or 7 around the penis area. LVN 2 stated she offered Tylenol and cold compress, but the resident had refused. When asked if LVN 2 documented the pain and intervention. LVN 2 verified the findings. On 9/24/24 at 1620 hours, an interview and concurrent closed medical record review was conducted with the Infection Preventionist. The Infection Preventionist was asked to show the care plan to address the problem of pain. The Infection Preventionist was unable to show the documentation. The Infection Preventionist was asked if the resident was assessed for the location, timing, frequency, duration of pain, pattern, radiation of pain when the patient complained of pain and nonpharmacological was offered. The Infection Preventionist was unable to provide the documentation. The Infection Preventionist verified the findings. 2. Review of the facility's P&P titled Skin assessment dated [DATE], showed the following related to documentation of the skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate. Review of Resident 4's Clinical admitted d 9/6/24, showed under the skin section, no skin issues were documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of the Order Summary Report dated 9/18/24, showed the following physician's orders for wound care: - dated 9/7/24, for the left lower leg area, to cleanse with normal saline, pat dry, apply with vitamin A and D ointment topically, then leave open to air, every day shift for scattered skin open lesions with hyper dark skin pigmentation for 21 Days. - dated 9/7/24, for the right heel area, to cleanse with normal saline pat dry apply with skin prep, cover with a foam dressing every day shift for DM (Diabetes Mellitus) ulcer for 21 Days. - dated 9/7/24, for the right lower leg area, to cleanse with normal saline pat dry apply with vitamin A and D ointment topically, then leave open to air every day shift for scattered open lesions with hyper dark skin pigmentation for 21 Days. Review of the Skin Only Evaluation dated 9/7/24, showed the resident's skin was warm and dry, skin color was WNL (within normal limit), and skin turgor was normal. However, the evaluation of the resident's skin failed to show documented evidence the resident's above skin issues, including the description of size, drainage, pain, odor, type of tissue in wound bed, the extend of redness, and skin discoloration. On 9/22/24 at 1100 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 was asked if she did the assessment for Resident 4 on 9/7/24. LVN 3 stated she assessed the resident's skin for heel, scattered lesion on both legs, and penis. LVN 3 was asked to provide the documentation for the resident's skin assessment upon admission and weekly. LVN 3 was unable to provide the documentation. LVN 3 stated the skin assessment should be completed during admission and weekly. LVN 3 verified the findings. On 9/24/24 at 1000 hours, an interview was conducted with RN 2. RN 2 was asked if she assessed the skin during admission. RN 2 stated the resident had refused to be touched or assessed. RN 2 was asked for the documentation showing the resident had refused the assessment and the reason for refusal, RN 2stated she forget to document it. RN 2 stated the next day, RN 2 informed LVN 3 regarding the skin assessment was not done. On 9/24/24 at 1620 hours, an interview and concurrent medical record review was conducted with the Infection Preventionist and LVN 3. The Infection Preventionist was asked if a care plan was developed to address the resident's skin issues. The Infection Preventionist was unable to provide the documentation. The Infection Preventionist verified the findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 5) remained free from accident hazards. * While residing at the facility, Resident 5 sustained five falls. On 9/19/24 at 1340 hours, Resident 5 informed the CNA she needed to use the bathroom; however, the CNA failed to provide the resident with assistance; and at 1430 hours (per the medical record), Resident 5 was found lying on the floor in the bathroom and sustained a fractured right humerus after she attempted to transfer herself to the toilet. This failure resulted in the resident sustaining a fracture to the right humerus and hospitalization . Findings: Review of the facility's P&P titled Accidents and Supervision revised 12/19/22, showed the resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes identifying hazards and risks and implementing interventions to reduce hazards and risks. Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision is based on the individual resident's needs. Review of the facility's P&P titled Fall Prevention Program revised 12/28/23, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Review of the facility's P&P titled Fall Risk Assessment revised 12/19/22, showed it is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. The fall care plan will include interventions, including adequate supervision. Review of the facility's P&P titled Helping a Resident with Toileting Needs revised 12/19/22, showed it is the practice of this facility to assist residents with toileting needs in order to maintain the resident's dignity as well as proper hygiene. Policy explanation and compliance guidelines include helping the resident to the bedside commode or to the bathroom. Medical record review for Resident 5 was initiated on 9/17/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's care plan focus revised 2/27/24, showed Resident 5 had impaired cognition. The interventions included cue, reorienting, and supervision as needed. Review of Resident 5's care plan focus revised 2/27/24, showed Resident 5 was incontinent of bowel. The interventions included to check Resident 5 at least every two hours and assist with toileting as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's care plan focus revised 3/19/24, showed Resident 5 was at risk for falls related to gait/balance problems and impaired mobility. The interventions included to anticipate and meet Resident 5's needs. The care plan showed Resident 5 had actual falls on 11/26/23, and 12/19/23. Review of Resident 5 care plan focus revised 7/17/24, showed Resident 5 sustained falls on 3/11 and 3/13/24. Review of Resident 5's Fall Risk dated 4/27/24, showed Resident 5 was at risk for falls. Resident 5's fall risks included a history of falls and being chair bound with assistance required for