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

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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	10/10/2024

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 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** 49258 Based on interview and medical record review, the facility failed to ensure the ST had evaluated the resident with an order for thicken liquid as per the facility's P&P for one of five sampled residents (Resident 2). This failure had the potential for not providing necessary care and services to the resident. Findings: Review of the facility's P&P titled Thickened Liquids date implemented 12/2022, showed the thickened liquids are provided when ordered by a physician/practitioner or when ordered by a dietitian or speech-language pathologist who has been delegated to write diet orders, to the extent allowed by state law. The use of thickened liquids will be based on the resident's individual needs as determined by the resident's assessment and will be in accordance with the resident's goals and preferences. The reason for thickened liquids is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. Residents with swallowing difficulties or orders for thickened liquids are to be referred to speech-language pathologist for screening and evaluated as indicated. The need for thickened liquids may be re-evaluated periodically, by the speech therapist. Thickened liquids - individual diet orders may include a specific level for liquid consistency to be served, including water. The three liquid consistencies are nectar, honey, and pudding. Medical record review for Resident 2 was initiated on 10/9/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/17/24, showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's Order Summary Report for October 2024 showed the following orders: - an order dated 5/17/24, for regular diet- regular texture, nectar consistency for nutrition - an order dated 5/17/24, for aspiration precautions (strict supervision), bite size/sit up for meals. Review of Resident 2's plans of care failed to show a care plan was developed for nectar thick consistency of beverages. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 2's medical record failed to show the resident was evaluated or seen by the ST as per the facility's P&P. On 10/9/24 at 1444 hours, an interview was conducted with the RD. The RD stated she did not perform any functional ability evaluation for resident. The RD stated once it was recommended for the resident to receive modified liquid such as nectar, the ST would follow up for evaluation of the resident. The RD further stated the ST did the evaluation for liquid consistency and food texture especially when it was to be upgraded. On 10/10/24 at 1510 hours, a follow-up interview was conducted with the RD. The RD stated if the resident would have a special need for modified liquid, a plan of care should be initiated, and she would also inform the care plan team. On 10/10/24 at 1530 hours, a concurrent interview and medical record review was conducted with RNs 1 and 2. RNs 1 and 2 stated if the resident had needs for modified liquids, it should have been addressed in the plan of care. RNs 1 and 2 stated Resident 2 was on nectar thickened liquids. RNs 1 and 2 verified the need for modified thickened liquids was not addressed in the resident's plan of care. On 10/10/24 at 1614 hours, a concurrent interview and medical record review was conducted with the ST. The ST stated she assessed the resident's swallowing function and part of her assessment to evaluate the type of liquid consistency the resident could have. The ST verified Resident 2 was not evaluated by the ST.

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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 49258

Based on interview, medical record review, and facility P&P review, the facility failed to ensure five of five sampled residents (Residents 1, 2, 3, 4, and 5) remained free from the accident hazards.

* The facility failed to assess the residents' ability to handle the containers and consume the hot beverages as per the facility's P&P for Residents 1, 2, 3, 4, and 5. Resident 1 spilled a cup of hot chocolate on her chest, causing redness and blisters to Resident 1's right side of chest. Resident 2 also spilled coffee on his lap. These failures posed the risk of injury to the residents who were consuming hot liquids in the facility.

Findings:

Review of the facility's P&P titled Hot Liquid Safety (undated) showed all residents are assessed for their ability to handle the containers and consume hot liquids. Residents with difficulties will receive the appropriate supervision and use of the assistive devices to drink hot liquids. Interventions will be individualized and noted on the resident's plan of care. Interventions include, but are not limited to:

a. Wide based cups;

b. Cups with lids and handles;

c. Aprons; and

d. Disallow hot liquids while lying in bed.

