

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 01/17/2025
NAME OF PROVIDER OR SUPPLIER Bonita Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on interview, medical record review, facility document, and facility P&P review, the facility failed to ensure Resident 1 was provided a bed hold for up to seven days when Resident 1 returned to a different room and bed upon readmission to the facility on [DATE]. In addition, the facility failed to provide Resident 1 and/or the resident's representative a written bed hold policy upon transfer to an acute care hospital. These failures had the potential for Resident 1 and/or the resident's representative to be not informed of their rights to return to the facility following hospitalization .</p> <p>Findings:</p> <p>Medical record review for Resident 1 was initiated on 1/17/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 1's MDS dated [DATE], showed Resident 1 had a BIMS score of two, indicating severe cognitive impairment.</p> <p>Review of Resident 1's eInteract Transfer Form dated 1/1/25, showed Resident 1 was transferred to the acute care hospital on 12/30/24.</p> <p>1. Review of the facility's document titled Bed-Hold Notice (form provided to the residents/representative) showed current regulations require that each long-term facility provide a bed-hold for up to seven days when a resident is transferred for hospitalization .</p> <p>Review of Resident 1's Order Summary Report showed a physician's order dated 1/2/25, to admit Resident 1 to the facility.</p> <p>Review of the facility's Daily Census Roster dated 12/30/24, showed Resident 1 had a bed hold for Room A.</p> <p>Review of the facility's Daily Census Roster dated 1/2/25, showed Resident 1 was in Room B (three bedroom).</p> <p>(continued on next page)</p>

