| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055622 | A. Building<br>B. Wing | 07/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bonita Hills Post Acute | 1233 West LA Habra Boulevard<br>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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if it was safe for two of 18 final sampled residents (Residents 59 and 72) and one nonsampled resident (Resident 9) to self-administer the medications.<br><br>* Resident 59 was observed with a bottle of Lung Cleansing Spray Fast Absorption Active Antibacterial Action (used to thin out mucus in the airways) at bedside. Resident 59 did not have the assessment, physician's order, and care plan addressing the resident's self administration of medications.<br><br>* Resident 72 was observed with two packets of hydrocortisone acetate (used to treat skin swelling, itching and redness) 1% cream and a tube of Pain-A-[NAME] (used to treat muscle pain) pain relieving cream at bedside. Resident 72 did not have the assessment, physician's orders, and care plan addressing the resident's self administration of medications.<br><br>* Resident 9 was observed with the medication at bedside. Resident 9 did not have the physician's order, assessment, and care plan for the self-administration of medication.<br><br>These failures had the potential for the residents to administer the medications inaccurately.<br><br>Findings:<br><br>Review of the facility's P&P titled Resident Self Administration of Medication revised 12/19/22, showed a resident may only self -administer medications after the facility's interdisciplinary team has determined which medications may be self administered safely.<br><br>1. Resident's preference so self- administer medications will be documented on the appropriate form and placed in the medical record.<br><br>2. When determining if self administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:<br><br>a. The medications appropriate and safe for self administration.<br><br>b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections.<br><br>(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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for.<br><br>d. The resident's capability to follow directions and tell time to know when medications need to be taken.<br><br>e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing and signs of side effects and when to report to facility staff.<br><br>f. The resident's ability to understand what refusal of medication is and appropriate steps taken by staff to educate when this occurs.<br><br>g. The resident's ability to ensure that medication is stored safely and securely.<br><br>3. The results of the interdisciplinary team assessment are recorded on the electronic health record.<br><br>1. On 7/9/24 at 0852 hours, during the initial tour of the facility, Resident 59 was observed lying in bed, and a bottle of Lung Cleansing Spray Fast Absorption Active Antibacterial Action was observed on top of Resident 59's bedside table.<br><br>Medical record review for Resident 59 was initiated on 7/9/24. Resident 59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's MDS dated [DATE], showed Resident 59 was cognitively intact and had no impairment to her bilateral upper extremities.<br><br>Review of Resident 59's H&P examination dated 12/1/23, showed Resident 59 had the capacity to understand and make decisions.<br><br>Review of Resident 59's medical record failed to show the physician's orders for the above medication and to self-administer the medication, nor an assessment was completed for Resident 59 to safely self-administer medications.<br><br>Review of Resident 59's plan of care failed to show a care plan problem addressing Resident 59's self-administration of medications.<br><br>On 7/9/24 at 1150 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2 for Resident 59. LVN 2 verified the above finding. LVN 2 stated the medication should have a physician's order, not be left unattended, and stored in the medication cart. LVN 2 verified the bottle of the Lung Cleansing Spray Fast Absorption Active Antibacterial Action did not have a physician's order, and/or a physician's order for Resident 59 to self-administer the medication. LVN 2 also verified Resident 59 did not have an assessment and care plan for self-administration of medications. Resident 59 stated she bought the medication online and administered the medication by herself.<br><br>On 7/12/24 at 1450 hours, an interview was conducted with the IP. The IP stated Resident 59 should have an assessment, care plan, and physician's order for self-administration medications.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. On 7/9/24 at 0915 hours, during the initial tour of the facility, two packets of hydrocortisone acetate 1% cream and a tube of Pain-A-[NAME] pain relieving cream were observed on top of Resident 72's bedside table.<br><br>Medical Record Review for Resident 72 was initiated on 7/9/24. Resident 72 was admitted to the facility on [DATE].<br><br>Review of Resident 72's MDS dated [DATE], showed Resident 72 had moderate cognitive impairment and no impairment to her bilateral upper extremities.<br><br>Review of Resident 72's H&P examination dated 6/10/24, showed Resident 72 could make needs known but could not make medical decisions.<br><br>Review of the Resident 72's medical record failed to show the physician's orders for the above medications and to self-administer the medications, nor an assessment was completed for Resident 72 to safely self-administer medications.<br><br>Review of Resident 72's plan of care failed to show a care plan problem was developed to address Resident 72 self-administration of the medications.<br><br>On 7/9/24 at 0924 hours an observation, interview, and concurrent medical record review was conducted with LVN 1 for Resident 72. LVN 1 stated the medications needed a physician's order and should not be left unattended. LVN 1 verified there was no physician's order for self-administration of medications, assessment, and careplan for the self-administration of medications. Resident 72 stated the Pain-A-[NAME] medication was brought in by her family and she administered the above medications by herself.<br><br>On 7/12/24 at 1450 hours, an interview was conducted with the IP. The IP stated Resident 72 should have an assessment, care plan, and physician's order for self-administration medications.<br><br>50967<br><br>3. On 7/09/24 at 0937 hours, during an initial tour of the facility, Resident 9 was observed sitting up in the wheelchair, and a bottle of antifungal powder (used to treat skin itching, burning and irritations related fungal infections) medication was observed on the bedside table in Resident 9's room. There was no licensed staff inside the room. Resident 9 stated she bought the antifungal powder medication online and would apply it on the folds behind her legs.<br><br>On 7/09/24 at 1006 hours, an observation and concurrent interview was conducted with the IP. Resident 9 was observed with the antifungal powder on the bedside table in her room. The IP verified the above finding. The IP stated the medication was supposed to be stored in the treatment cart and should have a physician's order to self-administer the medication.<br><br>Medical record review for Resident 9 was initiated on 7/9/24. Resident 9 was admitted to the facility on [DATE].<br><br>Review of Resident 9's H&P examination dated 9/28/23, showed Resident 9 had the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 9's Order Summary Report did not show a physician's order for Resident 9's antifungal medication and/or to self-administer the medication.<br><br>Review of Resident 9's plan of care did not show a care plan problem to address Resident 9's self-administration of medications.