General safety precautions when serving hot liquids include, but are not limited to:

a. Make sure resident is alert and in proper positioning to consume hot liquids;

b. Use cups, mugs, or other containers that are appropriate for hot beverages;

c. Do not overfill containers;

d. Regulate temperature of hot liquids to which residents have direct access;

e. Place filled containers directly on table. Do not hand them directly to residents;

f. Keep hot liquids away from the edges of the table; and

g. Do not refill containers while the resident is holding the container.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 1. Review of the facility's Letter to CDPH, L&C dated 9/25/24, showed an incident when Resident 1 spilled the hot chocolate on her chest. The letter showed Resident 1 appeared visibly distressed, crying, and noted with redness with blistering on her right side of the chest. The letter further showed Resident 1 was transferred to the acute hospital where she was diagnosed with second degree burn. Medical record review for Resident 1 was initiated on 10/3/24. Resident 1 was readmitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's H&P examination dated 4/23/24, showed Resident 1 could make needs known by nodding yes/no but could not make medical decisions. Review of Resident 1's MDS dated [DATE], showed Resident 1 was never or rarely understood. The section for Cognitive Patterns showed Resident 1 had a long and short term memory problems and severely impaired cognition skills for daily decision making. The section for Functional Abilities and Goals showed Resident 1 needed partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for eating. Review of Resident 1's Care Plan revised 10/26/22, showed a care plan addressing Resident 1's impaired cognitive ability/impaired thought processes related to impaired decision making, long term memory loss, and short-term memory loss. The interventions included cue, reorienting, and supervision as needed. Review of Resident 1's Care Plan revised on 4/18/24, showed a care plan problem addressing Resident 1's ADL self-care performance deficits related to activity intolerance, disease process, hemiplegia, and limited mobility. The interventions for eating included Resident 1 was limited assist with one staff. Review of Resident 1's Nurse's Progress Note dated 9/25/24 at 0845 hours, showed Resident 1 burned herself by spilling hot chocolate this morning at 0740 hours, Further review of Resident 1's medical record failed to show documented evidence the assessment was completed for Resident 1's ability to handle containers and consume hot liquids. On 10/4/24 at 1041 hours, an interview was conducted with RN 1. RN 1 was asked to describe Resident 1's burn incident on 9/25/24. RN 1 stated he was in the room with the other resident when the incident happened, then he heard Resident 1 cried and CNA 5 told him that the resident spilled the hot chocolate. When asked where the cup was, RN 1 stated he could not remember. RN 1 stated Resident 1 was crying and RN 1 saw redness on the chest and more on the right side and right arm. RN 1 stated this was the first time he heard that Resident 1 was getting hot chocolate. RN 1 further stated it could have been prevented if CNA 5 had asked him or the LVN if Resident 1 could have hot liquids. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 at 1334 hours, a telephone interview was conducted with CNA 5. CNA 5 stated she was mostly assigned to Resident 1. CNA 5 was asked to describe Resident 1's burn incident on 9/25/24. CNA 5 stated she offered Resident 1 a chocolate or coffee. Resident 1 nodded her head to indicate yes to the hot chocolate. CNA 5 went in and left the Resident 1 the breakfast tray on the over bed table and the resident went to grab the hot cholate over her bed. CNA 5 stated she told Resident 1, Be careful, it's hot. CNA 5 stated Resident 1 was sitting on the bed and was ready to eat her breakfast. CNA 5 stated she left the room and after almost 10 minutes, she went back to check Resident 1 and she found the Resident 1 spilled the hot chocolate all over her chest. CNA 5 stated she used to give the resident a hot chocolate before, and the resident was able to handle it. CNA 5 stated Resident 1 was a picky eater, and she knew the Resident 1 liked the hot chocolate, so she gave it to the Resident 1 every time she worked. CNA 5 stated Resident 1 was sitting upright, and the resident was able to move her bed up and down. When asked if she would give hot beverage to the residents with severe