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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>056042                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>02/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Bay Vista Healthcare & Wellness Centre, LP                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5901 Downey Ave<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                 |
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 1) was not physically assaulted by another resident (Resident 2).</p> <p>This deficient practice resulted in Resident 1 sustaining a laceration (a deep, jagged tear or cut in the skin, often caused by a sharp object or blunt trauma, resulting in an irregular wound that could bleed significantly) to his right hand between his right thumb and right pointer finger, that required eight sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision) and abrasions (a minor injury to the skin that occurs when the skin is rubbed or scraped) to his right forearm, right knee and left knee.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including metabolic encephalopathy (a brain disorder that occurs when there is a chemical imbalance in the blood caused by an illness), and gait and mobility abnormalities (changes in a person's walking patterns or balance that occur because of problems in the body).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/18/2025, the MDS indicated Resident 1 was able to make decisions that were consistent and reasonable, and he was independent ambulating (the act of walking and moving about) and transferring from bed/chair to chair in the facility.</p> <p>During a review of Resident 1's Change of Condition Evaluation (COC) dated 2/8/2025 and timed at 10:38 a. m., the COC indicated Resident 1 was hit on his hand by Resident 2 with a Wet Floor sign (a sign placed on a slippery/wet floor to alert people of a fall risk, typically measuring 25 inches tall by 11 inches wide) and sustained a cut to his right hand between his thumb and second finger requiring sutures. The COC indicated Resident 1 complained of pain rated two out of 10 on a pain rating scale (an eleven-point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain), to his right hand.</p> <p>During a review of Resident 1's Transfer Form dated 2/18/2025 and timed at 10:54 a.m., the Transfer Form indicated Resident 1 was transferred to a General Acute Care Hospital (GACH) because of a cut on his right hand between his thumb and second digit (finger).</p> <p>(continued on next page)</p> |                                                                                      |                                                 |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>                                                   | <p>During a review of Resident 2's Admission Record (Face sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including paranoid schizophrenia (a type of mental disorder that involves extreme feelings of paranoia [suspicions], delusions [false beliefs], hallucinations [seeing or hearing things that are not there], disorganized speech and behavior, difficulty concentrating, feelings of being controlled by someone and suicidal thoughts and behaviors).</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was able to make decisions that were consistent and reasonable and required partial to moderate assistance with walking in the facility.</p> <p>During a review of Resident 2's COC dated 2/8/2025 and timed at 10:19 a.m., the COC indicated Resident 2 had behavioral symptoms that included agitation (restless moving, shouting, twitching and jerking of the body) and psychosis (a condition when a person's thoughts and perceptions are disrupted, with difficulty recognizing what is real and what is not). The COC indicated Resident 2 was aggressive and went inside Resident 1's room, hit Resident 1 with a Wet Floor sign cutting Resident 1's right hand between his thumb and second finger.</p> <p>During a review of the GACH's Patient Education and Visit Summary dated 2/8/2025 and timed at 11:26 a.m., the Patient Education and Visit Summary indicated Resident 1 was brought to the GACH by paramedics for treatment because of a right-hand laceration after being assaulted by his roommate. The GACH Visit Summary indicated Resident 1's right hand laceration was sutured.</p> <p>During an interview on 2/12/2025 at 2:14 p.m., Resident 1 stated on 2/8/2025 around 10:30 a.m., he was in his room taking a nap, when Resident 2 came into his room screaming and accusing him (Resident 1) of killing her family. Resident 1 stated he was shocked and scared when Resident 2 hit him with a Wet Floor sign on his right hand/arm, right knee and left leg. Resident 1 stated he had injuries to his right hand, right forearm, right knee and left knee. Resident 1 stated multiple staff came to help him and to stop Resident 2 from hitting him, but it was too late because he was already hurt and bleeding badly from the cut on his right hand. Resident 1 stated his right hand was painful to touch and he was worried if his hand would function after this injury.</p> <p>During an interview on 2/13/2025 at 11:02 a.m., Certified Nursing Assistant 2 (CNA 2) stated on 2/8/2025 at around 10:30 a.m., she was in another resident's room washing her hands when she heard Resident 2 screaming angrily in a foreign language. CNA 2 stated she immediately when to check on Resident 2 and saw Resident 2 at the foot of Resident 1's bed and CNA 1 and a housekeeper (HK) trying to remove the Wet Floor sign from Resident 2's hands. CNA 2 stated Resident 1 was bleeding from his right hand.</p> <p>During an interview on 2/13/2025 at 11:32 a.m., the HK stated during the morning shift (unsure of the time) on 2/8/2025 she was cleaning a resident's bathroom when she heard a resident (Resident 2) screaming loudly. The HK stated she walked to the hallway and saw Resident 2 screaming angrily in a foreign language in front of Resident 1's room. The HK stated she saw Resident 2 enter Resident 1's room, pick up a Wet Floor sign and hit Resident 1 with the sign many times. The HK stated she asked for help and she and CNA 1 went inside Resident 1's room to stop Resident 2 from hitting Resident 1.</p> <p>(continued on next page)</p> |                                                                                      |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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Form Approved OMB  
No. 0938-0391

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>During a telephone interview on 2/13/2025 at 12 p.m., Licensed Vocational Nurse (LVN) 2 stated she was at the nursing station when she heard screaming and yelling coming from a resident's room. LVN 2 stated she went into Resident 1's room and observed CNA 1 telling Resident 2 to stop hitting Resident 1 while directing Resident 2 to leave the room.</p> <p>During an observation on 2/13/2025 at 12:51 p.m. in Resident 1's room, with Treatment Nurse 1 (TXN 1), Resident 1's right hand was observed with eight sutures and there were multiple dark purple discolorations to the palm of Resident 1's right hand surrounding the laceration/sutures and on the back of his right hand.</p> <p>During a telephone interview on 2/13/2025 at 1:13 p.m., CNA 1 stated she was providing care to another resident when she heard someone say shut up in a loud voice and saw Resident 2 run across the hallway into Resident 1's room. CNA 1 stated she saw Resident 2 pick up a Wet floor sign and hit Resident 1 with it.</p> <p>During an interview on 2/13/2025 at 4:35 p.m., the Administrator (ADM) stated it was everyone's responsibility to ensure residents were safe and free from any abuse.</p> <p>During a review of the facility's Policy and Procedure (P/P) titled Abuse-Prevention, Screening, &amp; Training Program revised 7/2018, the P/P indicated the facility does not condone any form of resident abuse.</p> |                                                                                      |                                                 |