<br><br>Further review of Resident 9's medical record failed to show an assessment was completed for Resident 9 to safely self-administer medications.<br><br>On 7/11/24 at 0844 hours, an interview and concurrent medical record review for Resident 9 was conducted with the Treatment Nurse. The Treatment Nurse verified the above findings. The Treatment Nurse verified Resident 9 did not have a physician's order, assessment, and care plan for the self-administration of medications.<br><br>On 7/11/24 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of three final sampled residents (Residents 62 and 476) reviewed for ADs were assisted in formulating the ADs. This failure had the potential for the facility to provide treatment and services against the resident's wishes.<br><br>Findings:<br><br>Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives revised on 12/2022 showed the facility is to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The P&P defines an AD as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (weather statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated. The P&P further showed on admission, the facility will determine if the resident has executed an AD, and if not, determine whether the resident, if cognitively able to, would like to formulate an AD. In the event the resident is unable to formulate an AD, the facility will provide information and education to the resident representative. The facility will provide the resident or resident representative information in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an AD. The P&P also showed upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.<br><br>1. Medical record review for Resident 62 was initiated on 7/9/24. Resident 62 was admitted to the facility on [DATE].<br><br>Review of Resident 62's H&P examination dated 6/10/24, showed Resident 62 had the capacity to understand and make decisions.<br><br>Review of the facility's document titled Social Service Assessment V3 dated 8/28/23, showed Resident 62 had an advance healthcare directive in place and a copy was requested.<br><br>Review of Resident 62's POLST dated 10/14/23, showed Resident 62 had no AD.<br><br>2. Medical record review for Resident 476 was initiated on 7/9/24. Resident 476 was admitted to the facility on [DATE].<br><br>Review of Resident 476's Admission MDS dated [DATE], showed Resident 476 had severely impaired cognitive skills.<br><br>Review of the facility's document titled Social Service Assessment V3 dated 6/26/24, showed Resident 476's family member was interested in formulating an AD.<br><br>Review of Resident 476's POLST dated 7/6/24, showed Resident 476 had no AD.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 1045 hours, a concurrent interview and facility document review was conducted with the QA Nurse. The QA Nurse verified Resident 62 and Resident 476's POLSTs showed no AD. The QA Nurse stated the AD was a directive of the resident's healthcare wishes in the event they were unable to make decisions or incapacitated.<br><br>On 7/11/24 at 1150 hours, a concurrent interview and facility document review was conducted with the SSD. The SSD stated the residents were asked about the AD upon admission and quarterly and the AD was used to indicate the resident's healthcare wishes. The SSD stated he requested a copy of the AD from Resident 62; however, he did not follow up with Resident 62 for the copy. The SSD stated he should have followed up with Resident 62 for a copy of AD at least quarterly. The SSD acknowledged he last requested for the copy on 8/28/23, as indicated on the Social Service Assessment V3 dated 8/28/23. Furthermore, the SSD also verified Resident 476 had no AD. The SSD stated Resident 476's family member requested for an AD to be formulated for the resident. The SSD acknowledged he did not follow up with the family member in assisting with the formulation of Resident 476's AD. The SSD stated he should have followed up with the family member to ensure Resident 476 could have an AD.<br><br>On 7/12/24 at 1600 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged above findings. |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the notice of transfer/discharge information and notification of Ombudsman regarding transfer/discharge were completed for one of three closed medical records (Resident 33) reviewed.<br><br>* The facility failed to document Resident 33's notice of transfer/discharge information in the medical record and provide documentation the Ombudsman was notified. This failure had the potential of miscommunication of information and not providing necessary care and services for this resident.<br><br>Findings:<br><br>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 resident' s representative in a language and manner in which they can understand. The notice will include all of the following at the time provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge c. the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address(mailing and email) and phone number of the representative of the Office of the State Long Term Care Ombudsman.<br><br>On 7/12/24 at 0937 hours, a closed medical record review was initiated for Resident 33. Resident 33 was admitted on [DATE], and transferred to an acute care hospital on 7/1/24.<br><br>Review of Resident 33's closed medical record showed no documented evidence of the following:<br><br>- Notice of transfer/discharge<br><br>- Faxed information or any evidence that Ombudsman was notified.<br><br>On 7/12/24 at 1343 hours, medical record review for Resident 33 and concurrent interview with the SSD was conducted. The SSD verified there was no documentation of the notice of transfer/discharge and no documented evidence the Ombudsman was notified.<br><br>On 7/12/24 at 1455 hours, the Medical Records Director acknowledged and verified there was no documentation of the notice of transfer/discharge on the closed medical records (paper and electronic in the PCC, PointClickCare, a cloud-based healthcare software used in healthcare facilities). |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to coordinate an assessment with the PASRR program for two of 18 final sampled residents (Residents 13 and18) reviewed for PASRR as evidenced by:<br><br>* The facility failed to update Resident 13's PASRR when the resident had a new diagnosis of mental disorder, for the PASRR level II review.<br><br>* Resident 18's initial Level 1 PASSR screening conducted on 4/22/22, was positive for mental illness and no Level II mental health evaluation was performed.<br><br>These failures posed the risk for Residents 13 and 18 not receiving the necessary specialized services specific to treat mental illness and had the potential for inappropriate placement in a skilled nursing facility.<br><br>Findings:<br><br>Review of the facility's P&P titled Resident Assessment - Coordination with PASRR Program revised 12/2023 showed the facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The P&P further showed any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly tot the state mental health or intellectual disability authority for a Level II resident review. Examples include the following:<br><br>a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder where dementia is not the primary diagnosis<br><br>b. A resident whose intellectual disability or related condition as not previously identified and evaluated through PASRR.<br><br>c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equal intensive treatment.<br><br>1. Medical record review for Resident 13 was initiated on 7/9/24. Resident 13 was admitted to the facility on [DATE].<br><br>Review of Resident 13's H&P examination dated 6/10/24, showed Resident 13 had the capacity to understand and make decisions.