impaired cognition, CNA 5 stated no. On 10/4/24 at 1351 hours, an interview and concurrent medical record review was conducted with the Rehab Director. The Rehab Director stated she normally did not assess the residents for their ability to handle containers with hot liquids, and if the nursing had a concern regarding that then they could always reach out. The Rehab Director further stated she did not assess Resident 1 specific to her ability to handle containers and hot liquids. On 10/4/24 at 1407 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 stated the facility did the assessment for handling hot liquids. RN 2 was asked if she could show the documentation of Resident 1's assessment for the ability to handle hot liquids. RN 2 reviewed the medical record and stated she was not able to find if Resident 1 was assessed for her ability to handle containers with hot liquids. 2. Medical record review for Resident 2 was initiated on 10/9/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/17/24, showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's MDS dated [DATE], showed Resident 2 had a BIMS score of 00 (severe cognitive impairment). Further review of the MDS showed Resident 2 needed supervision or touching assistance (Helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity and assistance may be provided throughout the activity or intermittently) for eating. Review of Resident 1's Care Pan revised on 8/29/24, showed a care plan problem addressing Resident 2's impaired cognitive function and impaired thought processes related to diagnosis of encephalopathy. The interventions included cue, reorienting, and supervision as needed. Further of Resident 2's medical record failed to show documented evidence the assessment was done for Resident 2's ability to handle containers and consume hot liquids. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1256 hours, an interview was conducted with CNA 8. CNA 8 verified Resident 1 spilled his coffee to himself. CNA 8 stated Resident 1 was able to wheel himself around the facility. CNA 8 stated if Resident 1 was in the wheelchair, she would not give the Resident 1 a cup of hot coffee because the resident was not stable. CNA 8 further stated she was not the only one who was giving coffee to Resident 1. On 10/9/24 at 1310 hours, an interview was conducted with LVN 4. LVN 4 stated she was familiar with Resident 2. LVN 4 stated Resident 2 liked hot coffee and the resident had a descent control of drinking liquids. LVN 4 stated the nurses would just do a straightforward assessment for eating and drinking but not the ability to handle or consume hot beverage. LVN 4 stated she had never given Resident 1 coffee while he was in wheelchair because it was not safe. On 10/9/24 at 1337 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 stated Resident 2 was not assessed for the ability to handle container and consume hot liquids because they did not perform the specific assessment. 3. Medical records reviews for Residents 3, 4, and 5 was initiated on 10/8/24. The medical records showed the following: a. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 1/11/24, showed Resident 3 had the capacity to understand and make decisions. Further review of Resident 3's medical record showed no documented evidence Resident 3 was assessed for the ability to handle containers and consume hot liquid. b. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 5/1/24, showed Resident 4 had the capacity to understand and make decisions. Further review of Resident 4's medical record showed no documented evidence Resident 4 was assessed for the ability to handle containers and consume hot liquid. c. Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE]. Review Resident 5's H&P examination dated 4/21/24, showed Resident 5 had the capacity to understand and make decisions. Further review of Resident 5's medical record showed no documented evidence Resident 5 was assessed for the ability to handle containers and consume hot liquid. On 10/10/24 at 1250 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified there was no assessment performed for the ability to handle containers and consume hot liquids for Residents 3, 4, and 5 as per the facility's P&P. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1641 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed of the above findings. The DON stated the facility had not done a specific assessment to assess the ability of the resident to consume hot beverage.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49258

