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	09/10/2024

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 45269 Based on observation, interview, and record review, the facility failed to protect the resident rights to be free from physical abuse for two of six sampled residents (Resident 2 and Resident 4). The facility failed to: 1. Ensure Certified Nursing Assistant (CNA 1) separated Resident 1 and Resident 2 immediately when the two residents were arguing over a wheelchair which resulted to Resident 1 throwing a coffee cup to Resident 2's right side of the head. Resident 1 had a recent history of resident-to-resident altercation last June 2024 and Resident 2 had a known aggressive behavior against staff and residents. 2. Protect and prevent Resident 3 from hitting Resident 4 on the face. These failures resulted in Resident 2 sustained a skin abrasion (superficial skin wound) on the right side of the head and Resident 4 getting hit on the face and fell on the floor. Findings: 1.During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia(serious mental illness that affects how a person thinks, feels and behaves), schizoaffective disorder (a mental condition characterized by abnormal thought processes and unstable mood) and chronic obstructive pulmonary disease (COPD, group of lung diseases causing restricted airflow and breathing problems). During a review of Resident 1's History and Physical (H&P) dated 7/3/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions due to diagnosis of schizophrenia. During a review of Resident 1's Minimum Data Set ([MDS] a comprehensive assessment and care screening tool) dated 7/24/2024, the MDS indicated Resident 1was independent with bed mobility, eating, transferring from bed to chair, toileting hygiene and personal hygiene. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Change of Condition Evaluation (COC, a sudden clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember), behavioral, or functional condition) dated 6/21/2024, at 7:40 a.m., the COC indicated Resident 1 pushed and hit a resident (unknown) on the chin when the staff was passing coffee in the hallway. During a review of Resident 1's COC Evaluation dated 8/31/2024, at 7:31 a.m., the COC indicated Resident 1 was receiving coffee in the hallway and saw Resident 2 sitting on the chair. The COC indicated Resident 1 told Resident 2 to get up and then threw the coffee cup which landed at the right side of Resident 2's head. The COC indicated Resident 2 had a small abrasion on the right side of his head. During a review of Resident 1's Care Plan titled Aggressive behavior related to schizophrenia initiated 2/23/2024, indicated Care Plan's goal of Resident 1 will not harm self or others. The Care Plan interventions indicated including intervene before agitation (state of anxiety) escalates, to guide away from source of distress and engage calmly in conversation. During a review of Resident 1's Care Plan titled Recent episodes of altercation with another resident initiated 8/31/2024, the Care Plan goal indicated the resident will not have any changes in mood, behavior, and socialization. The Care Plan's interventions included educating all staff about triggers, de-escalation (to become less dangerous) and signals of the onset of agitation. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (associated with episodes of mood swings ranging from feeling very low and feeling very high or overactive) and unspecified dementia (loss of cognitive functioning such as thinking, remembering, and reasoning which can affect and interfere with daily life and activities). During a review of Resident 2's H&P dated 8/8/2024, the H &P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had impaired cognition and was independent with bed mobility but required set up or clean up assistance (helper sets up or cleans up) with eating and personal hygiene. During a review of Resident 2's COC Evaluation dated 8/31/2024, timed at 8:30 a.m., the COC Evaluation indicated Resident 2 was sitting in a chair when Resident 1 told him to get up and then threw the coffee cup towards Resident 2's right side of the head. During a review of Resident 2's Nursing Progress Notes dated 8/18/2024 timed at 9:08 p.m. the Nursing Progress Notes indicated Resident 2 was verbally aggressive and an increased in agitation was noted. The Nursing Progress Notes indicated resident was pacing in and out of his room to the hallways with non-stop swearing while walking back and forth. During a review of Resident 2's Nursing Progress Notes dated 8/28, and 8/29/2024, the Nursing Progress Notes indicated Resident 2 was being monitored for verbal aggression and increased agitation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Care Plan titled Resident-to-resident altercation initiated 8/31/2024, the Care Plan's goal indicated the resident will have no further episodes of resident-to-resident altercation through the review period. The Care Plan's interventions included to monitor interactions and encourage group and social activities of choice. During a