<br><br>Review of Resident 13's Physician's Orders for July 2024 showed the following physician's orders:<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - dated 1/22/24, to administer Haldol Decanoate (antipsychotic medication) 50 mg/ml one ml intramuscularly one time a day every four weeks on Monday for schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) manifested by paranoia delusion related to schizophrenia.<br><br>- dated 6/21/24, to administer Remeron (mood medication) 7.5 mg one tablet by mouth at bedtime related to major depression disorder (mood disorder characterized by loss of interest and feelings of sadness).<br><br>- dated 1/3/24, to administer Zyprexa (antipsychotic medication) 5 mg one tablet by mouth at bedtime for schizophrenia m/b paranoid delusions m/b verbalizing that someone is putting something in food.<br><br>On 7/11/24 at 1419 hours, an interview and concurrent medical record review was conducted with the QA Nurse. The QA Nurse stated the PASRR offered the residents with mental health disorders who qualified under Level II services additional assistance and services. The QA Nurse stated a PASRR was completed for the new residents upon admission if the acute care hospital did not provide one, and with new mental health diagnosis. The QA Nurse verified Resident 13 was admitted to the facility on [DATE], with no diagnosis of mental health; however, Resident 13 was diagnosed with schizophrenia on 2/27/24, psychosis on 2/16/24, and depression and anxiety on 2/16/24. The QA Nurse further verified the facility should have submitted a new PASRR for Resident 13 to update the resident's medical condition.<br><br>On 7/12/24 at 1600 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings.<br><br>49324<br><br>2. Medical record review for Resident 18 was initiated on 7/9/24. Resident 18 was admitted to the facility on [DATE].<br><br>Review of Resident 18's level 1 PASSR evaluation dated 4/22/22, showed Resident 18 had a positive level I screening.<br><br>Further review of Resident 18's medical record did not show documented evidence of coordination for a level II assessment.<br><br>On 7/11/24 at 1420 hours, an interview and concurrent medical record review was conducted with the QA Nurse. The QA Nurse verified Resident 18 needed to have the PASRR level II evaluation. When asked if the level II mental health evaluation was performed, the QA Nurse verified and acknowledged it was not done. |

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| F 0657<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127<br><br>Based on interview and medical record review, the facility failed to ensure the comprehensive plan of care for one nonsampled resident (Resident 21) was revised to reflect the current care needs and interventions.<br><br>* Resident 21's plan of care was not accurately updated to reflect the resident's DNR status. This failure had the potential for not providing care and services to meet the resident's needs.<br><br>Findings:<br><br>Medical record review for Resident 21 was initiated on [DATE]. Resident 21 was admitted to the facility on [DATE].<br><br>Review of Resident 21's Physician Orders for Life Sustaining Treatment (POLST) form dated [DATE], showed DNR, OK for hospitalization , no artificial means of nutrition, including feeding tubes, and was signed by a physician and Resident 21 on [DATE].<br><br>Review of Resident 21's H&P examination dated [DATE], showed Resident 21 had the capacity to understand and make decisions.<br><br>Review of Resident 21's current care plan for [DATE] showed the resident's POLST showing attempt CPR, full treatment, and no artificial means of nutrition. The goal was to honor Resident 21's POLST and the interventions included a full code.<br><br>On [DATE] at 1330 hours, an interview and concurrent medical record review was conducted with RN 2. When asked to read and confirm Resident 21's POLST form, RN 2 stated it showed DNR. RN 2 reviewed the current plan of care for [DATE] and stated it showed to attempt CPR and the resident decided to remain a full code. When asked why it was important to follow the POLST and resident's wishes, RN 2 stated to know what action to take, to give CPR or not, and the care plan should have reflected the POLST.<br><br>On [DATE] at 1340 hours, an interview and concurrent record review of Resident 21's medical record was conducted with the DON. The DON verified Resident 21's POLST showing DNR and the plan of care showed attempt CPR. The DON stated, I will change the care plan right now. When asked what the reason was for revising the care plan, the DON stated it was important to match the POLST, resident's wishes, with the current care plan for accuracy and correct documentation. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332<br><br>Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services for one of 18 final sampled residents ( Resident 57) to ensure the resident maintained their highest physical well-being.<br><br>* The facility failed to follow Resident 57's physician's order to provide the winged LALM (a special mattress designed to distribute the resident's body weight to prevent skin breakdown). This failure had the potential for Resident 57 to not receive the appropriate care and services needed.<br><br>Findings:<br><br>Medical record review for Resident 57 was initiated on 7/9/24. Resident 57 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 57's H&P examination dated 3/10/24, showed Resident 57 could make needs known but could not make medical decisions due to Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).<br><br>Review of Resident 57's physician's order dated 6/14/24, showed to provide winged LALM, check setting by the resident's weight and comfort, every shift for skin management.<br><br>On 7/9/24 at 1312 hours, an observation on Resident 57's low air loss mattress was conducted with the Treatment Nurse. Resident 57's LALM had no wing (bolster) as per the physician's order. The Treatment Nurse verified there was an order for winged LALM but there was no implementation of the winged LALM as ordered. The QA nurse also verified there was no wing on the resident's LALM. The Treatment Nurse was asked what the purpose of the winged LALM was. The Treatment Nurse stated the LALM was for skin maintenance and Resident 57 may roll out of bed if no winged LALM. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for three of five final sampled residents (Residents 57, 62, and 726) reviewed for respiratory care.<br><br>* The facility failed to ensure Resident 57 was administered oxygen as ordered by the physician.<br><br>* The facility failed to ensure Resident 62's continuous oxygen was administered as ordered.<br><br>* The facility failed to ensure Resident 726's incentive spirometer was stored in a bag when not in use and the use of incentive spirometer addressed in the plan of care.<br><br>These failures had the potential to negatively affect the respiratory health and well-being of the residents in the facility.<br><br>Findings:<br><br>Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goal and preferences. Oxygen Therapy is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. Under the Policy Explanation and Compliance Guidance section, the policy showed the following:<br><br>1. Oxygen is administered under the orders of a physician, except in the case of emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.<br><br>2. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, Rehab and Respiratory therapists.<br><br>3. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to:<br><br>a. The type of oxygen delivery system<br><br>b. When to administer, such as continuous or intermittent and/or when to discontinue.<br><br>c. equipment setting for the prescribed flow rates.<br><br>1. On 7/10/24 at 1048 hours, Resident 57 was observed lying in bed with the oxygen concentrator machine (machine to provide continuous flow of oxygen) on at three liters per minute. The nasal cannula was observed on the floor, not connected to the resident and the oxygen concentrator machine.