Based on interview, medical record review, and facility P&P review, the facility to ensure the food was prepared in a form to meet the resident's needs for one of five sampled residents (Resident 2).

* Resident 2 did not receive thickened liquids as ordered.

* The facility staff who were serving the hot beverage lacked knowledge in preparing a thickened liquid.

These failures placed Resident 2 at risk for aspiration (when food or liquids are breathed into the lungs).

Findings:

Review of the facility's P&P titled Serving a Meal revised 12/2022 showed diets should be served in accordance with the physician's order. The P&P showed to use thickened liquids as provided by the dietary department.

a. On 10/3/24 at 1140 hours, a concurrent observation and interview was conducted with Resident 2. Resident 2 was observed in his room sitting in a wheelchair and using his right leg to move the wheelchair. A maroon-colored cup was observed with regular consistency light brown colored liquid at the resident's overbed table. Resident 2 stated it was his coffee with creamer. Resident 2 stated he drank it and every day, the staff brought it to him.

On 10/3/24 at 1400 hours, an interview was conducted with CNA 8. CNA 8 stated she was familiar with Resident 2. CNA 8 stated the resident drank coffee every day and for her shift, he drank coffee during breakfast and lunch.

On 10/9/24 at 1240 hours, a follow-up concurrent observation and interview was conducted with Resident 2. Resident 2 was observed in the hallway holding a maroon-colored cup with his right hand slightly slanted towards himself. The cup was filled with black coffee with thin consistency.

Medical record review for Resident 2 was initiated on 10/9/24. Resident 2 was admitted to the facility on [DATE].

Review of Resident 2's H&P dated 5/17/24, showed Resident 2 did not have the capacity to understand and make decisions.

Review of Resident 2's Order Summary Report for October 2024, showed the following orders:

- an order dated 5/17/24, for regular diet- regular texture, nectar consistency for nutrition