elimination. Review of Resident 5's Nurse's Progress Note dated 9/19/24 at 1527 hours, showed Resident 5 had an unwitnessed fall at 1430 hours. The staff was in Room A assisting another resident when the staff heard a loud sound coming from the restroom. When approaching the restroom, Resident 5 was seen lying on the restroom floor. Upon assessment, Resident 5 exhibited shoulder pain. Resident 5's physician was notified, and the physician ordered Resident 5 to be transferred to Acute Care Hospital 1. On 9/25/24 at 1114 hours, an interview was conducted with CNA 2. CNA 2 was asked to describe Resident 5's fall incident which occurred on 9/19/24. CNA 2 stated Resident 5 could make her needs known and would inform staff when she needed to use the bathroom. CNA 2 stated Resident 5 would use the bathroom two to three times during the eight-hours shifts. CNA 2 stated Resident 5 could not walk and utilized a wheelchair. CNA 2 stated Resident 5 could not stand by herself and had unsteady gait, which contributed to her risk for falls. CNA 2 stated Resident 5 required assistance when using the bathroom. CNA 2 stated Resident 5 needed assistance with transferring from her wheelchair to the toilet. CNA 2 stated at approximately 1340 hours, before the fall incident, CNA 2 saw Resident 5 sitting in her wheelchair in front of the nursing station, at which time Resident 5 told CNA 2 she needed to use the bathroom. CNA 2 stated she was not assigned to care for Resident 5 and was on her way to assist another resident. CNA 2 stated she then notified the CNA Team Lead (CNA 3) that Resident 5 needed to use the bathroom and asked CNA 3 to inform the CNA assigned to care for Resident 5 (CNA 4) to assist Resident 5 with using the bathroom. CNA 2 was asked if she followed up to ensure a CNA assisted Resident 5 with using the restroom. CNA 2 stated she did not follow up to ensure Resident 5 received assistance. CNA 2 stated at the time Resident 5 sustained her fall, she was assisting another resident in Room A. CNA 2 stated at approximately 1400 hours, she recalled hearing a scream for help. CNA 2 stated she then opened the Room A bathroom door and observed Resident 5 lying on the floor while complaining of the right shoulder pain. On 9/25/24 at 1430 hours, an interview was conducted with the CNA Team Lead (CNA 3). CNA 3 was asked to describe Resident 5's fall incident which occurred on 9/19/24. CNA 3 stated Resident 5 could make her needs known and would inform the staff when she needed to use the bathroom. CNA 3 stated Resident 5 would request to use the restroom three to four times per shift. CNA 3 stated Resident 5 required staff assistance when using the bathroom and transferring from her wheelchair to the toilet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Bonita Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 West LA Habra Boulevard LA Habra, CA 90631	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 3 was asked if CNA 2 had informed her on 9/19/24, that Resident 5 needed to use the bathroom before Resident 5 sustained a fall in the bathroom. CNA 3 stated yes, she was assisting CNA 2 reposition a resident in Room A, at which time CNA 2 informed her that Resident 5 needed to use the restroom. CNA 3 stated after assisting CNA 2 reposition the resident, she (CNA 3) utilized the facility wide audible staff paging system and requested CNA to Room B (Resident 5 lived in Room B). CNA 3 was asked if she followed-up after having utilized the paging system, to ensure a CNA assisted Resident 5 with using the restroom. CNA 3 stated she did not follow up, because the treatment nurse requested her assistance, and she then assisted the treatment nurse. On 9/25/24 at 1147 hours, an interview was conducted with CNA 4 (the CNA assigned to care for Resident 5 at the time of Resident 5's fall). CNA 4 was asked to describe Resident 5's fall incident which occurred on 9/19/24. CNA 4 stated at the time of Resident 5's fall on 9/19/24, she was assigned to care for Resident 5. CNA 4 stated Resident 5 could make her needs known. CNA 4 stated Resident 5 required assistance with using the bathroom, requiring staff assistance when transferring from her wheelchair to the toilet. CNA 4 stated Resident 5 could not be left unattended when needing to use the bathroom, as Resident 5 was a fall risk. CNA 4 stated she assisted Resident 5 use the toilet three times during her shift on 9/19/24. CNA 4 stated at approximately 1330 hours, before Resident 5 fell , she observed Resident 5 in the lobby watching television. CNA 4 was asked at any time from 1330 hours until the time Resident 5 fell , if she was informed Resident 5 needed assistance using the bathroom, to which CNA 4 replied, no. CNA 4 stated she first became aware Resident 5 had sustained a fall in the bathroom after a staff had notified her. On 9/25/24 at 1041 hours, an interview was conducted with LVN 4. LVN 4 was asked to describe Resident 5's fall incident which occurred on 9/19/24. LVN 4 stated she was assigned to care for Resident 5 on 9/19/24, at the time Resident 5 fell in the bathroom. LVN 4 stated on 9/19/24 at approximately 1430 hours, she arrived at the Room B resident bathroom. LVN 4 stated she observed Resident 5 lying on the ground in the Room B resident bathroom. LVN 4 stated Resident 5 complained of pain to her right shoulder. LVN 4 stated she contacted Resident 5's physician and obtained an order to transfer Resident 5 to Acute Care Hospital 1. LVN 4 stated Resident 5 told her that she attempted to transfer herself from her wheelchair to the toilet and fell . A concurrent review of the facility's investigative report and interview with the DON was conducted on 9/25/24 at 1126 hours. The investigative report showed the resident attempted to use the restroom on her own and lost balance. Review of Resident 5's Acute Care Hospital 1 Admission History and Physical dated 9/20/24, showed Resident 5 underwent a workup in the emergency department and was found to have a nondisplaced fracture in the right humerus. The facility staff failed to assist Resident 5 to the restroom when the resident requested. The resident attempted to transfer herself and fell to the floor resulting in a fracture to the right humerus.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Bonita Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1233 West LA Habra Boulevard LA Habra, CA 90631	