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Medical record review for Resident 57 was initiated on 7/9/24. Resident 57 was readmitted to the facility on [DATE].<br><br>Review of Resident 57's H&P examination showed dated 3/10/24, showed Resident 57 could make needs known but could not make medical decisions.<br><br>Review of Resident 57's Order Summary Report showed a physician's order dated 6/17/24, to administer oxygen at three liters per minute via nasal cannula for SOB continuously.<br><br>Further review of Resident 57's medical record showed Resident 57 had chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, and acute congestive heart failure.<br><br>On 7/10/24 at 1105 hours, an observation and concurrent interview was conducted with the QA Nurse and LVN 4 for Resident 57. The QA Nurse and LVN 4 verified Resident 57's nasal cannula was on the floor, not connected to Resident 57 and the oxygen concentrator machine. The QA Nurse checked Resident 57's oxygen saturation level which showed 59%. LVN 4 was observed replacing the nasal cannula and applying it into Resident 57's nostrils. LVN 4 was then observed rechecking Resident 57's oxygen saturation level which showed 94%.<br><br>47474<br><br>2. Medical record review for Resident 62 was initiated on 7/9/24. Resident 62 was admitted to the facility on [DATE].<br><br>Review of Resident 62's H&P examination dated 6/10/24, showed Resident 62 had the capacity to understand and make decisions.<br><br>Review of Resident 62's Physician's Orders for July 2024 showed a physician's order dated 4/8/24, to administer continuous oxygen via nasal cannula at 2 LPM.<br><br>On 7/9/24 at 0909 hours, an initial observation of the facility was conducted. Resident 62 was observed wearing an oxygen nasal cannula attached to an oxygen concentrator machine with a setting of 3.5 LPM. When Resident 62 was asked how much oxygen he received, Resident 62 stated he was on continuous oxygen, usually at 2 LPM.<br><br>On 7/9/24 at 0917 hours, an observation, medical record review and concurrent interview was conducted with the IP. The IP verified Resident 62's oxygen concentrator was observed setting at 3.5 LPM. The IP further verified Resident 62's physician's order for oxygen was ordered for continuously at 2 LPM. The IP stated the physician's orders should be followed.<br><br>On 7/12/24 at 1600 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.<br><br>50967<br><br>3. On 7/09/24 at 0946 hours, during the initial tour of the facility, Resident 726 was observed lying in bed with the head of the bed elevated. An incentive spirometer was observed on Resident 726's bedside table and not stored in a bag.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/09/24 at 1006 hours, an observation and concurrent interview was conducted with the IP at Resident 726's bedside. The IP verified Resident 726's incentive spirometer was on the bedside table and not stored in a bag.<br><br>Medical record review for Resident 726 was initiated on 7/9/24. Resident 726 was admitted to the facility on [DATE].<br><br>Review of Resident 726's Order Summary Report showed no physician's order for the incentive spirometer usage and frequency.<br><br>Review of Resident 726's plan of care failed to show a care plan problem addressing Resident 726's incentive spirometer use.<br><br>On 7/10/24 at 1132 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 was asked to show the physician's order regarding the current use of incentive spirometer for Resident 726. LVN 3 verified Resident 726 did not have a physician's order for the current use of incentive spirometer and stated there should be a physician's order. In addition, LVN 3 verified there was no care plan developed to address Resident 726's incentive spirometer use.<br><br>On 7/11/24 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the ongoing assessment before, during, and after dialysis treatments for one of two final sampled residents (Resident 476) reviewed for dialysis services was accurate. This failure had the potential of not identifying negative outcomes for the dialysis resident (Resident 476).<br><br>Findings:<br><br>Review of the facility's P&P titled Hemodialysis revised 9/2022 showed ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices. The P&P also showed the nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications.<br><br>Medical record review for Resident 476 was initiated on 7/9/24. Resident 476 was admitted to the facility on [DATE].<br><br>Review of Resident 476's dialysis care plan dated 6/24/24, showed an intervention to monitor the resident's hemodialysis access site, permacath located on the right upper chest.<br><br>Review of Resident 476's physician's order dated 7/2/24, showed Resident 476 had dialysis scheduled on Mondays, Wednesdays, and Fridays.<br><br>Further review of Resident 476's dialysis communication form titled Pre and Post Dialysis Assessments showed inaccurate documentation of Resident 476's access site on the following dates:<br><br>- dated 7/12/24, the pre dialysis assessment access site was marked as bruit and thrill present;<br><br>- dated 7/10/24, the pre and post dialysis assessment access site was marked as bruit and thrill present;<br><br>- dated 7/8/24, the post dialysis assessment access site was marked as bruit and thrill present;<br><br>- dated 7/5/24, the pre and post dialysis assessment access site was marked as bruit and thrill present;<br><br>- dated 7/3/24, the pre and post dialysis assessment access site was marked as bruit and thrill present; and<br><br>- dated 7/1/24, the pre dialysis assessment access site was marked as bruit and thrill present.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/12/24 at 1120 hours, a concurrent interview and medical record review with the QA Nurse was conducted. The QA Nurse verified Resident 476 received hemodialysis on Mondays, Wednesdays, and Fridays and had a permacath access site to the right upper chest. The QA Nurse further verified Resident 476's pre and post dialysis assessments dated from 7/1/24 to 7/12/24, showed the bruit and thrill were present. The QA Nurse stated the bruit and thrill were checked for the dialysis residents with an AV fistula to ensure the dialysis access site was functioning. Furthermore, the QA Nurse stated the bruit and thrill were not assessed for the dialysis residents with permacath and stated marking for the presence of bruit and thrill was an inaccurate assessment.<br><br>On 7/12/24 at 1357 hours, a concurrent interview and medical record review with LVN 1 was conducted. LVN 1 stated the pre and post dialysis assessments were completed by the charge nurses prior to the resident going to the dialysis and upon return from the dialysis. LVN 1 further stated the facility must ensure accurate assessments for the residents on dialysis with a permacath to ensure proper care was provided.<br><br>On 7/12/24 at 1600 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the proper storage, and disposal of medications.<br><br>* The facility failed to dispose of the expired medications including three pieces of Bisacodyl (laxative) 10 mg suppositories which were stored together with Goodsense Clearlax Polyethylene Glycol 3350 Powder for Solution Osmotic Laxative (oral medication house supply).<br><br>* The facility failed to dispose of the wasted narcotic medication stored in Medication Cart A.<br><br>These failures had the potential for the medications to be accidentally administered and/or diverted.<br><br>Findings:<br><br>1. Review of the facility's P&P titled Medication Storage revised 12/19/22, showed the facility ensures all medications on their premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. Internal Products: Medications to be administered by mouth are stored separately from other formulations. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective or deteriorated medications with worn, illegible or missing labels. These medications are destroyed in accordance with facility policy.<br><br>On 7/10/24 at 1045 hours, inspection of Medication Room A and concurrent interview with the IP was conducted. Three pieces of Bisacodyl 10 mg suppository with an expiration date of 8/2022 was observed being stored in Medication Room A together with Goodsense Clearlax Polyethylene Glycol 3350 Powder for Solution Osmotic Laxative, an oral medication house supply. The IP verified the expired medication should have been disposed and the oral medications should not be stored together with the rectal medications.<br><br>2. Review of the facility's P&P titled Disposal of Medications and Medication-related supplies revised 1/2013 showed the medications included in the Drug enforcement Administration (DEA) classification as controlled substances are subject to special handling , storage, disposal, and recordkeeping in the facility in accordance with Federal and State laws and regulations. The DON and consultant pharmacist are responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing the dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/10/24 at 1237 hours , an inspection of Medication Cart A, medical record review, and concurrent interview was conducted with LVN 3. A medication was labeled with handwritten black marker showing Resident 726's name, oxy 10 mg 1/2 tablet dated 7/1/24, and 1230 PM in a small plastic transparent Silent Knight bag stored in a divider box in the locked narcotic drawer. LVN 3 stated she did not know it was there, and it was a wasted narcotic and verified it should have been given to the DON since last 7/1/24, for disposal.<br><br>Medical record review for Resident 726 was initiated on 7/10/24. Resident 726 was admitted to the facility on [DATE].<br><br>Review of Resident 726's MDS dated [DATE], showed Resident 726 was with BIMS score of 15 (score of 15 means the resident was cognitively intact) and had no impairment to the bilateral upper extremities.<br><br>Review of Resident 726's H&P examination dated 12/1/23, showed Resident 726 had the capacity to understand and make decisions.<br><br>Review of the Resident 726's medical record showed the physician's order dated 7/1/24, for oxycodone HCl opioid narcotic analgesic) oral tablet 15 mg one tablet by mouth every six hours as needed for severe pain level (levels 8-10), not to exceed 3 gm/24 hours.<br><br>Review of Resident 726's Antibiotic or Controlled Record for oxycodone HCL 10 mg tablet showed with handwritten date and time, 7/1/24 at 1230, staff signature and with documentation, 0.5 wasted oxycodone HCL 10 mg one tablet by mouth every eight hours as needed for severe pain.<br><br>On 7/12/24 at 1519 hours, an interview was conducted with the DON. The DON verified the wasted controlled medications should be immediately given to her by the licensed nurses for proper disposal. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>50967<br><br>Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when:<br><br>1. The kitchen equipment were not air dried before storage.<br><br>2. The cutting boards were not kept in sanitary condition and with cleanable surfaces.<br><br>3. A thawing process was not followed for meats.<br><br>4. The ice machine ice storage bin's splash guard and outside left area of ice machine were not clean.<br><br>These failures posed the risk for food borne illnesses in highly susceptible resident population of 75 facility residents who received food prepared in the kitchen.<br><br>Findings:<br><br>Review of the facility matrix showed 75 of 77 residents consumed food prepared in the kitchen.<br><br>1. Review of the facility's P&P titled Dish and Utensil Procedure dated 3/03/20, showed dishes, trays, and utensils shall be air dried before storage. Do not towel dry.<br><br>On 7/09/24 at 0742 hours, during the initial tour of the kitchen with the Dietary Supervisor, the following items were observed stored wet:<br><br>- two clear containers stored on top of each other; and<br><br>- two metal pans stored on top of each other.<br><br>The Dietary Supervisor verified the findings.<br><br>2. According to the USDA Food Code 2022, 4-501.12, Cutting Surfaces, surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.<br><br>According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/09/24 at 0742 hours, during the initial tour of the kitchen with the Dietary Supervisor, two white cutting boards were observed to be heavily marred with knife marks, and frayed laminate material. The Dietary Supervisor verified the cutting boards had knife marks and frayed laminate material were not cleanable surfaces and needed to be replaced.<br><br>3. According to the USDA Food Code 2022 Annex 6 Food Processing Criteria, (F) Recommendations for Safe Curing of Meat and Poultry, (3) HACCP (Hazard Analysis and Critical Control Point: food safety management system that aims to reduce the risk of foodborne illness by identifying and controlling potential problems before they occur), (b) Raw Material Handling, (i) Thawing must be monitored and controlled to ensure thoroughness and to prevent temperature abuse. Improperly thawed meat could cause insufficient cure penetration. Temperature abuse can cause spoilage or growth of pathogens.<br><br>On 7/09/24 at 0817 hours, during initial tour of the kitchen with the Dietary Supervisor, one container of completely thawed bacon with a pulled date of 7/8/24 was observed inside the walk-in refrigerator. Review of the facility's document titled Thawing Log failed to show the entry for bacon with a pulled date of 7/8/24. The Dietary Supervisor verified the finding.<br><br>On 7/10/24 at 0810 hours, a follow-up interview was conducted with the Dietary Supervisor. The Dietary Supervisor stated the bacon were delivered and stored frozen. The Dietary Supervisor stated the thawed bacon in the walk-in refrigerator were removed from the freezer and placed in the walk-in refrigerator by the weekend dietary staff. The Dietary Supervisor stated the bacon should have been documented on the Thawing Log.<br><br>4. According to the USDA Food Code 2022, Section 4-601.11 Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils, (A) Equipment, food contact surfaces and utensils shall be clean to sight and touch and (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris.<br><br>Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2020 showed the ice machine needs to be cleaned and sanitized monthly, the internal components cleaned monthly or per manufacture's recommendations, and the date recorded when cleaned, the maintenance supervisor can keep this record or it can be posted on the ice machine. Be sure special attention is paid to cleaning the door molding and the lid of the machine.<br><br>On 7/09/24 at 1147 hours, an observation of the ice machine was conducted with Treatment Nurse inside Nurse Station 1's utility room. The following was observed:<br><br>- the ice machine splash guard had a black residue when wiped with a paper towel;<br><br>- the outside panel, on the left side of the ice machine, had multiple streaks of white hard residue; and<br><br>- the outside seal on the left side, which separated ice machine motor cover and ice bin had brown/orange and white hard residue.<br><br>The Treatment Nurse verified the above findings and stated facility had only one ice machine.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/9/24 at 1156 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor was informed and verified the above findings.<br><br>On 7/11/24 at 1445 hours, an interview was conducted with the RD, Dietary Supervisor, Administrator, and DON. The RD, Dietary Supervisor, Administrator, and DON were informed and acknowledged the above findings. |