- an order dated 5/17/24, for aspiration precautions (strict supervision), bite size/sit up for meals.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1330 hours, an interview was conducted with CNA 8. CNA 8 stated Resident 2 needed thickened liquid and further verified Resident 2's coffee was not nectar-thick consistency. On 10/9/24 at 1422 hours, a concurrent observation and interview was conducted with the Assistant Dietary Manager. The Assistant Dietary Manager was requested to make a nectar consistent coffee with creamer. The Assistant Dietary Manager made a half-filled cup of coffee in nectar consistency. The Assistant Dietary Manager stated when the meal ticket was printed, it would indicate what type of beverage for the resident. The Assistant Dietary Manager verified Resident 2's liquid consistency showed nectar thick. The Assistant Dietary Manager stated the thickener used for hot beverage was usually placed in the hot beverage carts delivered to the stations. The Assistant Dietary Manager further stated the CNAs and nurses were the ones who would prepare the hot beverage thickened when they served it to the resident who required thickened liquids. b. Review of the manufacturer's instructions located on the side of the Simply Thick thickener's plastic container, showed to dispense the appropriate amount of gel into the beverage and stir briskly for 30 seconds: - Slightly thick, 1 stroke for 180 ml; - Mildly thick, Nectar thick, 1 stroke for 120 ml; 2 strokes for 240 ml; - Moderately thick, Honey thick, 2 strokes for 120 ml; 4 strokes for 240 ml; and - Extremely thick, Pudding thick, 4 strokes for 120 ml; 8 strokes for 240 ml. Review of the manufacturer's instruction from the Sysco website of the Sysco Imperial Instant Food Thickener, showed the manufacturer's instruction indicated recommended usage for four fluid ounces (120 ml) serving of hot coffee or tea: - Mildly thick-nectar consistency, 1-1/2 tablespoon; - Moderately thick-honey consistency, 1 tablespoon + 2 teaspoons; and - Extremely Thick, 2 tablespoons On 10/9/26 at 1330 hours, an interview was conducted with CNA 8. CNA 8 stated Resident 2 was on thickened liquids. CNA 8 stated they prepared beverages with the thickener provided on the beverage cart for the residents who needed thickened liquids. CNA 8 stated they used the gel thickener. CNA 8 stated Resident 2 had nectar thickened liquids and she would add one pump of the thickener with his hot coffee. On 10/9/24 at 1406 hours, an interview was conducted with CNA 9. CNA 9 stated he was familiar with Resident 2. CNA 9 stated Resident 2 liked to drink coffee. CNA 9 stated he believed Resident 2 could have either nectar or honey thickened. CNA 9 stated they used either the powder or liquid as thickener and he was not sure how much to add. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1607 hours, an interview was conducted with CNA 10. CNA 10 stated when the resident needed a thickener for the coffee, she would go to the kitchen to get the powder. CNA 10 stated she did not know how much thickener to use when it needed to be nectar or honey thickened. CNA 10 further stated she would ask the charge nurse if the resident needed a thickened coffee. On 10/9/24 at 1700 hours, an interview was conducted with CNA 11. CNA 11 stated when he needed a thickener to add to his resident's coffee, he would get it from the kitchen. CNA 11 stated he was not sure how much thickener to add but the pump one had an instruction. On 10/9/24 at 1115 hours, an interview was conducted with CNA 12. CNA 12 stated the thickener powder was included in the hot beverage cart and if it did not have, he would get it from the kitchen. CNA 12 stated he would pour 75% of hot liquid in the cup by estimating it and not filled the cup then he would add the powder thickener using the white disposable spoon. CNA 12 further stated he did not fill the spoon totally and the powder was leveled flat in the spoon when asked how he prepared a nectar and honey thickened hot beverage. CNA 12 stated he did not get an in-service how to prepare a nectar, honey or pudding thickened hot beverage. On 10/9/24 at 1200 hours, an interview was conducted with CNA 13. CNA 13 stated the thickener used to mix with the hot beverage was usually in the hot beverage cart and if there was none, they would get it from the kitchen. CNA 13 stated for the nectar or honey thickened hot beverage, she would first fill the cup up to 50-60% of the liquid, then add one teaspoon of the powder. CNA 13 stated the powder was in a canned canister and the instruction was on the can. CNA 13 stated if she used the liquid thickener, she would add two pumps for the beverage to be nectar thickened. CNA 13 further stated there was an instruction in the bottle of the liquid thickener. CNA 13 stated she had received an in-service training last week regarding how to mix the thickener in the hot beverage. On 10/10/24 at 1250 hours, an interview was conducted with RN 2. RN 2 stated the thickener used for the hot beverage was usually in the beverage cart and if it was not available, they could get it in the kitchen. RN 2 stated they had the powder thickener which came in a can and it had a scoop. RN 12 stated she did not know exactly how much thickener to add to the hot beverage to be nectar, honey, or pureed thickened. RN 2 stated the residents might aspirate if the liquid was not thickened enough to meet the need of the residents. RN 2 stated she had not received an in-service training regarding proper preparation of beverage for it to be nectar, honey, or pudding thickened. On 10/10/24 at 1510 hours, an interview was conducted with the RD and Dietary Manager. The Dietary Manager stated as of today, they had six residents on modified liquid. The Dietary Manager stated the cup they used for the hot beverage could hold a 240 ml of liquid. The Dietary Manager brought in the gel thickener but stated he ran out of the powder thickener, and they threw the can away already. The Dietary Manager showed the powder thickener they used on his cellphone. The Dietary Manager further stated the CNAs, nurses, and kitchen staff could refer to the instructions on the container and can for the correct measurement of thickener to be added for a nectar, honey or pudding consistency. The RD stated if the liquid was not in the right consistency, there would be a concern regarding the resident aspirating. The RD stated she conducted in-service trainings mainly for the kitchen department and believed the DSD was the one providing it for the nursing staff. The RD further stated the nursing staff could always reach out to her or the kitchen department if they needed assistance with preparing the beverage for the residents on modified liquid. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1641 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated the CNAs could check with the nurses or kitchen what type of liquid consistency that the resident could have if they were not sure. The DON stated the residents' rooms also had a blue dot beside the name of the resident indicating the resident was on thickened liquids. The DON stated the type of liquid each resident had was also indicated in the meal ticket. The DON verified Resident 2's plan of care did not show the need and indication for thickened liquids was initiated. The DON stated the CNAs and nurses received an in-service training for how to prepare and mix the correct amount of thickener used by the facility to the hot beverage being served to the residents. The DON stated the DSD had the in-service training when requested for it and she did not have access to the DSD's file. The DON was informed a request had been made for the two most recent in-service training related to the topic. The DON was informed of the findings. On 10/11/24 at 1448 hours, an in-service training titled Diet and Fluid Changes/Updates dated 9/25/24 at 1330 to 1630 hours, was received from the facility via email. Reviewed of the in-service training's lesson plan and clinical reference provided did not show the staff was educated regarding the proper or correct way of mixing the correct amount of the two types of thickener used for the beverage to become nectar, honey, or pudding thickened. The DSD was informed of the findings via email.