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	04/04/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview and record review, the facility failed to ensure the resident, who had a history of banging her head on the wall, did not banged her head on the wall and sustained an injury for one of three sampled resident (Resident 1). The facility failed to: 1. Ensure a Certified Nursing Assistant (CNA) 1, who was assigned to provide Resident 1 with 1:1 (a constant observation provided by a care giver/sitter) supervision for safety, prevented Resident 1 from walking towards the wall and start banging her head on the wall. 2. Ensure CNA 1 was informed and had knowledge of Resident 1's behavior of banging her head on the wall. 3. Ensure the facility's policy and procedure (P&P) titled, Resident Safety, dated 4/15/25, which indicated, the purpose is to provide a safe and hazard free environment was followed. These failures resulted in Resident 1 banging her head on the wall and falling on the floor sustaining laceration (a deep cut or tear in the skin) on the left forehead (the left [NAME] of the front head) requiring six sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision [surgical cut]). On 3/26/25 at 2:47 p.m. Resident 1 was transferred to the General Acute Care Hospital (GACH) for evaluation and treatment. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (is a type of schizophrenia [mental illness that is characterized by disturbance in thoughts] characterized by prominent delusions {these are fixed, false beliefs that are not based on reality}, hallucinations, (sensory experiences that are not real, such as hearing voices or seeing things that aren't there), anxiety disorders (excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life), chronic obstructive pulmonary disease (COPD a chronic lung disease causing difficulty breathing). (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 2/15/2025, the MDS indicated Resident had severe impairment in cognitive skills (ability to think, understand, learn, and remember) for daily decision-making. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) from staff for activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting) and with transfers between surfaces. During a review of Resident 1's Physician's Order Summary dated, 3/11/25, the Physician Order Summary indicated a physician's order on dated 3/11/25 for Resident 1 to have a care companion in the room and line of sight in the hallway/outside of room for safety. During a review of Resident 1's care plan titled, Resident 1 bangs head on the wall initiated on 03/12/25 and revised on 03/27/25, the care plan indicated the goal for Resident 1 was to minimize injury related to hitting head on the wall. The care plan interventions included Resident 1 to wear helmet (used to protect resident from head injuries), as necessary when banging head on the wall for safety, install pads on walls, and continue to monitor Resident 1's behavior (banging head on the walls) causing harm to self. During review of Resident 1's care plan titled, Resident 1 is non-complaint with wearing a helmet initiated on 03/13/2025, the care plan indicated the goal for Resident 1 was to minimize injury related to hitting the head. The care plan interventions included to have a care companion in the room and line of sight for safety. During a review of Resident 1's Transfer Form dated 3/26/2025, the Transfer Form indicated Resident 1 was transferred to the GACH for evaluation and treatment related to a fall on 3/26 at 2:47 pm. During a review of Resident 1's GACH's Trauma Flow Sheet dated 3/26/25, the GACH's Trauma Flow Sheet indicated Resident 1 was brought to the ER from the facility with four-centimeter (cm-unit of measurement) long laceration to the left forehead. The GACH's Trauma Flow Sheet indicted Resident 1 received six sutures (a stitch or row of stitches holding together the edges of a wound) to the left forehead. During a review of Resident 1's Nursing Progress Notes dated 03/26/25 and timed at 8:16 pm, Resident 1 return to facility from the GACH's emergency room (ER) with sutures on the left forehead open to air with lump (a swelling or bump on or under the skin) in the middle of forehead. The Nursing Progress Notes indicated to continue with 1:1 supervision at bed side for safety. During a review of Resident 1's Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Note dated 03/27/25 and timed at 5:25 pm, the IDT Note indicated Resident 1 had a history of hitting her head on the wall. The IDT Note indicated interventions included for Resident 1 to wear a padded helmet to prevent injury, but the resident was non-compliant with wearing a helmet. The IDT Note indicated due to Resident 1's noncompliance in wearing the padded helmet, Resident 1 to have a care companion in the room and within line of sight in the hallway for safety. The IDT Note indicated the new safety measures implemented included to remove Resident 1's side table and television and pad the wall to prevent further injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During record review of Change of Condition Evaluation (COC) dated 3/31/25, the COC indicated Resident 1 had the left forehead laceration, with lump/hematoma (a solid swelling of clotted blood within the tissues) on the center of Resident 1's forehead. The COC indicated Resident 1 remains on continued frequent monitoring, and 1:1 supervision with a sitter (a caregiver who provides constant observation and is often used for residents at risk of falls or injury). During a concurrent observation and interview on 04/03/25 at 3:06 pm with Resident 1, in Resident's 1 room, Resident 1 was observed sitting in bed with 1:1 sitter (CNA 2) who was sitting in a chair by the resident's bed side. During the observation it was noted that the wall in front and all at the sides of Resident 1's bed was padded. Resident 1 was observed to have six sutures on her left forehead with no dressing over it. Resident 1 was observed to have a purple discoloration around the left eye with swelling. CNA 2 stated her responsibilities as 1:1 sitter included to keep close supervision on Resident 1 for safety and prevent Resident 1 from falling or banging her head on the walls. CNA 2 stated she was not working on the day Resident 1 bang her head on the wall and fell on the floor (3/26/25). CNA 2 stated to prevent Resident 1 from banging her head on the wall, she will sit closer to Resident 1 and will get up anytime Resident 1 gets out of bed or chair to provide safety. During a phone interview on 4/03/25 at 3:47 pm CNA 1 stated she was the 1:1 sitter for Resident 1 on 3/26/25 from 7 am to 3 pm shift. CNA 1 stated she was sitting beside Resident 1 when Resident 1 suddenly got up and walked towards the wall near the room door. CNA 1 stated Resident 1 started to hit and bang her head on the wall. CNA 1 stated she could not catch Resident 1 in time because Resident 1 got up too quickly. CNA 1 stated she was able to grab Resident 1 partway down as she was falling to the floor. CNA 1 stated she yelled for help because Resident 1 was bleeding from the front of her head. CNA 1 stated she felt bad over Resident 1's injury as it could have been prevented. CNA 1 stated that she was not informed about Resident 1 banging her head against the walls until after the incident on 3/26/25. CNA 1 stated she was told that the reason why Resident 1 required 1:1 sitter was because the resident was losing her balance and wandering (moving from place to place without a fixed plan) in the hallway. CNA 1 stated that if she had been aware of Resident 1's behavior of banging her head against the walls, she could have been more vigilant and sat closer to Resident 1 to help prevent injuries and falls. During a phone interview on 03/3/25 at 4:01 pm Licensed Vocational Nurse l (LVN 1) stated she was the charge nurse on 3/26/25. LVN 1 stated she was passing medication when she heard CNA 1 yelling for help. LVN 1 stated when she entered Resident 1's room, Resident 1 was sitting on the floor and blood was coming out of Resident 1's forehead. LVN 1 stated Resident 1 was sent to the GACH via 911 due to laceration on the forehead. During a phone interview on 3/4/25 at 4:13 pm Resident 1's Family member (FM 1) stated Resident 1's injury could have been prevented if the facility staff (CNA 1), who was watching Resident 1, paid a close attention to Resident 1. FM 1 stated she was surprised when she saw Resident 1' s face with bruises and laceration on her left forehead. During an interview on 4/4/25 at 4:03 pm the Director of Nursing, (DON) stated Resident 1 has a history of wandering and throwing herself on the floor. The DON stated the incident happened so fast, in spite CNA 1 sitting close to Resident 1, as Resident 1's behavior was unpredictable. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 04/04/25 at 4:26 pm with the Administrator (ADM) and the DON, in Resident 1's room, the ADM demonstrated on how the incident happened on 3/26/25 based on CNA 1's interview. The ADM demonstrated that CNA 1 was seated at the foot of Resident 1's bed facing the resident, who was sitting on the side of the bed. Resident 1 quickly crossed in front of CNA 1 and bang her head against the wall near the cabinet, which was located at the foot of the bed. During the observation, the distance from where Resident 1 was seated on the side of the bed to the wall near the cabinet where Resident 1 bangs her head was approximately eleven steps. The DON stated the incident could have been prevented if CNA 1 was fast enough to stop Resident 1. During a review of the facility's P&P titled, Resident Safety, dated 4/15/25, the P&P indicated the purpose of this policy is to provide a safe and hazard free environment. Residents will be evaluated on admission, quarterly and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident. During a review of the facility's P&P titled, Sitters dated 1/25/24, the P&P indicated, to assist residents who need additional observation and/or companionship in obtaining sitters or companion care.