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| | 055622 | A. Building<br>B. Wing | 07/12/2024 |

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

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>50967<br><br>Based on interview and facility P&P review, the facility failed to ensure the use and storage of food brought to the facility by the family members or visitors with safe food handling practices. This failure had the potential for unsafe food handling which could lead to food borne illness.<br><br>Findings:<br><br>Review of the facility's P&P titled Food: Safe Handling for Foods from Visitors dated (unknown) showed it is the center's policy to assist residents in properly storing and safely consuming foods brought into the center for residents by visitors. When bringing food items intended for later consumption, the responsible staff member will:<br><br>- Ensure that foods are in a sealed container to prevent cross contamination.<br><br>- Label foods with resident name and the current date.<br><br>- Determine whether food items are shelf stable and can be stored in the resident room or properly stored under refrigeration.<br><br>On 7/10/24 at 0845 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated the facility did not have a designated refrigerator for the residents' food brought by the family members or visitors. LVN 1 stated any food brought by the family members or visitors were marked with the resident's name and date when it was received and stored in the employee's refrigerator located inside the employee breakroom. An observation of the employee breakroom was conducted with LVN 1. The designated employee refrigerator was observed with a posted signage showing No resident's food should be stored in here. When LVN 1 was asked about the signage and the facility's policy when a resident wanted to store their perishable food items brought by the visitors, LVN 1 stated he would have to ask the DON or the dietary staff. LVN 1 was observed speaking with the DON. LVN 1 then stated the facility could not keep or store the residents' food brought in by the family members or visitors inside the designated employee refrigerator and the residents must eat the food right away.<br><br>On 7/10/24 at 0855 hours, an interview was conducted with the DON. The DON stated any leftover from the resident's food brought by the family members or visitors were thrown away. The DON stated the family members were advised to bring in food within two hours of the resident's consumption.<br><br>On 7/10/24 at 0901 hours, an interview was conducted with the RD and Dietary Supervisor. The RD and Dietary Supervisor stated the facility did not have a refrigerator to store the residents' perishable food brought by the family members or visitors.<br><br>On 7/10/24 at 1120 hours, an interview was conducted with CNA 5. When asked about where the facility would store the residents' perishable food brought by the family member or visitors, CNA 5 stated she was not aware if the residents' had a designated refrigerator.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 1445 hours, an interview was conducted with the RD, Dietary Supervisor, Administrator and DON. The RD, Dietary Supervisor, Administrator, and DON were informed and acknowledged the above findings. |

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| F 0814<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>50967<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure two of two compost bins were overflowing with lids not properly closed. This failure had the potential to attract pests/rodents that carry diseases.<br><br>Findings:<br><br>According to the USDA Food Code 2022, 5-501.15, Outside Receptacles, for receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.<br><br>According to USDA Food Code 2022, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (b) with tight-fitting lids or doors if kept outside the food establishment.<br><br>Review of the facility's P&P titled Garbage and Trashcans revised 5/20/20, under the section for Sanitation of Equipment, showed all food waste must be placed in covered garbage and trash cans and the dumpster area must be free from debris on the ground and the lid must be closed.<br><br>On 7/10/24 at 0826 hours, an observation of the garbage disposal was conducted. Two of two compost bins were observed overflowing with trash and lids not completely covering the compost bins. Multiple insects and flies were observed on and flying around the overflowing trash and compost lids. The Maintenance Supervisor verified the findings. The Maintenance Supervisor stated the compost bins were used for the food scraps from the kitchen.<br><br>On 7/11/24 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for two of 18 final sampled residents ( Residents 18 and 72) were complete.<br><br>* Resident 18's MAR was incomplete for monitoring signs and symptoms of bleeding and bruising related to anticoagulant therapy, monitoring for bipolar disorder manifested by angry outburst for no apparent reason, and monitoring of pain levels.<br><br>* Resident 72's MAR was incomplete and accurate for the monitoring for the resident's body temperature and oxygen saturation level every shift for suspected/confirmed Covid 19 and the pain evaluation every shift.<br><br>These failures had the potential for the residents' care needs not being met.<br><br>Findings:<br><br>Review of the facility's P&P titled Documentation on 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 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. Documentation can be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation shall be accurate, relevant and complete, containing sufficient details about the resident's care and/or responses to care.<br><br>1. Medical record review for Resident 18 was initiated on 7/9/24. Resident 18 was admitted to the facility on [DATE].<br><br>Review of Resident 18's MAR showed the following entries:<br><br>- Monitoring of the signs and symptoms of bleeding and bruising (tarry stools, bleeding gums, hematuria, coffee ground emesis) related to anticoagulation therapy.<br><br>- For Seroquel (antipsychotic medication), to monitor for bipolar disorder manifested by angry outburst for no apparent reason every shift.<br><br>- Monitoring the resident's level of pain every shift by using the pain scale as follows: no pain = 0, mild pain = 1-3, moderate pain = 4-6, severe pain = 7-10.<br><br>However, the MAR showed missing documentation as follows:<br><br>- There was no monitoring for bleeding and bruising on 6/15/24, for the 7-3 shift; and 6/27/24, for the 3-11 shift.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | - There was no monitoring for bipolar disorder manifested by angry outburst on 6/20/24, for the 3-11 shift.<br><br>- There was no pain level monitoring on 6/15/24, for the 7-3 shift.<br><br>On 7/12/24 at 1448 hours, medical record review and concurrent interview was conducted with the Medical Records Director. The Medical Records Director verified the above findings.<br><br>2. Medical Record Review for Resident 72 was initiated on 7/9/24. Resident 72 was admitted to the facility on [DATE].<br><br>Review of Resident 72's MAR showed the following entries:<br><br>- Monitoring of the resident's body temperature and oxygen saturation every shift for suspected/confirmed Covid 19<br><br>- Pain evaluation every shift<br><br>However, the MAR showed missing documentation as follows:<br><br>- There was no documentation of monitoring for the resident's body temperature and oxygen saturation level on 6/15/24, for the 7-3 shift.<br><br>- There was no pain evaluation on 6/15/24, for the 7-3 shift.<br><br>On 7/12/24 at 1455 hours, medical record review and concurrent interview was conducted with the Medical Records Director. The Medical Records Director verified the above findings.