STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056042	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Vista Healthcare & Wellness Centre, LP	5901 Downey Ave Long Beach, CA 90805

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46036 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was not subjected to a physical abuse by Resident 2. The facility failed to: 1. Ensure Resident 1, who had a history of aggressive behavior toward residents and staff and was sent out to a general acute care hospital (GACH) on 5150 (temporary, involuntary psychiatric commitment of residents who present a danger to themselves or others due to signs of mental illness) hold on 4/18/2024, was not placed in the same room with Resident 2 upon re-admission to the facility on [DATE]. 2. Ensure staff followed Resident 2's care plan titled, Alleged altercation per another roommate on 4/11/2024, to prevent Resident 2 altercations with Resident 1 on 4/27/2024. 3. Provide Resident 2 with 1:1 sitter (constant observation by a staff member for the residents and companions safety) to prevent Resident 2 from altercation with other residents per care plan titled, Alleged altercation per another roommate (Resident 3) on 4/11/2024. 4. Ensure Resident 1 was assessed upon re-admission to the facility and ongoing for the appropriate placement in the same room with Resident 2 to prevent possible altercation between both residents per facility's policy and procedure (P&P) titled, Abuse-Prevention, Screening, & Training Program. As a result, Resident 2 punched Resident 1 in the face leading Resident 1 to fall on the floor. Resident 1 sustained a left upper eye lid laceration (skin cut) and skin tears (traumatic wounds that may result from a variety of mechanical forces such as falls) on a right forearm (arm area between the elbow and wrist). Resident 1 was transferred the GACH on 4/27/2024 for evaluation of head trauma. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (involves delusions [false beliefs], hallucinations [hearing or seeing things that do not exist), unusual physical behavior, disorganized (abnormal thought process, thinking or speech) and bipolar disorder (a mental illness that causes extreme shifts in a person's mood, energy, activity levels, and concentration). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's History and Physical (H&P) dated 4/26/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 5/3/2024, the MDS indicated Resident 1 had a moderate impairment in cognitive (relating to the process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated, Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, toileting, hygiene, and showering/bathing. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including paranoid schizophrenia suicidal ideations (suicidal thoughts or ideas), restlessness, agitation, and violent behavior. During a review of Resident 2's H&P dated 4/14/2024, the H&P indicated Resident 2 was able to make decisions for activities of daily living. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had a moderate impairment in cognitive skills for daily decision-making. The MDS indicated, Resident 2 required partial to moderate assistance (helper does less than half the effort) with oral hygiene, toileting, hygiene, and showering/bathing. During a review of Resident 1's care plan titled, Resident has a behavior problem: Defecating and urinating on a floor, initiated on 3/14/2024, the care plan indicated the goal for Resident 1 was to have fewer behavioral episodes weekly by the target date 6/15/2024. The care plan indicated the interventions included to intervene as necessary to protect the rights and safety of others, remove Resident 1 from the situation (unspecified), to take the resident to alternative location as needed, monitor behavior episodes, and attempt to determine underlying cause, and consider location, time of day, person involved and situation. During a review of Resident 1's Nursing Progress Notes (NPN) dated 4/18/2024 and timed at 7:32 a.m., the NPN indicated Resident 1 tried to get out of the facility, was physically aggressive toward staff when redirected, pacing (walk at a steady and consistent speed back and forth) the entire night and making sexual comments to staff. During a review of Resident 1's NPN dated 4/18/2024 and timed at 2:02 p.m., the NPN indicated Resident 1 was on monitoring for increased agitation, verbal, and physical aggression. The NPN indicated Resident 1 was not cooperative with care and refused medication. Resident 1 was sent out to a GACH on 5150 hold. During a review of Resident 1's Admission record dated 4/26/2024, the Admission Record indicated Resident 1 was readmitted back to the facility from the GACH and was placed in the same room with Resident 2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's change of condition ([COC]-a sudden change from the resident's baseline) note dated 4/27/2024, the COC indicated around 4:15 a.m., Resident 1 was observed sitting on the floor at the foot of his bed and leaning with his back against the wall. The COC indicated Resident 1 verbalized Resident 2 hit him on the face and he fell on the floor. The COC