concurrent observation and interview on 9/9/2024, at 9:05 a.m. with Resident 2 in Resident 2's room, observed Resident 2 appeared clean and was walking back and forth in the room and hallways. Resident 2 stated he remembered getting hurt but refused to talk about the altercation with Resident 1. During an interview on 9/9/2024, at 9:06 a.m. with Resident 5, Resident 5 stated all the nurses were aware of Resident 2's behavior of yelling and screaming in their room and hallways. During a concurrent observation and interview on 9/9/2024, at 9:35 a.m. with Resident 1 in the room of Resident 1, observed Resident 1 was lying in bed, wearing a pair of sneakers and clean pajama and long sleeves. Resident 1 stated he could not remember what happened, got up from the bed and stepped out of the room in a hurry. During a telephone interview on 9/9/2024, at 10:32 a.m. with Certified CNA1, CNA 1 stated she was in the hallway and saw Resident 1 was sitting on a wheelchair and got up to ask for coffee. CNA 1 stated Resident 2 sat on the wheelchair where Resident 1 was sitting and when Resident 1 got back Resident 2 was sitting on the wheelchair. CNA 1 stated she saw Resident 2 arguing with Resident 1 and told Resident 2 to get up from the wheelchair. CNA 1 stated Resident 1 threw the coffee cup to Resident 2. CNA 1 screamed at Resident 1 to stop. CNA 1 stated did not separate them when both residents are arguing about the wheelchair because she was scared. CNA 1 stated felt scared considering Resident 1's physical built and knew how Resident 1 would snap out of nowhere and could get aggressive towards others. CNA 1 stated Resident 1 and Resident 2 were not listening to her and continued to argue. CNA 1 stated she went to get help, but no one was available but saw Licensed Vocational Nurse (LVN1) went in between the two residents and separated them. CNA 1 stated Resident 2 liked to pace around the facility, ask for food, and sometimes talking to himself or cursing while Resident 1 could get aggressive if someone was on his face. CNA 1 stated she should have separated Resident 1 and Resident 2 when they were arguing about the chair and redirected them so it would not escalate in Resident 1 throwing a coffee cup to Resident 2. During an interview on 9/9/2024, at 2:51 p.m. with CNA 4, CNA 4 stated they were short of staff on 8/31/2024 (7 a.m. to 3 p.m.) shift because a CNA (unknown) called off and was sick. CNA 4 stated she heard the commotion but was not able to help because she was in another resident's room provident personal care. CNA 4 stated she heard Resident 1 yelling but could not leave her resident. CNA 4 stated she had a lot of residents assigned to her on 8/31/2024 and when she came to check what was happening, LVN 1 was already taking care of the situation and had separated Resident 1 and Resident 2. During a telephone interview on 9/9/2024, at 12:32 p.m. with LVN 1 stated she separated Resident 1 and Resident 2. LVN 1 stated Resident 2's head was hurting and was bleeding on the right side of the head after the altercation with Resident 1. LVN 1 stated residents (in general should be separated right away to prevent altercation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During a review of Resident 3's Admission Record , the Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including paranoid schizophrenia (mental illness characterized by a pattern of behavior where a person feels distrustful and suspicious of other people and surroundings) and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities causing impairment in daily life). During a review of Resident 3's H&P dated 7/2/2024, the H &P indicated Resident 3 was able to make decisions for activities of daily living (ADL, basic self-care tasks that people perform every day). During a review of Resident 3's MDS dated [DATE], MDS indicated Resident 3 had impaired cognition and was independent with eating, and bed mobility. During a review of Resident 3's Care Plan titled Physical altercation with other resident initiated 9/6/2024, the Care Plan's goals indicated the resident will be able to express emotions of physical altercation. The Care Plan's interventions included encouraging alternate dispute resolution by talking versus violence. The Care Plan interventions indicated providing safe and hazard-free environment to the resident and transfer to general acute hospital (GACH) for psychiatric evaluation (relating to mental illness and treatment). During a review of Resident 3's Care Plan titled Physical aggression manifested by inappropriately touching female staff related to poor impulse control, the Care Plan's goal indicated the resident will not harm self or others and will seek out staff when agitation occurred. The Care Plan's interventions included analyzing times of day, places, circumstances, triggers, and what deescalates behavior and document. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, generalized anxiety disorder and seizure (sudden, uncontrolled burst of electrical activity in the brain that can cause changes in behavior, movements, feelings, and level of consciousness). During a review of Resident 4's H & P dated 8/3/2024, the H & P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 was independent with bed mobility, chair/bed-to-chair transfer, sitting and standing. During a review of Resident 4's COC Evaluation dated 9/6/2024 timed at 5:30 p.m., the COC indicated the Registered Nurse Supervisor (RNS) noted a staff member at the hallway yelling stop and Resident 4 was hit on the face by Resident 3 who was hallucinating (experiencing a sensory perception that is not real). During a review of Resident 4's Care Plan titled Allegation of physical altercation with other resident initiated on 9/6/2024, the Care Plan's goal indicated the resident will have no further episodes of physical altercation. The Care Plan's interventions included providing safe, hazard free environment and transfer to GACH for further evaluation and treatment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/9/2024, at 4:08 p.m. in Resident 4's room, Resident 4 was lying in bed, wearing a soft helmet with periorbital redness or discoloration on her right eye. Resident 4 got up immediately when asked questions regarding the altercation and observed involuntary movements of both arms and hands while walking out of her room. During a telephone interview on 9/10/2024, at 4:44 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated Resident 4 was punched on the face by Resident 3 while walking towards her. CNA 2 stated he ran towards Resident 4 as soon as she fell down the floor together with other staff members. CNA 2 stated Resident 4 did not do anything to Resident 3 to provoke the incident or make Resident 3 angry. During an interview on 9/9/2024, at 3:33 p.m. with CNA 6, CNA 6 stated he was assigned to Resident 4 on that day but did not know what happened between Resident 3 and Resident 4's altercation because he was in another resident's room. CNA 6 stated Resident 4 had redness on her right eye and ice pack was applied. CNA 6 stated he monitored Resident 4 and instructed her not to get near Resident 3. CNA 6 stated Resident 4 looked afraid and scared after the incident and stayed in her room. During an interview on 9/10/2024, at 8:38 a.m. with DSD, DSD stated Resident 3 does not like getting close to by anyone and on that day Resident 4 came close to Resident 3 when they crossed paths. DSD stated she was in her office but was doing something else and was not really looking at both residents when it happened. During an interview on 9/10/2024, at 11:23 a.m. with Director of Social Service (DSS), DSS stated she spoke to Resident 3 after the incident and told her You can go. DSS stated Resident 3 would only talk if she wanted to and liked to stay near the Nursing Station. DSS stated it's important to conduct monitoring of behavior to ensure residents will be safe and will receive adequate care. During a telephone interview on 9/10/2024, at 2:27 p.m. with RN Supervisor (RNS1), RNS 1 stated he was at the desk in the Nursing Station when the incident happened on 9/6/2024 and rushed to the scene. RNS 1 stated the DSD and CNA 2 separated Resident 3 and Resident 4. RNS 1 stated Resident 3 had paranoid schizophrenia and Resident 4 had some tics (compulsive, repetitive movement that's often difficult to control) or movements on her hands and arms which probably made Resident 3 thought she was getting attacked by Resident 4 and this led to Resident 3 hitting Resident 4. RNS 1 stated when he talked to Resident 3, the resident told him that Resident 4 was touching her. RNS 1 stated monitoring of residents with behavioral problems, decluttering the hallway, reporting of any change of behavior, anticipating residents' needs and placing a CNA in the hallway will help ensure safety and prevention of injury of residents. During an interview on 9/10/2024, at 4:00 p.m. with the Director of Nursing (DON), the DON stated the facility needed to monitor residents' behavior properly to prevent injury or altercation. The DON stated the staff should have intervened and separated Resident 1 and Resident 2 when the residents were arguing over the chair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled Abuse-Prevention, Screening, & Training Program revised 7/2018, the P&P indicated the facility conducts resident pre-admission, admission and ongoing assessments and care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect. The P&P indicated the facility maintains adequate staffing on all shifts to ensure that each resident's needs are reasonably met. The P&P indicated the facility will identify, correct, and intervene in situations in which abuse, neglect, exploitation is more likely to occur. During a review of facility's P&P titled Resident-To- Resident Altercations revised 11/2015, the P&P indicated the facility will observe residents for aggressive or inappropriate behavior toward other residents, family members, visitors, or Facility Staff. The P&P indicated if after carefully evaluating the situation and determined that care cannot be readily given within the facility, transfer the resident.