<br><br>On 7/12/24 at 1515 hours, the IP verified all the missing documentation of Residents 18 and 72's MARs. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>48332<br><br>Based on observation, interview, medical record review, and facility document review, the facility failed to implement their infection control program when:<br><br>* CNA 2 failed to wear the proper PPE when performing the high-contact care for one nonsampled resident (Resident 579) who was on Enhanced Barrier Precautions.<br><br>* A soiled cloth pad was placed on top of the toilet tank of adjoining bathroom of Rooms A and C.<br><br>* CNA 4 did not sanitize her hands before and after providing care for one of 18 final sampled residents (Resident 55) and one nonsampled resident (Resident 53).<br><br>These failures posed the risk for transmission of communicable diseases to other residents in the facility.<br><br>Findings:<br><br>1. Review of the facility's guideline Titled Enhanced Barrier Protection in Nursing Homes (undated) showed a quiz form showing Question #2. Enhanced Barrier Precautions include the use of gowns and gloves during which high contact care activities? The provided key answers include: A. Bathing/showering; C. Providing Hygiene; D. Changing briefs or assisting with toileting; E. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; and F. Wound care; any of skin opening requiring dressing.<br><br>On 7/9/24 at 1035 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 was observed getting in and out of Resident 579's room with posted Enhance Barrier Precaution outside of the room. CNA 2 stayed for more than 10 minutes providing the care to Resident 579, without wearing a gown. CNA 2 was asked the meaning of the sign in front of the room. CNA 2 stated the resident had to be protected from infection and he should also be wearing gown when he was providing the resident's care because the Enhanced Barrier Precaution signage posted outside the resident's room showed to wear gloves and a gown for the high contact resident care activities.<br><br>On 7/9/24 at 1054 hours, an interview was conducted with the DON. The DON verified the findings and stated CNA 2 should be wearing gown when providing Resident 579's care.<br><br>On 7/9/24 at 1548 hours, Resident 579's medical record review was initiated. Resident 579's diagnosis included Enhanced Barrier Precaution due to dialysis.<br><br>50127<br><br>2. Review of the facility's P&P titled Infection Prevention and Control Program dated 9/2/22, showed the facility has established and maintains an infection prevention and control program designed to provide a safe and comfortable environment and to help prevent the development and transmission of disease and infections as per accepted national standard and guidelines. Linens: soiled linens should not be kept in the resident's room or bathroom.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/9/24 at 0922 hours, during the initial tour, a soiled cloth pad was observed on top of the toilet tank in the adjoining bathrooom of Rooms A and C.<br><br>On 7/9/24 at 0929 hours, an observation and concurrent interview were conducted with CNA 3. CNA 3 verified the soiled cloth pad was on top of the toilet tank in the adjoining bathrooom of Rooms A and C. CNA 3 stated it should not be there and was observed removing the soiled cloth pad and placed it in the dirty linen bin.<br><br>On 7/10/24 at 1124 hours, an interview and concurrent record review was conducted with the IP. When asked, the IP stated the dirty linens should be placed in the dirty laundry bin.<br><br>3. On 7/9/24 at 0952 hours, CNA 4 was observed stopping in front of Room A while transporting Resident 55 in a shower chair in Station 1 hallway towards the shower room. CNA 4 was observed not sanitize her hands and walked in to Room A directly to Resident 53's bedside and provided care to Resident 53. CNA 4 was observed assisting with rearranging Resident 53's pillow and blankets while searching for a TV remote control in Resident 53's bed. CNA 4 left Room A without sanitizing her hands and transported Resident 55 to the shower room. CNA 4 was asked if the CNA was supposed to sanitize her hand and don gloves before providing care to Resident 53, CNA 4 stated she forgot and should have washed her hands and used gloves for infection control. When asked if CNA 4 should have sanitized her hands prior to leaving Room A and prior to resuming care to Resident 55, she stated yes, she forgot and had gloves in her pocket.<br><br>On 7/10/24 at 1110 hours, an interview was conducted with the DON. When asked about the facility's standard practice for hand hygiene, the DON stated the staff were supposed to sanitize and wash their hands if their hands were soiled and after each resident care for infection control.<br><br>On 7/10/24 1124 hours, an interview and concurrent record review of the facility's P&P on Handwashing/Hand Hygiene was conducted with the IP. The IP was asked about the facility's standard practice for hand hygiene as to when the staff should sanitize or wash their hands. The IP stated before and after assisting a resident and before and after leaving the room. The IP verified the facility's P&P on Handwashing/Hand Hygiene showed all the staff to wash their hands before and after the resident contact. The IP stated CNA 4 told him today that she forgot to sanitize her hands before and after helping Residents 53 and 55. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>50967<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in safe operating condition when:<br><br>* The ice machine was not cleaned and sanitized as per the manufacturer's instructions. This failure had the potential for the essential equipment not functioning in the way they were intended and in turn cause contamination of food, leading to illnesses for the residents.<br><br>Findings:<br><br>Review of the USDA Food Code 2022, 4-501.11, Good Repair and Proper Adjustment showed equipment shall be maintained in a state of repair and condition.<br><br>Review of the facility's P&P titled Ice Machine Cleaning Procedures showed dated 2020 showed the ice machine needs to be cleaned and sanitized monthly, the internal components are cleaned monthly or per the manufacturer's recommendations; and information about the operation, cleaning and care of the ice machine can be obtained from owner's manual, the manufacturer and/or in the directional panel on the side of the ice machine.<br><br>Review of the Scotsman Ice System Installation and User's manual dated 10/2014, under Ice Storage Bin, showed the following:<br><br>1. Remove and discard all ice.<br><br>2. Mix a solution of 7 ounces of Scotsman Clear 1 ice machine scale remover in 84 ounces of potable water and wash all interior surfaces of the ice storage bin to remove any mineral scale build up. Pour excess cleaner solution into the bin's drain.<br><br>On 7/10/24 at 0904 hours, an interview and concurrent facility document review was conducted with the Maintenance Supervisor. When the Maintenance Supervisor was asked about the cleaning of the ice machine, the Maintenance Supervisor stated he only cleaned the ice machine bin and the outside of the ice machine once a week. The Maintenance Supervisors stated an outside company was responsible to clean the internal parts of the ice machine every three months. The Maintenance Supervisor stated he used bleach spray to clean the ice storage bin. The Maintenance Supervisor verified the findings and verified he did not use Scotsman Clear 1 solution to clean ice storage as per the manufacturer's instructions.<br><br>On 7/11/24 at 1445 hours, an interview was conducted with the RD, Dietary Supervisor, Administrator, and DON. The RD, Dietary Supervisor, Administrator, and DON were informed and acknowledged the above findings. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for two of 18 final residents (Residents 17 and 62) and one nonsampled resident (Resident 726) reviewed for the side rails use.<br><br>* The facility failed to ensure Residents17, 62, and 726's entrapment assessments were completed and included the assessments for Zones 6 and 7.<br><br>These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.<br><br>Findings:<br><br>According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are:<br><br>- Zone 1: within the rail;<br><br>- Zone 2: under the rail, between the rail supports or next to a single rail support;<br><br>- Zone 3: between the rail and the mattress;<br><br>- Zone 4: under the rail, at the ends of the rail;<br><br>- Zone 5: between split bed rails;<br><br>- Zone 6: between the end of the rail and the side edge of the head or foot board; and<br><br>- Zone 7: between the head or foot board and the mattress end.<br><br>Review of the facility's P&P titled Proper Use of Bed Rails revised 12/19/22, showed the following:<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Bed rails are adjustable metal or rigid plastic bars that are attached to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eight lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to side rails, bed side rails, grab bars and assist bars;<br><br>- Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail;<br><br>- Assessment should assess resident's risk of entrapment between mattress and bed rail or in the bed rail itself;<br><br>- The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: (a) checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. Rails should be selected and placed to discourage climbing over rails, (b) ensuring that the bed's dimensions are appropriate for the resident by confirming that the bed rails are appropriate for the size and weight of the resident using the bed,<br><br>ensuring that the bed's dimensions are appropriate for the resident by, installing bed rails using the manufacturer's instructions and specifications to ensure a proper fit, inspecting and regularly checking the mattress and bed rails for areas of possible entrapment, and ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth, (c) observing ongoing precautions such as following manufacturer's equipment alerts and recalls and increasing resident supervision, especially with the use of air-filled mattresses or therapeutic air-filled beds that may present a different entrapment risk than rail entrapment, (d) conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair.<br><br>During a concurrent observation, medical record review, and facility document review for Residents 17, 62, and 726 showed the residents' bed entrapment assessments were not completed or the bed inspection gap measurements for Zones 6 and 7 were not documented. For example:<br><br>1. On 7/9/24 at 0946 hours, during the initial tour of the facility, Resident 726 was observed lying in bed with the bilateral side rails elevated. Resident 726 stated she used the side rails when she repositioned to her side.<br><br>Medical record review for Resident 726 was initiated on 7/10/24. Resident 726 was admitted to the facility on [DATE].<br><br>Review of Resident 726's H&P examination dated 6/27/24, showed Resident 726 had the capacity to understand and make medical decisions.<br><br>Review of Resident 726's Order Summary Report showed a physician's order dated 6/27/24, for bilateral 3/4 side rails as an enabler for assistance for bed mobility, transfers, repositioning, and ADL care.<br><br>(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 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 726's Bed System Measurement Device Test Results Worksheet dated 7/3/24, failed to show the bed assessment result of pass or not pass. The worksheet showed, P was circled for Zones 2 and 4. The worksheet failed to show the assessments of the entrapment for Zones 6 and 7 applicable for Resident 726's side rails.<br><br>On 7/10/24 at 1510 hours, an observation and concurrent interview was conducted with the Treatment Nurse. The Treatment Nurse verified Resident 726's bilateral side rails were elevated.<br><br>On 6/20/24 at 0834 hours, a concurrent interview and document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified he documented the entrapment assessment on the Bed System Measurement Device Test Results Worksheet. When asked about the assessments of the entrapment, the Maintenance Director verified the bed entrapment assessments for Zones 6 and 7 were incomplete. The Maintenance Supervisor verified the above findings.<br><br>On 7/11/24 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.<br><br>47474<br><br>2. Medical record review for Resident 17 was initiated on 7/9/24. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 17's H&P examination dated 11/6/23, showed Resident 17 had the capacity to understand and make decisions.<br><br>Review of Resident 17's Physician's Orders for July 2024 showed a physician's order dated 5/7/24, for bilateral 3/4 side rails as enabler for assistance with bed mobility, transfers, repositioning, and ADL care as enabler and not as a restraint. The order also showed a consent obtained by the physician, and consent signed and obtained from the responsible party, and pros and cons discussed with the responsible party.<br><br>Review of the facility's document titled Bed System Measurement Device Test Results Worksheet dated 10/18/23, showed no documented evidence Zones 6 or 7 measurements were assessed. Further review of the facility's document showed no documented evidence showing the overall bed assessment of entrapment zones passed or failed.<br><br>3. Medical record review for Resident 62 were initiated on 7/9/24. Resident 62 was admitted to the facility on [DATE].<br><br>Review of Resident 62's H&P examination dated 6/10/24, showed Resident 62 had the capacity to understand and make decisions.<br><br>Review of Resident 62's Physician's Orders for July 2024 showed a physician's order dated 5/7/24, for bilateral 3/4 side rails as enabler for assistance with bed mobility, transfers, repositioning, and ADL care as enabler and not as a restraint. The order also showed a consent obtained by the physician, consent signed and obtained from the responsible party, and pros and cons discussed with the responsible party.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055622 | A. Building<br>B. Wing | 07/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bonita Hills Post Acute | 1233 West LA Habra Boulevard<br>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 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's document titled Bed System Measurement Device Test Results Worksheet dated 1/3/24, showed no documented evidence Zones 6 or 7 measurements were assessed. Further review of the facility's document showed no documented evidence showing the overall bed assessment of entrapment zones passed or failed.<br><br>On 7/11/24 at 0832 hours, a concurrent interview and facility document review with the Maintenance Supervisor was conducted. The Maintenance Supervisor verified Residents 17 and 62 had side rails and the facility's entrapment assessment titled Bed System Measurement Device Test Results Worksheet did not assess for Zones 6 and 7. The Maintenance Supervisor stated the assessment of bed entrapment should have also included Zones 6 and 7. The Maintenance Supervisor further verified the facility document did not show documented evidence Resident 17 or 62's bed assessments were passed or failed. The Maintenance Supervisor stated the assessments of the bed zones and the assessment for the risk of entrapment were to ensure the residents did not get trapped between the side rails or cause injury.<br><br>On 7/12/24 at 1600 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings. |