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	01/28/2026

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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the discharge process was followed for one of five sampled residents (Resident 1). * The discharge section of the Resident's Clothing and Possessions form for Resident 1 was not completed. This failure had the potential to affect the ability of the resident or resident's responsible party to be informed of their belongings.Findings: Review of the facility's P&P titled Resident Personal Belongings revised 12/19/22, showed it is the policy of this facility to protect the resident's right to possess personal belongings such as clothing and furnishings for their use while in the facility and assure the personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative in the event of the resident's death or discharge from the facility. Review of the facility's P&P titled Documentation in Medical Record revised 12/19/22, showed each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. The Policy Explanation and Compliance Guidelines showed the licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Closed medical record review for Resident 1 was initiated on 1/23/26. Resident 1 was admitted to the facility on [DATE], and discharged on 1/5/26. Review of Resident 1's Resident's Clothing and Possessions form dated 12/12/25, showed two sections on the form. The bottom section showed On Admission with various types of items the resident brought with them on admission. The top section of the form showed On Discharge. The On Discharge section showed a slash across the form with the words discharge AMA. Review of Resident 1's MDS assessment dated [DATE], showed the resident was cognitively intact. On 1/28/26 at 1047 hours, an interview and concurrent closed medical document review for Resident 1 was conducted with CNA 5. CNA 5 verified Resident 1's Resident's Clothing and Possessions form showed the On Discharge section of the form was incomplete. CNA 5 stated Resident 1's belongings should have been counted and sorted by the licensed nurse or a CNA and placed in the bag with Resident 1's name. CNA 5 stated the licensed nurse or CNA should have given the resident's belongings to the social services. On 1/28/26 at 1318 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with RN 2. RN 2 verified Resident 1's Resident's Clothing and Possessions form was incomplete. RN 2 stated the licensed nurse or the CNA team lead should have filled the form to make sure there were no items missing. On 1/28/26 at 1545 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON acknowledged the above findings. The DON stated Resident 1's Resident's Clothing and Possessions form should have been filled out when the staff packed everything. The DON stated whoever packed the belongings should have specified the items on the form so the facility would have an accurate account of Resident 1's belongings.

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 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the services to attain or maintain the highest practicable well-being for one of five sampled residents (Resident 1). * The facility failed to ensure Resident 1 had a physician's order for podiatry appointment on 1/5/26. This failure had the potential for the resident to not receive the necessary care and services to maintain their highest physical well-being and potentially delay the necessary care and treatment.Findings: Review of the facility's P&P titled Transportation revised 1/23/24, showed the facility shall help arrange transportation for residents as needed. The Policy Explanation and Compliance Guidelines section showed the social services will help the resident as needed to obtain transportation. Review of the facility's P&P titled Documentation in Medical Record revised 12/19/22, showed each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. The Policy Explanation and Compliance Guidelines showed the licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Closed medical record review for Resident 1 was initiated on 1/23/26. Resident 1 was admitted to the facility on [DATE], and discharged on 1/5/26. Review of Resident 1's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 1's Progress Note dated 1/5/26, showed the resident walked out of the facility to the bus stop. Resident 1 stated she had an appointment and was leaving the facility. The bus picked up the resident from the facility, the physician was made aware. Review of Resident 1's Order Summary Report dated 1/23/26, failed to show a physician's order was obtained for a podiatry appointment on 1/5/26. On 1/28/26 at 1318 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with RN 2. RN 2 stated the licensed nurse would put the order for an appointment on behalf of the physician and find out if the resident needed transportation and a companion. RN 2 verified there was no physician's order for Resident 1's podiatry appointment on 1/5/26. RN 2 stated there should be an order for the resident's appointment for all the department personnel to be aware to see and coordinate, and for the resident not to miss the appointment. On 1/28/26 at 1522 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the Social Services Assistant. The Social Service Assistant stated Resident 1 scheduled her podiatry appointment on 1/5/26 at 1500 hours. The Social Services Assistant verified Resident 1 would need a physician's order to go to the appointment. On 1/28/26 at 1545 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON verified there was no physician's order for Resident 1's appointment for podiatry on 1/5/26, and acknowledged the Social Services Assistant knew Resident 1 had an appointment. The DON stated there should have been an order for Resident 1's podiatry appointment so everybody would know the appointment. On 1/28/26 at 1629 hours, a telephone interview was conducted with RN 1. RN 1 further stated she could not recall if the Social Services Assistant told her about Resident 1's podiatry appointment on 1/5/26. RN 1 further stated if there was an appointment for any resident, she usually put the physician's order in the electronic medical record, printed it, and gave it to the social services. RN 1 stated the physician would usually write the appointment in the physician's order. On 1/28/26 at 1659 hours, the DON was informed and acknowledged the above findings.