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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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/17/25 at 1528 hours, an interview and concurrent medical review was conducted with the DON and RN Consultant. When the DON and RN Consultant were asked about the facility's bed capacity, the RN Consultant stated the facility's bed capacity was 86. The DON and RN Consultant were asked why Resident 1 was not readmitted to the same bed in Room A when the facility had six beds (equivalent to two or three rooms) available. The DON and RN were not able to provide an answer.</p> <p>2. Review of the facility's P&P titled Bed Hold Prior to Transfer revised 12/19/22, showed it is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave. The facility will have a process in place to ensure the residents and/or their representatives are made aware of the facility's bed-hold and reserve bed payment policy well in advance of being transferred to the hospital.</p> <p>Review of the facility's P&P titled Bed Hold Notice Upon Transfer revised 12/19/22, showed at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident.</p> <p>Review of Resident 1's Notice of Transfer/discharge date d 12/30/24, showed Resident 1 was transferred to the acute care hospital because the transfer/discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility.</p> <p>Further review of Resident 1's medical record failed to show Resident 1 and/or the resident's representative were informed of the facility's bed hold policy before transferring to the acute care hospital on 12/30/24.</p> <p>On 1/17/25 at 1528 hours, an interview and concurrent medical record review was conducted with the DON and RN Consultant. The DON and RN Consultant verified there was no bed hold information was provided to Resident 1 and/or the resident's representative prior to Resident 1 transferring to the acute care hospital on 12/30/24.</p> <p>On 1/17/25 at 1640 hours, the Administrator was informed and acknowledged the above findings.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of disease and infections.</p> <p>* Resident 2 who had salmonella was cohorted with Resident 1 who did not have salmonella.</p> <p>* RN 1 failed to perform hand hygiene and don the gloves and gown on while providing care for Resident 2 who was on contact isolation precautions.</p> <p>* The facility failed to ensure a visitor donned the gloves and gown on while sitting on Resident 2's bed.</p> <p>* The facility failed to ensure Caregiver 1 donned a gown on while feeding Resident 1 who was inside an isolation room for a contact precaution.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Transmission-Based (Isolation) Precautions revised 7/18/23, showed it is the policy to take appropriate precautions to prevent transmission of pathogens, based on pathogens' modes of transmission. Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Transmission-based precautions (Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections. When implementing transmission-based precaution, the facility will consider the following: cohorting residents with the same pathogen; and sharing a room with a roommate with limited risk factors (example, without indwelling or invasive devices, without open wounds, and not immunocompromised) as appropriate based on the pathogen and method of transmission.</p> <p>a. Medical record review for Resident 1 was initiated on 1/17/25. Resident was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 1's MDS dated [DATE], showed Resident 1 had a BIMS score of two, indicating severe cognitive impairment.</p> <p>Review of Resident 1's MAR for January 2025 showed Resident 1's medications were administered via G tube.</p> <p>Review of Resident 1's TAR for January 2025 showed wound treatments were provided to Resident 1's abdominal area for the stoma/G tube, coccygeal, right forehead, and scrotal skin tear.</p> <p>Further review of Resident 1's medical record failed to show Resident 1 required a contact isolation precautions and/or had salmonella infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Medical record review for Resident 2 was initiated on 1/17/25. Resident was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's MDS dated [DATE], showed Resident 2 had a BIMS score of three, indicating severe cognitive impairment.</p> <p>Review of Resident 2's Order Summary Report showed a physician's order dated 1/8/25, for contact isolation related to salmonella.</p> <p>On 1/17/25 at 1238 hours, an interview was conducted with LVN 1. LVN 1 stated Residents 1 and 2 were both totally dependent on the staff for their care and both residents had G tubes. LVN 1 verified Resident 2 was on contact isolation precaution and stated Resident 1 should not be cohorted with Resident 2 because of the high risk for contamination for Resident 1.</p> <p>On 1/17/25 at 1330 hours, an interview and concurrent medical review was conducted with RN 1. RN 1 verified Resident 1 should not be cohorted with Resident 2 because Resident 1 was not infected with salmonella. RN 1 stated both Residents 1 and 2 shared the same bathroom with only one sink to use so there was a high risk for contamination for Resident 1.</p> <p>On 1/17/25 at 1528 hours, an interview and concurrent medical review was conducted with the DON and RN Consultant. The DON verified Resident 1 should not be cohorted with Resident 2 because of the high risk for contamination for Resident 1.</p> <p>2. Review of the facility's P&P titled Standard Precautions Infection Control revised 12/19/22, showed all the staff members are to assume that all the residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all the staff members shall adhere to Standard Precautions to prevent the spread of infection to residents, staff and visitors. Under the Policy Explanation and Compliance Guidelines section, showed the following: 1. Hand hygiene: (a) during the delivery of resident care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. (b) Perform hand hygiene. 2. Using personal protective equipment (PPE): all staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely.</p> <p>On 1/17/25 at 1220 hours, an observation was conducted on Room C. At the entrance of the room, a contact precaution sign was posted. The sign showed the following:</p> <ul style="list-style-type: none"> -Everyone must clean their hands, including before entering and when leaving the room. -Providers and staff must also put on gloves before room entry. -Discard gloves before room exit. -Put on gown before room entry. -Discard gown before room exit. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. On 1/17/25 at 1223 hours, an observation and concurrent interview was conducted with RN 1. RN 1 was observed not performing hand hygiene before entering and leaving Room C. Furthermore, RN 1 was observed without gloves and gown while touching the enteral pump button of Resident 2 inside Room C. RN 1 verified the above findings and stated it was important to perform hand hygiene and don the proper PPE when going into a contact precaution room for infection control.</p> <p>b. On 1/17/25, at 1520 hours, an observation was conducted on Room C. Resident 2's visitor was observed sitting on the resident's bed without gloves and gown. LVN 1 verified the above findings.</p> <p>c. On 1/17/25 at 1230 hours, an observation and concurrent interview was conducted with Caregiver 1 inside Room C. Caregiver 1 was observed wearing a mask and gloves while feeding Resident 1. When asked, Caregiver 1 stated she did not know a gown should be worn while inside a contact precaution room. Caregiver 1 further stated the facility did not provide her training or education regarding contact precaution.</p> <p>On 1/17/25 at 1640 hours, the Administrator, DON, and RN Consultant were informed and acknowledged the above findings.</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of disease and infections.</p> <p>* Resident 2 who had salmonella was cohorted with Resident 1 who did not have salmonella.</p> <p>* RN 1 failed to perform hand hygiene and don the gloves and gown on while providing care for Resident 2 who was on contact isolation precautions.</p> <p>* The facility failed to ensure a visitor donned the gloves and gown on while sitting on Resident 2's bed.</p> <p>* The facility failed to ensure Caregiver 1 donned a gown on while feeding Resident 1 who was inside an isolation room for a contact precaution.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Transmission-Based (Isolation) Precautions revised 7/18/23, showed it is the policy to take appropriate precautions to prevent transmission of pathogens, based on pathogens' modes of transmission. Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Transmission-based precautions (Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections. When implementing transmission-based precaution, the facility will consider the following: cohorting residents with the same pathogen; and sharing a room with a roommate with limited risk factors (example, without indwelling or invasive devices, without open wounds, and not immunocompromised) as appropriate based on the pathogen and method of transmission.</p> <p>(continued on next page)</p>		

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