indicated Resident 1 sustained a left upper eye lid cut and the right lower arm skin tear from the fall. During a review of Resident 1's Physician's Order Summary Report dated 4/27/2024, the Physician's Order Summary Report indicated the following orders: 1. Cleanse left upper eyelid cut with Normal Saline (cleansing solution) gently pat dry, then leave it open to air every day and as need daily for 14 days. 2.Cleanse skin tear to the right lower dorsal (back) arm with Normal Saline gently pat dry then cover with foam dressing daily and as needed for 14 days. 3.Computerized Tomography scan ([CT]- diagnostic imaging procedure) of the head. During a review of Resident 1's GACH Emergency Department (ED) note dated 4/27/2024, the GACH ED' note indicated Resident 1 was brought in by ambulance from the facility for evaluation of head injury status post (after) assault (physical attack). The ED note indicated, Resident 1 was punched in the face five times, mainly around the left eye, which caused Resident 1 to fall on the ground. The ED note indicated, Resident 1 hit his head on the wall, slid down and fell , landing on his right elbow on the floor. The ED note indicated, Resident 1 experienced the left eye pain, left eye swelling, and right elbow pain. During a review of Resident 1's NPN dated 4/30/2024, the NPN indicated Resident 1 had the left periorbital (around the eye) swelling with discoloration, left upper eyelid cut and the right forearm multiple skin tears. During a review of Resident 2's care plan titled, Alleged altercation per another roommate (Resident 3) on 4/11/2024, initiated on 4/11/2024, the care plan indicated the goal for Resident 2 was not to have further altercations with another residents by target date of 7/4/2024. The care plan intervention included to continue to provide 1:1 sitter (constant observation by a staff member for the residents and companions safety) until Resident 2 discharged , administer medication as ordered, send to the hospital for behavior management, and separate Resident 1 and Resident 3 immediately to prevent further altercation. During a review of Resident 2's COC dated 4/11/2024, the COC indicated Resident 2 took Resident 3's walker threw the walker toward Resident 3's direction and punched him on the forehead. The COC indicated, the facility informed the psychiatrist (a physician specialized in mental illness) and had an order to transfer Resident 2 to a GACH. During a review of Resident 2's GACH record, dated 4/12/2024, indicated Resident 2 was presented on a 5150 hold for danger to others. The GACH's clinical record indicated Resident 2 was placed on 5150 hold for aggression towards other residents. The GACH's record indicated, upon one-to-one interaction with nursing staff on admission to the GAHC Resident 2 remained silent, refused to cooperate with admission process, and remained unpredictable for violence. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's Psychiatric Progress Note from the GACH, dated 4/20/2024, indicated, Resident 2 was still very disorganized in thought process and was unable to engage in any reality-based conversation. The Psychiatric Progress Note indicated Resident 1 will continue to require ongoing psychiatric management in a structured environment such as GACH. During a review of Resident 2's COC dated 4/27/2024 indicated Resident 2 had alleged physical altercation with Resident 1, his roommate. The COC indicated when Resident 2 was asked what happened he did not respond. The COC indicated Resident 2 was placed on 1:1 sitter observation for safety. During a review of Resident 2's care plan titled, Resident 2 had a behavior problem of refusing all care and medications, spitting on the floor and spreading feces on the facility walls, initiated on 4/25/2024, the care plan indicated the goal for Resident 2 was to have fewer episodes of refusing care, spitting on the floor, refusing medications, and spreading feces on the wall daily/weekly by a target date of 7/04/2024. The care plan intervention included to monitor Resident 2 behavioral episodes and attempt to determine underlying causes, consider location, time of day, persons involved, and situations, and document behavior and potential causes. During an interview on 5/9/2024 at 10:40 a.m., a Certified Nursing Assistant (CNA 1) stated Resident 2 was very short tempered and shout at the facility's staff. CNA 1 stated, Resident 1 was very hard to take care of because he was getting mad when he was asked a question. CNA 1 stated, it was not safe for Resident 2's door to be close for safety. CNA 1 stated, he should have done more frequent visual check every 1-2 hours and get another nurse to check Resident 2 for safety. During a concurrent observation and interview on 5/9/2024 at 11:08 a.m., Resident 1 was observed with dry dark scabs on his right forearm and light discoloration under his left eyelid. Resident 1 stated, he remembered about the alleged incident with Resident 2. Resident 1 stated, on the day of the incident (4/27/2024), Resident 1 used the bathroom and on the way back to his bed he noticed Resident 2 was closing the room door and started punching Resident 1's face. Resident 