

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Casa Bonita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  535 E Bonita Avenue San Dimas, CA 91773	

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.  (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Casa Bonita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  535 E Bonita Avenue San Dimas, CA 91773	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide care and services to prevent a fall (unintentionally coming to rest on the ground, or lower level) for one of three sampled residents (Resident 1) as indicated in the facility's policy and procedure (P&amp;P) titled, Falls and Fall Risk, Managing, by failing to:1. Implement a resident-centered fall prevention plan of care for Resident 1.2. Monitor Resident 1's response to fall prevention interventions. 3. Assess the causative factors of Resident 1's multiple falls per Resident 1's Care Plan (CP, a form where one can summarize a person's health conditions, specific care needs, and current treatments).As a result, on 9/3/2025 at 9:45 AM, Resident 1 fell onto the floor mat on the right side of the bed. Resident 1 sustained a fracture (a break or crack in a bone) in the subtrochanteric left femur extending into the less trochanter (near the left hip and upper part of the thigh bone), and a nondisplaced fracture through the right intertrochanteric region (break in the upper part of the thigh bone where the fragments remain aligned and in their normal position). Resident 1 was transferred and admitted to General Acute Care Hospital (GACH) 1 on 9/3/2025 at 10:28 AM.Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encephalopathy (brain disorder that affects normal function leading to a range of symptoms like confusion, memory problems, and physical symptoms such as tremors or difficulty walking) and type 2 diabetes (condition in which the body cannot properly store or use sugar, the body's main source of energy).During a review of Resident 1's untitled Care Plan Report (CP), date initiated5/8/2025 and revised on 6/9/2025, the CP indicated Resident 1 had altered behavior patterns related to constant attempts to get out of bed unassisted and was at risk for falls. The CP's interventions indicated to assess what may cause and trigger Resident 1's behavior; attempt to reduce/ eliminate those triggers if possible. The CP's goal was to reduce the episodes of behavior daily and minimize the risk of decline daily through the next assessment on 11/3/2025.During a review of Resident 1's Licensed Nursing Note (LNN), dated 7/24/2025 at 11:34 AM, the LNN indicated Resident 1 was found in Resident 1's room, sitting on the floor mat and holding onto the [bed's] side rail.During a review of Resident 1's Interdisciplinary Team (IDT, a group of different healthcare professionals who meet to plan, coordinate, and implement a resident's care) - Narrative - Other Concerns (IDTN), dated 7/25/2025, the IDTN indicated the interdisciplinary (two or more professionals or departments) team conference was conducted due to Resident 1's fall incident that occurred on 7/24/2025. The IDTN indicated the facility implemented the following interventions: low bed, floor mats on each side of the bed, call light within resident's reach, bed alarm, room near the nurse's station, bilateral upper side rails, physical therapy reassessment for bed mobility training, improved body mechanics, sequencing of movements, and safety with completing transfers. The IDTN further indicated to have Resident 1 out of bed with structured activities to promote socialization and engagement.During a review of Resident 1's LNN dated 8/27/2025 at 9 PM, the LNN indicated Resident 1's bed alarm was beeping, and Resident 1 was noted attempting to get out of bed and was found leaning on the bed's side rails. The LNN indicated Resident 1 had episodes of getting out of bed and attempted to self-transfer, but the LNN did not indicate the number of episodes or if the episodes had increased or decreased.During a review of Resident 1's untitled CP, date initiated 8/27/2025 and revised 8/29/2025, the CP indicated Resident 1 had altered behavior patterns related to Resident 1 attempting to get out of bed. The CP's interventions indicated to assess what may cause behavior and what may trigger Resident 1's behavior; attempt to reduce/ eliminate those triggers if possible. The CP's goal was to reduce the episodes of behavior daily through the next assessment and minimize the risk of decline daily through the next assessment on 11/3/2025.During a review of Resident 1's IDTN dated 8/28/2025, the IDTN indicated an interdisciplinary team conference was conducted due to Resident 1 sliding from the bed onto the floor mat on 8/27/2025. The IDTN indicated the facility implemented and exhausted multiple interventions to promote safety and the current plan of care would remain in place and be monitored for effectiveness. The IDTN did not indicate any new fall prevention interventions.During a review of Resident 1's Change of Condition (COC, a sudden clinically important deviation in the resident's health or functioning that requires further assessments and interventions), dated 9/3/2025, the COC indicated on 9/3/2025 at 9:43 AM, the charge nurse was in the hallway and heard Resident 1's bed alarm sounding inside Resident 1's room. The COC indicated Licensed Vocational Nurse (LVN) 2 found Resident 1 lying on the floor mat. The COC indicated Resident 1 was noted with a small skin tear on the left elbow and Resident 1 complained of</p>		