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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 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32179

Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for the indwelling urinary catheter care to restore as much normal bladder function as possible for one of five sampled residents (Resident 4).

* The catheter care was not provided in accordance with the facility's P&P for Resident 4. This failure posed the risk for the development of infection.

Findings:

Review of the facility's P&P titled Appropriate Use of Indwelling Catheters dated 12/19/22, showed each resident will be assessed at admission regarding continence status and whenever there is a change in urinary tract function (such as admitted continent of urine and subsequently becomes incontinent). Staff completing the assessment should consider the following:

- patterns of fluid intake, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output,

- documentation to support decision making will be included in the medical record, including but not limited to: assessment of psychosocial and functional factors affecting urinary continence status, services provided to restore normal bladder function to the extent possible.

The plan of care will address the use of an indwelling urinary catheter, including strategies to prevent complications.

Review of the facility's P&P titled Catheter Care dated 12/19/22, showed the catheter care will be performed every shift and as needed by nursing personnel.

Closed medical record review of Resident 4 was initiated on 9/18/24. Resident 4 was admitted to the facility on [DATE].

Review of the Skilled Evaluation dated 9/9 and 9/10/24, showed under the genitourinary section, the bladder (urine) catheter, size, complaints, care provided for perianal, and catheter was blank.

Review of the Skilled Evaluation dated 9/14/24, showed under the genitourinary section, care provided for peri and catheter was blank.

Review of the TAR for 9/2024 showed the following entries:

- lidocaine hydrochloride external gel 3 % apply to penile base topically every day shift for prior to wound care.

- mupirocin external ointment 2 % apply to penile area topically every day shift for open wound for 21 days.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055622	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonita Hills Post Acute	1233 West LA Habra Boulevard LA Habra, CA 90631

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, the further review of the TAR failed to show documented evidence the indwelling urinary catheter care was performed every shift. On 9/23/24 at 1715 hours, an interview and concurrent closed medical review was conducted with LVN 3. LVN 3 stated she had performed the urinary catheter care when she administered the medication treatment, but she did not document it. LVN 3 stated the indwelling urinary catheter care should be given every shift but there was no documentation. LVN 3 further stated the nurse should clarify the order for indwelling urinary catheter care every shift with the resident's physician. LVN 3 was asked about the care plan to address the use of the indwelling urinary catheter. LVN 3 was unable to provide the documentation for the indwelling urinary catheter care and care plan. LVN 3 was asked about the assessment of the indwelling urinary catheter care on 9/9 and 9/10/24. LVN 3 stated the nurse should complete the assessment for the indwelling urinary catheter. LVN 3 verified the findings. On 9/24/24 at 1620 hours, an interview and concurrent closed medical record review was conducted with the Infection Preventionist. The Infection Preventionist was asked to show the care plan to address the use of the resident's indwelling urinary catheter and care. The Infection Preventionist was unable to provide the documentation. The Infection Preventionist verified the above finding.