1 was observed with increased tone of voice. Resident 1 stated he did not feel safe and felt scared when he thought about the incident. During an interview on 5/9/2024 at 10:30 a.m., the Social Service Director (SSD) stated Resident 2 had another altercation with another resident (Resident 3) on 4/11/2024 when Resident 2 took Resident 3's walker in the hallway and threw it towards Resident 3's direction. The SSD stated Resident 2 was sent out to the hospital via Psychiatric Emergency Team ([PET] a mobile [NAME] operated by psychiatric hospitals) on 5150 hold. The SSD stated Resident 2 was physically violent toward Resident 1. The SSD stated Resident 1 had a bruise on his left eye at that time. The SSD stated upon police arrival on 4/27/2024 to the facility, Resident 1 wanted to press charges against Resident 2, and Resident 2 was detained by the police. During an interview on 5/9/2024 at 11:40 a.m. CNA 2 stated on the days she took care of Resident 2 (dates unknown), the resident was getting angry and was aggressive toward other residents and staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/9/2024 at 11:56 a.m., the Registered Nurse Supervisor (RNS 1) stated based on Resident 2's diagnoses of mental illnesses and history of aggressive behavior toward other residents, the facility staff should make frequent rounds every hour or two hours and ensure the room door was not close to check on residents' safety and prevent possible altercation between Resident 1 and Resident 2. During a phone interview on 5/09/2024 at 12:27 a.m. CNA 3 stated she heard a loud sound, like something fell on the ground. CNA 3 stated she ran to check where the sound came from when she reached Resident 1 and 2's room, the door was close. CNA 3 stated, when she attempted to open the door, it was hard to open and felt like someone was pushing against the door. CNA 3 stated she had to call for help to open Resident 1 and Resident 2's room door. CNA 3 stated when the door was opened, she saw Resident 1 was sitting on a floor next to his bed, leaning towards the right side of his body. CNA 3 stated Resident 2 was standing next to the door. CNA 3 stated, Resident 1 looked very scared. CNA 3 stated Resident 1 verbalized Resident 2 punched him. CNA 3 stated Resident 2's facial expression looked like the one that conveys anger or frustration. CNA 3 stated, around 11 p.m. Resident 1 was observed sleeping in bed. CNA 3 stated Resident 2 was observed pacing inside the room and outside of the room. CNA 3 stated the last time she checked on Resident 1 and Resident 2 was 11 pm. CNA 3 stated that Resident 2 had no 1:1 sitter on 4/27/2024 to prevent the altercation between Resident 1 and Resident 2. During a phone interview on 5/9/2024 at 12:50 p.m. the Licensed Vocational Nurse (LVN 1) stated when they were trying to open Resident 2's room door it was hard to open as if someone was pushing against it. LVN 1 stated when the door was finally opened Resident 1 was observed sitting on the floor. LVN 1 stated upon assessment Resident 1 had a skin tear on his right lower arm, and laceration of his left eyelid approximately 1.5 centimeters ([cm] a unit of measurement) long on his left eyelid. LVN 1 stated Resident 1 and Resident 2 last checked was around between 12 1 a.m. on 4/27/2024. LVN 1 stated the incident happened around 4 a. m. on 4/27/2024. LVN 1 stated, staff should make rounds often at least every 2 hours especially Resident 1 and 2 who have history of aggressive behavior toward other residents and staff, and to assess and monitor their behavior such as anxiety, restlessness, verbal agitation, or pacing and to ensure safety of both residents. During a concurrent interview and record review on 5/13/2024 at 9:10 a.m., with the Director of Nursing Service (DON), the DON stated Resident 2 had a history of alleged physical aggression towards other residents when Resident 2 threw a walker towards the direction of Resident 3 and punched Resident 3 in the hallway. The DON stated based on Resident 2's history of physical aggression toward other residents the facility should have assess and consider who could be the roommate for Resident 2 to prevent any trigger, outburst, and anger. The DON stated the facility staff should have monitored Resident 2's behavior every shift for the first 72 hours of readmission to the facility for any outburst of anger, and monitor behavior every 2 hours. The DON stated the facility will move Resident 2 to room closer to the nursing station to monitor the resident's facial expression, body language, and pacing or any environment that can bother Resident 2. The DON stated the facility should have assessed if Resident 1 would be compatible to be in one room with Resident 2 who had a history of aggressive behavior. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Abuse-Prevention, Screening, & Training Program, revised 07/2018, the P&P indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment which is physical punishment used to correct and/or control behavior. The facility conducts resident pre-admission, admission, and ongoing assessments (screening) and care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect.