STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056291	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Bonita Convalescent Hospital	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36288 Based on interviews and record review, the facility failed to ensure five of nine sampled residents (Residents 41,30, 25, and 53) and/or their legal representatives (RP) were informed and/or provided written information about Advance Directives (AD, legal document that provides instructions regarding medical care according to the resident's wishes and only goes into effect if the resident can no longer communicate their wishes). This failure had the potential to result in lack of knowledge regarding care and treatment decision making for Residents 41, 30, 25, and 53. Findings: A. During a review of Resident 41's Admission Record (AR), the AR indicated the facility admitted Resident 41 on [DATE] with multiple diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with daily activities) and type 2 diabetes mellitus (disorder causing elevated sugar level in the blood). The AR indicated Resident 41 had Responsible Party 1 (RP 1) as the emergency contact. During a review of Resident 41's History and Physical (H&P), dated [DATE], the H&P indicated Resident 41 did not have the capacity to understand and make decisions. The H&P's portion indicating, Advanced Directive Executed, was left blank/unchecked. During a review of Resident 41's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated [DATE], the MDS indicated Resident 41 had severely impaired cognitive skills (ability to obtain and process information) for daily decision-making. During a concurrent interview and record review on [DATE] at 1:51 PM with Registered Nurse 3 (RN 3), Resident 41's medical records were reviewed. RN 3 stated RP 1 did not sign Resident 41's Advance Directive Acknowledgment [ADA, document that indicates residents and/or their legal RP were informed and/or provided written information about AD] form. RN 3 stated there was no documented evidence RP 1 was provided information regarding AD and written information on AD formulation. (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 05/30/2024
NAME OF PROVIDER OR SUPPLIER Casa Bonita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 535 E Bonita Avenue San Dimas, CA 91773	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:38 AM with the Social Services Director (SSD), the SSD stated the SSD offered AD information upon a resident's (in general) admission to the facility. The SSD stated if the H&P indicated a resident was unable to make decisions, the SSD offered the RP the AD information and/or written information on AD formulation and would have the resident and/or RP sign the Advance Directive Acknowledgment form. The SSD stated it was important to offer AD information upon admission to obtain the resident's wishes regarding his/her medical care if the resident's decision-making capacity was compromised. During a review of the facility's policy and procedure (P&P), titled Advance Directives, dated ,d+[DATE], the P&P indicated the following: 1. Prior to or upon admission of a resident, the SSD must inquire if the resident had any written AD. 2. The resident and/or resident's RP must be provided with written information that is easily understood by the resident or RP concerning the resident's right to refuse or accept medical or surgical treatment and to formulate an AD if he/she chooses to do so. 3. Written information must include a description of the facility's policies to implement ADs and applicable state law. 37662 B. During a review of Resident 30's AR, the AR indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hypertension, aphasia (loss of ability to understand or express speech, caused by brain damage). During a review of Resident 30's H&P, dated [DATE], the H&P indicated Resident 30 did not have the capacity to understand and make decisions. During a review of Resident 30's quarterly MDS, dated [DATE], the MDS indicated Resident 30 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident 30 was dependent for eating, oral hygiene, toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated Resident 30 was dependent for rolling left to right. During a review of Resident 30's physical chart (medical record), there was no ADA or AD found in Resident 30's chart. During a concurrent interview and record review on [DATE] at 12:47 PM with the SSD, the SSD stated Resident 30 had been at the facility since 2018. The SSD stated Resident 30 did not have an ADA or AD in Resident 30's chart. During a concurrent interview and record review on [DATE] at 2:32 PM, RN 2 stated the ADA should be in every resident (in general) chart so the facility staff was aware of the resident's wishes. RN 2 stated if the ADA was not in the chart, the facility staff would not be able to respect the resident's wishes. RN 2 stated Resident 30 did not have an ADA or AD in Resident's 30 chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy, titled, Advance Directives, revised on ,d+[DATE], indicated the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 42307 C. During a review of Resident 25's AR, the AR indicated, Resident 25 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing) status, gastrostomy (a surgical procedure used to insert a tube, often referred to as G-Tube [GT] through the belly that brings nutrition and/or medications directly to the stomach) status and cerebral palsy (a congenital disorder that affects movement, muscle tone, or posture). During a review of Resident 25's H&P, dated [DATE], the H&P indicated, Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's MDS, dated [DATE], the MDS indicated, Resident 25's cognitive (ability to think and process information) skills for daily decision making was severely impaired (never/rarely made decisions). During a review of Resident 25's Care Plan [CP], titled, CPR (Cardiopulmonary Resuscitation, an emergency lifesaving procedure performed when the heart stops beating), date initiated [DATE], the CP indicated, interventions included to respect resident's and/or family's wishes. D. During a review of Resident 53's AR, the AR indicated, Resident 53 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for attention to tracheostomy, encounter for attention to gastrostomy and unspecified dementia. During a review of Resident 53's H&P, dated [DATE], the H&P indicated, Resident 53 did not have the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated, Resident 53's cognitive skills for daily decision making was severely impaired. During a review of Resident 53's CP, titled, Advance Directive initiated as follows, date initiated [DATE], the CP indicated, interventions included to respect resident's and/or family's wishes. During a review of Resident 53's undated (date left blank) Advance Directive Acknowledgement (ADA), the ADA indicated, the ADA form was not filled out (left blank) and had a physician's signature only. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 1:11 PM with Registered Nurse (RN) 6, Resident 25's medical record was reviewed. RN 6 could not find an ADA form filed in Resident 25's chart. RN 6 stated, it was the responsibility of the admitting nurse and Social Service [staff] to inquire about the AD. RN 6 stated, according to the SSD (Social Services Director), there was no ADA on the chart for Resident 25. RN 6 stated, facility just started implementing the ADA earlier this year. Additionally, RN 6 stated for Resident 53, Resident 53's's husband was Resident 53's responsible party but was homeless and could not come to the facility to fill out the ADA form. RN 6 stated Resident 53 did not have an AD in Resident 53's chart and stated, it was important to have an AD so facility will know what to do with the patient, in case of emergency. During an interview on [DATE] at 1:41 PM with the SSD, the SSD stated, it was the admitting nurse who asked about [resident having an] AD upon admission and the SSD followed up. The SSD stated, the facility just implemented the ADA earlier this year. The SSD stated, Resident 25 was originally admitted 2014 and readmitted on [DATE] and the ADA form was just mailed to Resident 25's brother last week. The SSD stated, it was important to have an AD in Resident 25 and Resident 53's chart to let the facility know what the resident's last wishes and medical treatments were, if residents wanted to prolong their life, wanted CPR or to be DNR (Do Not Resuscitate). During a review of the facility's policy and procedure (P&P) titled, Advance Directives, revised ,d+[DATE], the P&P indicated, the resident had the right to formulate an AD, including the right to accept or refuse medical or surgical treatment. The P&P indicated, the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an AD if he or she chose to do so. The P&P indicated, information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record in a section of the record that is retrievable by any staff.

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F 0636

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36288

Based on interview and record review, the facility failed to ensure comprehensive assessments of the disease diagnoses, health conditions, and/or medications, were complete and accurate, for two of two sampled residents (Residents 27 & 20).

This failure had the potential to result in a decline in the residents' physical and psychosocial well-being due to inaccurate or inconsistent plan of care.

Findings:

A. During a review of Resident 27's Admission Record (AR), the AR indicated the facility admitted Resident 27 on 5/7/2021 with multiple diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with daily activities), Parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), and major depressive disorder (depression, mental disorder with persistently depressed mood or loss of interest in activities that interfere with daily life]).

During a review of Resident 27's History and Physical (H&P), dated 7/6/2023, the H&P indicated Resident 27 did not have the capacity to understand and make decisions.

During a review of Resident 27's physician order (PO), dated 7/14/2023, the PO indicated healthcare provider 1 (HCP 1) initially ordered Ativan (generic name lorazepam, medication to treat anxiety [excessive and persistent feelings of worry, fear, dread, and uneasiness that interfere with daily life]) 0.5 milligrams (mg, unit of measurement) 1 tab by mouth twice a day for generalized anxiety disorder (a mental health disorder characterized by feelings of fear, anxiety, or fear that are strong enough to interfere with daily activities) manifested by verbal outbursts screaming for help.

During a review of Resident 27's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 4/8/2024, the MDS indicated Resident 27 had moderate impairment in cognition (ability to obtain and process information). The MDS indicated Resident 27 required substantial/maximal assistance with most self-care activities and partial/moderate assistance with mobility.

During a review of Resident 27's Order Summary Report (OSR) for 5/2024, the OSR indicated the following physician's order:

1. Order Date: 10/30/2023 - lorazepam tablet 1 mg by mouth two times a day for generalized anxiety disorder manifested by verbal outburst, screaming for help and tally by hashmarks.

During a review of Resident 27's Medication Administration Record (MAR) for 5/2024, MAR indicated the following:

1. Lorazepam 1 mg 1 tablet was administered at 9 AM and at 5 PM from 5/1/2024 through 5/28/2024.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 27 had 6 episodes of verbal outbursts/screaming for help on 5/1/2024 and 8 episodes on 5/4/2024. During a concurrent interview and record review on 5/29/2024 at 10:19 AM with Registered Nurse 4 (RN 4), Resident 27's AR, physician notes, physician orders, MDS, and MARs were reviewed. RN 4 stated Resident 27's AR, MDS, dated [DATE], and MDS, dated [DATE] did not indicate Resident 27 had generalized anxiety disorder. RN 4 stated it was important to ensure accurate comprehensive MDS assessment was done for [Resident 27] to ensure appropriate care was provided. B. During a review of Resident 20's Admission Record (AR), the AR indicated the facility admitted Resident 20 on 2/6/2023 with multiple diagnoses including dementia. During a review of Resident 20's History and Physical (H&P), dated 2/9/2024, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20's MDS (MDS), dated [DATE], the MDS indicated Resident 20 had severe impairment in cognition. MDS 2 indicated Resident 20 required substantial/maximal assistance with most self-care activities and partial/moderate assistance with mobility. During a review of Resident 20's MARs from 3/2024 through 5/2024, the MARs indicated a physician's order, dated 2/27/2024, indicated to administer Ativan 0.5 mg by mouth every 8 hours as needed (PRN) for anxiety manifested by constant worrying about her health condition for 90 days. The MARs indicated the following: 1. On 3/3/2024 - Resident 20 received Ativan 0.5 mg by mouth four times. 2. On 3/4/2024 - Resident 20 received Ativan 0.5 mg by mouth four times. 3. On 3/5/2024 - Resident 20 received Ativan 0.5 mg by mouth four times. During a concurrent interview and record review on 5/29/2024 at 10:19 AM with RN 4, Resident 20's AR, MDS, physician orders, physician notes, MAR, and nursing notes were reviewed. RN 4 stated Resident 20's MDS, dated [DATE], and MDS, dated [DATE] did not indicate Resident 20 had anxiety. RN 4 stated Ativan 0. 25 mg was initially ordered for Resident 20 on 9/2023 for anxiety. RN 4 stated Resident 20's MDS, dated [DATE], did not indicate Resident 20 was on any anti-anxiety medication. During an interview on 5/30/2024 at 4:22 PM, the Director of Nursing (DON) stated the MDS nurse must physically assess the residents (in general), interview the staff assigned to the residents, interview the family member/s of the residents, and review all the resident's medical records to complete an accurate MDS assessment and determine the correct plan of treatment for the resident. During a review of the facility's policy and procedure (P&P), titled Resident Assessment, dated 4/2014, the P&P indicated the following: 1. Sources of information to complete the MDS assessment include: review of the resident's record, observation of and communication with the resident, communication with the health provider, physician, and resident's family. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Once the MDS is completed, the Interdisciplinary Team (IDT) must develop the plan of care. 3. Care plans must be updated as the resident's condition or needs change by coordinating with the physician's orders as they are received, and/or with calls to the physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to ensure resident-centered care plans (CP) related to risk of side effects of medication use for Depakote (medication used to control seizures, a sudden uncontrolled burst of electrical activity in the brain) and a CP related to Resident 2's allergies were developed for one of one sampled resident (Resident 2) in accordance with the facility's policy and procedure (P&P). This failure had the potential for Resident 2 to not receive the necessary care and services to achieve their optimal level of functioning. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (disease that occurs when a person's blood sugar is too high), generalized anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread and uneasiness) and bipolar disorder (serious mental illness that causes unusual shifts in mood). The AR indicated Resident 2's allergies were: iodine, penicillin, coconut, lemon, and shrimp. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/8/2024, the MDS indicated Resident 2 had severely impaired cognition (the ability to make daily decisions). The MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity) on staff for eating, toilet use, and personal hygiene. During a review of Resident 2's Order Summary Report (OSR), dated active as of 5/30/2024 indicated Resident 2 had a physician order for Depakote extended release 24-hour 500 mg (milligram, unit of measurement) tablet with order date 12/27/2023. During a concurrent interview and record review on 5/30/2024 at 11:40 AM with the Registered Nurse Supervisor (RNS), Resident 2's CP related to Depakote, dated 3/22/2023, was reviewed. The CP indicated interventions to monitor for cognitive impairment, tardive dyskinesia (TD - a drug induced movement disorder causing uncontrollable movements like lip-smacking), akathisia (inability to remain still), Parkinsonism Syndrome (a collection of movement symptoms that include slowness, stiffness, tremors, and balance issues) and orthostatic blood pressure (sudden drop in blood pressure upon standing from a sitting or lying down position). The RNS stated these interventions indicated in the CP should be in Resident 2's Medication Administration Record (MAR), the RNS did not find the interventions in the MAR (all monitoring is documented in the MAR). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/30/2024 at 11:56 AM with the Director of Nursing (DON), Resident 2's CP related to Depakote, dated 3/22/2023, was reviewed. The DON stated the specific interventions indicated to monitor for cognitive impairment, TD, akathisia, Parkinsonism Syndrome and orthostatic blood pressure on the CP were not being implemented but they were also not needed and it would be removed from the CP. The DON further stated the DON had just called the Facility Consultant Pharmacist (FCP) and the FCP stated these side effects did not need to be monitored because Depakote was not an antipsychotic medication and [the medication] did not typically have these side effects. During a concurrent interview and record review on 5/30/2024 at 12 PM with the MDS Coordinator (MDSC), Resident 2's CP related to Depakote, dated 3/22/2023, was reviewed. The MDSC stated the interventions indicated in the CP were not centered toward Resident 2's care and they should be. During a review of Resident 2's Order Summary Report (OSR), dated active as of 5/30/2024, indicated Resident 2 had a physician order for Insulin Aspart injection (rapid-acting medication used to control blood sugar) solution 100 unit per milliliter (ml-unit of measurement) with order date 8/1/2023 and insulin glargine (long-acting medication used to control blood sugar) 100 unit/ml with order date 4/10/2024. During a concurrent interview and record review on 5/30/2024 at 12 PM with the MDSC, Resident 2's CP related to Resident 2's allergies, dated 3/22/2023, was reviewed. The CP indicated Resident 2's allergies were penicillin, iodine, shrimp, coconut, lemon, and insulin. The MDSC stated the facility failed to develop an individualized person-centered care plan for Resident 2 as evidenced by inaccurate allergies listed on the Resident 2's CP related to Resident 2's allergies, additionally, the interventions listed for Depakote that were not implemented. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2023, the P&P indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to provide necessary care and services for one of one sampled resident (Resident 96) when Certified Nursing Assistant (CNA) 2 did not utilize a communication board when attempting to communicate with Resident 96 as indicated in the facility's Policy and Procedure (P&P) titled, Accommodation of Needs Related to Communication. This failure had the potential to result in unmet needs to Resident 96. Findings: During a review of Resident 96's Admission Record (AR), the AR indicated Resident 96 was admitted to the facility on [DATE] with severe dementia (a group of conditions, decline in mental ability, that interfere with daily activities) with agitation, hypertension (high blood pressure), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 96's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/22/2024, the MDS indicated Resident 96 was severely impaired with cognitive skills (ability to make daily decisions). The MDS indicated Resident 96 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting and dressing. During an interview on 5/28/2024 at 9:30 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 96 sometimes yelled, and CNA 1 sat next to Resident 96 until Resident 96 was calm. CNA 1 stated Resident 96 spoke a different language but also English. CNA 1 stated Resident 96 was sometimes confused and did not speak English when he was confused. During an interview on 5/28/2024 at 10:26 AM with CNA 2, CNA 2 stated Resident 96 yelled often. CNA 2 stated Resident 96 did not speak English to CNA 2. CNA 2 stated CNA 2 did not understand what Resident 96 was trying to communicate to CNA 2 when she took care of Resident 96. CNA 2 stated CNA 2 did not use a communication board when providing care to Resident 96. CNA 2 stated CNA 2 did not think staff had a communication board available [to communicate with] Resident 96. CNA 2 stated a communication board would be helpful when trying to communicate with Resident 96. During a review of Resident 96's care plan titled Resident is at Risk for Having Needs Unmet Related to Difficulty in Communication Secondary to [being] Non-English Speaking ., dated 4/17/2024, the care plan's interventions indicated the use of a communication board when communicating with Resident 96. During a review of the facility's P&P titled, Accommodation of Needs Related to Communication, undated, the P&P indicated, The facility will take reasonable steps to ensure the staff will communicate with residents to accommodate the needs of residents. The P&P indicated a procedure included, Provide communication board with written translation as indicated.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on observation, interview, and record review, the facility failed to provide care and services, for one of three sampled residents (Resident 30), to reduce the risk of developing pressure ulcer-injuries [PU/PI, localized injury to the skin and or underlying tissue usually over a bony prominence as result of pressure or pressure in combination with shear (mechanical force that cause the skin to break off) and/or friction (movement of one surface of the skin against the other]) by failing to: follow the facility's Policy and Procedures (P&P), titled, Prevention of Pressure Injuries, Pressure Sore Management, and the, Certified Nursing Assistant [CNA] Job Description, for Resident 30, who was on a low air loss (LAL, a mattress designed to distribute body weight and prevent and treat pressure wounds) mattress and who was at high risk for developing PIs. This deficient practice had the potential to result in a physical decline and the development of PIs to Resident 30. Findings: During a review of Resident 30's Admission Record (AR), the AR indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hypertension (high blood pressure), aphasia (loss of ability to understand or express speech, caused by brain damage). During a review of Resident 30's Risk for developing pressure sore, bruising, and other types of skin breakdown Care Plan (CP), dated 3/16/2023, the CP indicated the goal for Resident 30 was to minimize the risk of skin breakdown/bruising/pressure sore daily. During a review of Resident 30's H&P, dated 5/30/2023, the H&P indicated Resident 30 did not have the capacity to understand and make decisions. During a review of Resident 30's quarterly Minimum Data Set (MDS, a standardized resident assessment care planning tool), dated 3/4/2024, the MDS indicated Resident 30 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident 30 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) for eating, oral hygiene, toileting hygiene, showering/bathing, and personal hygiene. The MDS indicated Resident 30 was dependent for rolling left to right. The MDS indicated Resident 30 did not have PU/PI. The MDS indicated Resident 30 had the following skin treatments: pressure reducing device for the chair, a pressure reducing device for the bed, nutrition or hydration intervention to manage skin problems, and applications of ointments/medication other than to feet. During a review of Resident 30's Wound Risk Assessment (WRA), dated 3/6/2024, the WRA indicated Resident 30's score was 17 (a score of 8 or greater is considered high risk for skin breakdown). During a review of Resident 30's Order Summary Report (OSR), active orders as of 5/28/2024, the OSR included a physician's order (PO), dated 3/2/2024, the PO indicated Resident 30 may have a LAL mattress for wound care and skin maintenance every shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Casa Bonita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 535 E Bonita Avenue San Dimas, CA 91773	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident 30 on 5/28/2024 at 9:45 AM, Resident 30 was laying on a LAL mattress and had a sling (a device used with a mobility tool to assist with transfers of residents that have mobility challenges, allows a resident to be lifted and transferred with minimum physical effort) under Resident 30's back and a [NAME]-Lift (a mobility tool used to help lift and transfer patients safely) on the left side of Resident 30's bed. During a concurrent observation and interview on 5/28/2024 at 9:58 AM, with a certified nursing assistant 4 (CNA 4), CNA 4 stated the purpose of a LAL mattress was to prevent PIs. CNA 4 stated the facility staff taught CNA 4 that one sheet was acceptable when a resident used a LAL mattress. CNA 4 stated if there was more than one sheet, the LAL mattress would not work [to prevent] PIs. CNA 4 stated CNA 4 brought Resident 30 back to bed at 9:30 AM and was going to get Resident 30 up on the wheelchair at 10:30 AM. CNA 4 stated CNA 4 left the sling under Resident 30 because CNA 4 was going to get Resident 30 up again. CNA 4 stated if CNA 4 did not [plan] to get Resident 30 up, CNA 4 would not leave the sling under Resident 30. During an observation, Resident 30 had five layers of material between Resident 30 and the LAL mattress. The layers included: a flat sheet, chux (disposable pad that is highly absorbent and designed to protect beds, bedding, furniture, or other surfaces from incontinence [loss of bladder control] accidents or spills), cloth incontinence pad, adult diaper, and [NAME]-Lift sling. During a concurrent observation and interview with the Director of Nursing (DON) on 5/28/2024 at 10:08 AM, the DON stated CNA 4 should have removed the sling under Resident 30 after putting Resident 30 back to bed because Resident 30 was on a LAL mattress. The DON stated if the sling was [kept] under Resident 30, [this defeated] the purpose of the LAL mattress. The DON stated Resident 30 should only be [laying] on a flat sheet with an adult diaper or a flat sheet with a chux pad. The DON stated if the sling was left underneath Resident 30, Resident 30 could develop a PI. During a concurrent observation and interview with CNA 5 on 5/29/2024 at 9:34 AM, Resident 30 was laying on a LAL mattress, a flat sheet, was wearing pants, and wearing an adult diaper. CNA 5 stated Resident 30 was wearing pants, but Resident 30 should only be [laying] on a flat sheet and [wearing an] adult diaper when Resident 30 was [laying] on the LAL mattress. CNA 5 stated consistent pressure on Resident 30's buttocks could cause an opening, [put the resident at] risk of infection and development of PI. CNA 5 stated facility staff wanted to avoid and prevent those types of skin issues. During a review of the [NAME]-Lift II's (brand name) Operating Manual, dated 3/2007, the manual indicated [for the user] to back the lift away from the wheelchair, chair, etc. and remove the sling. During a review of the facility's Certified Nursing Assistant Job Description, dated 8/23/2011, the CNA Job Description indicated the CNA would utilize appropriate linens for specialized pressure-reducing beds. During a review of the facility's P&P, titled, Prevention of Pressure Injuries, revised on 3/2023, the P&P indicated to ensure that all residents will receive the proper care based on their assessments to reduce the risks for pressure injuries. During a review of the facility's P&P, titled, Pressure Sore Management, revised on 3/21/2024, the P&P indicated all available measures shall be taken to reduce skin breakdown and pressure sores.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 36288 Based on interviews and record review, the facility failed to ensure one of two sampled residents (Resident 41), who had limited range of motion (ROM, full movement potential of a joint), received the necessary rehabilitation services to maintain or prevent further decline in ROM by failing to follow up on the Occupational Therapist 2's (OT 2's, healthcare professional who involves the use of daily activities [occupations] to treat the physical, mental, and emotional ailments that impact a resident's ability perform daily tasks) recommendation to obtain an OT evaluation/treatment order on 5/30/2022. This failure had the potential to cause further decline in ROM with worsening contractures (deformity and joint stiffness) to both upper extremities (arms), which could lead to increased pain to Resident 41. Findings: During a review of Resident 41's Admission Record (AR 1), AR 1 indicated the facility admitted Resident 41 on 9/29/2020 with multiple diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with daily activities), osteoarthritis (joint disease that worsens over time), and contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and tightness of the joints) of the right elbow and right hand. During a review of Resident 41's OT Discharge Summary (OTDS), dated 10/15/2020, the OTDS indicated Resident 41 was discharged from Skilled OT and was placed on a Restorative ROM Program (nursing-based rehabilitative care aimed at maintaining and/or improving self-involvement in ADLs) with passive ROM (PROM, movement of a joint through the ROM with no effort from the resident) to both upper extremities (BUE). The OTDS indicated the recommendation for the application of right hand and right elbow splints (rigid devices used to prevent and treat contractures) with Resident 41 tolerating 5 hours of wear time, for functional maintenance. During a review of Resident 41's Minimum Data Set (MDS 1, a standardized resident assessment and care-planning tool), dated 11/28/2020, the MDS 1 indicated Resident 41 had severely impaired cognitive skills (ability to obtain and process information) for daily decision-making. The MDS 1 indicated Resident 41 had impairment in both sides of the upper and lower extremities. The MDS 1 indicated Resident 41 was totally dependent on staff for all activities of daily living (ADL, term used in healthcare that refers to self-care activities). The MDS 1 indicated Resident 41 received Occupational Therapy (OT, profession aimed to increase or maintain a person's capability of participating in everyday life activities) from 10/1/2020 to 10/14/2020. During a review of Resident 41's Joint Mobility Screening (JMS 1), dated 1/11/2022, JMS 1 indicated Resident 41 had severe ROM loss (greater than 50%) on the right wrist, right hand/fingers, right elbow, and both shoulders. JMS 1 indicated Resident 41 had minimal ROM loss on the left wrist, left hand/fingers, and left elbow. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 41's JMS 2, dated 5/30/2022, JMS 2 indicated Resident 41 had a decline in the ROM of the left wrist, left hand/fingers, and left elbow from minimal ROM loss (less than 25%) to moderate ROM loss (26% - 50% loss). JMS 2 indicated OT 2 documented Resident 41 would benefit from skilled OT eval/tx [evaluation or treatment] for contracture management and would request OT eval order. During a review of Resident 41's MDS 2, dated 4/30/2024, MDS 2 indicated Resident 41 had severely impaired cognitive skills for daily decision-making. MDS 2 indicated Resident 41 was dependent on staff for all self-care activities. MDS 2 did not indicate Resident 1 received OT in the facility. During a review of Resident 41's Order Summary Report (OSR) for 5/2024, the OSR indicated the following active RNA physician orders for BUE: 1. Order Date: 11/10/2023 - PROM to BUE daily 7 times per week as tolerated. 2. Order Date: 11/10/2023 - Application of right-hand roll daily 7 times per week for 4-5 hours a day or as tolerated. During an interview on 5/30/2024 at 9:38 AM, OT 1 stated the JMS must be conducted upon a resident's (in general) admission, readmission, yearly, and if there were any changes in the resident's condition. OT 1 stated the goal was to maintain the current ROM, mobility, and function at the highest possible level. OT 1 stated if a decline in ROM was identified in the JMS, the resident (in general) could be evaluated by rehabilitation staff, and placed on rehabilitation therapy with new goals and care plans to improve or maintain the current ROM. During a concurrent interview and record review on 5/30/2024 at 2:09 PM with the Director of Rehabilitation (DOR), Resident 41's rehabilitation notes, physician orders, JMS, and care plans were reviewed. The DOR stated Resident 41 received OT in the facility on 10/1/2020-10/14/2020. The DOR stated Resident 41 had a decline in LUE ROM during the JMS on 5/30/2022, but there was no OT evaluation/treatment ordered and/or provided to Resident 41. During a concurrent interview and record review on 5/30/2024 at 4:16 PM, Registered Nurse 5 (RN 5) stated there was no documented evidence that nursing [staff] obtained a physician's order for OT evaluation or treatment regarding the change in Resident 41's LUE ROM on 5/30/2022. During an interview on 5/30/2024 at 4:22 PM, the Director of Nursing (DON) stated if the resident had a decline in ROM, was refusing and/or not tolerating the ordered splints, had an actual skin breakdown, and was having pain, the nursing staff must consult with the rehabilitation department to obtain recommendations and/or new interventions. The DON stated nursing staff would then call the primary care physician to obtain the new orders related to the resident's ROM or mobility. The DON stated the miscommunication between nursing staff and the rehabilitation team could result in further decline for the resident's ROM and worsening of contractures. During a review of the facility's policy and procedure (P&P 1), titled Occupational Therapy, dated 2/19/2021, P&P 1 indicated the following: 1. Occupational therapy goals include, but is not limited to, reduction of physical disability and contracture management. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Occupational Therapist's must perform the application of purposeful, goal-oriented activity/activities in the evaluation, problem identification, and treatment of persons whose function is impaired by physical illness or aging process to achieve optimum functioning to prevent disability and to maintain health. During a review of the facility's policy and procedure (P&P 2), titled Joint Mobility Assessment (JMA), dated 3/21/2024, P&P 2 indicated the following: 1. The purpose of JMA was to determine the resident's ROM for all major joint and to implement plans of care to increase, maintain, or prevent deterioration of joint mobility. 2. All residents must be assessed for joint mobility limitations upon admission and at a minimum of every three months thereafter. 3. Resident care plans must be updated as necessary.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review the facility failed to ensure appropriate treatment and services were provided for three of three sampled Residents (Resident 36, 25 and 252) by failing to ensure: A.Resident 36's head of bed (HOB) was elevated to at least 30 - 45 degrees while receiving g-tube (GT, gastrostomy tube; a type of tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) feedings as indicated in the facility's policy and procedure (P&P), titled, Enteral Feeding- Safety Precautions. B - C.Residents 25 and 252, who were receiving enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) received appropriate care and services by failing to respond timely to the GT pump that was continuously beeping (alarming). These failures had the potential to result in GT complications and harm to Residents 36, 25 and 252, additionally, there was a potential for aspiration (condition in which food, liquids, saliva, or vomit is breathed into the airways) pneumonia (infection that inflames the air sacs of the lungs) to Resident 36. Findings: A.During a review of Resident 36's Admission Record (AR), the AR indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included gastrostomy placement (a surgical procedure used to insert a tube, often referred to as GT through the belly that brings nutrition and/or medications directly to the stomach) dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and gastro-esophageal reflux disease (GERD; digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]). During a review of Resident 36's History and Physical (H&P), dated 1/4/2024, the H&P indicated, Resident 36 did not have the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/27/2024, the MDS indicated Resident 36 had severe impairment in cognitive (ability to understand and process information) skills for daily decision making. The MDS indicated Resident 36 had impairment on bilateral (both sides) upper extremities (shoulders, elbows, wrists, or hands) and bilateral lower extremities (hip, knee, ankle, foot). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 36's Order Summary Report (OSR), dated active as of 5/28/2024, the OSR included a physician's order (PO), dated 12/30/2024, that indicated to elevate the HOB 30 to 45 degrees at all times during GT feeding for aspiration precautions. Additionally, the ORS included a physician's order, dated 12/31/2023, that indicated to administer Glucerna 1.2 (calorically dense formula of low glycemic [presence of sugar in the blood] and slowly digestible carbohydrates designed to help minimize blood sugar) at 65 millimeters (ml, volume measurement) per hour for 20 hours to provide 1300 ml/1560 calories per day. During a review of Resident 36's GT feeding at risk for aspiration Care Plan (CP), dated 5/20/2024, the CP indicated to keep the HOB elevated. During an observation of Resident 36 in the Resident 36's room on 5/28/2024 at 10:19 AM, Resident 36 was receiving GT feeding at 55 cc and hour (cc/hr) and Resident 36's HOB was elevated at 20 -25 degrees. During an observation of Resident 36 and concurrent interview with Licensed Vocational Nurse 1 (LVN 1) on 5/28/2024 at 10:23 AM, LVN 1 suctioned (the act of sucking, removal of solids or fluid with air) Resident 36's mouth and stated Resident 36's HOB looked about 20 to 25 degrees. LVN 1 stated the resident's HOB should be at 30 degrees or higher to avoid aspiration. During an interview with the Assistant Director of Nursing (ADON), on 5/29/2024 at 10:43 AM, the ADON stated residents receiving GT feedings could not swallow and should have the HOBs [raised] greater than 30 to 40 degrees to prevent aspiration. During an observation and concurrent interview with Licensed Vocational Nurse 4 (LVN 4) on 5/29/2024 at 4:05 PM, LVN 4 stated residents who received GT feedings were placed on aspiration precautions because [those residents] usually did not have the capacity to swallow, and the HOB [for those residents] should be at least 30 degrees [raised] when the g-tube feeding was turned on. During an interview with the Director of Nursing (DON), on 5/30/2024 at 8:24 AM, the DON stated the HOB for residents who received GT feedings must be kept at least 30 degrees or higher to prevent aspiration from the feeding or from secretions (saliva). The DON stated the HOB should be greater than 30 degrees, so the residents do not aspirate. During a review of the facility's P&P, titled, Enteral Feeding- Safety Precautions, revised on 11/2018, indicated to elevate the head of bed (HOB) at least 30 degrees during tube feeding and at least 1 hour after feeding to prevent aspiration. 42307 B. During a review of Resident 25's AR, the AR indicated, Resident 25 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including tracheostomy (a surgically created hole [stoma] in the windpipe [trachea] that provides an alternative airway for breathing) status, gastrostomy status, cerebral palsy (a congenital disorder that affects movement, muscle tone, or posture) and unspecified severe protein-calorie malnutrition (lack of sufficient nutrients in the body). (continued on next page)

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Casa Bonita Convalescent Hospital	535 E Bonita Avenue San Dimas, CA 91773

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 25's CP titled, Resident is on GT feeding, date initiated 6/2/2023, the CP indicated, interventions included to monitor GT patency every shift. During a review of Resident 25's H&P, dated 2/3/2024, the H&P indicated, Resident 25 did not have the capacity to understand and make decisions. During a review of Resident 25's MDS, dated [DATE], the MDS indicated, Resident 25's cognitive (ability to think and process information) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 25 had a feeding tube for nutritional approach. During a review of Resident 25's OSR, dated active as of 5/29/2024, the OSR indicated, an order dated 2/2/2024 for enteral feeding: Fibersourse (nutritionally complete tube feeding formula with fiber) HN 1.2 at 55cc (millimeters) per hour for 20 hours or until dose completed via pump to provide 1100 cc/1320 kcal (kilocalories, unit of heat energy) per day. The OSR indicated, an order dated 2/3/2024 to monitor GT patency every shift. During a review of Resident 25's Medication Administration Record (MAR), dated 5/2024, the MAR indicated, Resident 25 was receiving enteral feeding during the day, evening, and night shifts. C.During a review of Resident 252's AR, the AR indicated, Resident 252 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including cerebral infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), encounter for attention to gastrostomy and unspecified protein-calorie malnutrition. During a review of Resident 252's CP, titled, Resident is on GT feeding, date initiated 10/3/2023, the CP indicated, interventions included to check and maintain placement and patency of GT. During a review of Resident 252's MDS, dated [DATE], the MDS indicated Resident 252's cognition was severely impaired. The MDS indicated, Resident 252 had a feeding tube for nutritional approach. During a review of Resident 252's H&P, dated 5/24/2024, the H&P indicated Resident 252 did not have the capacity to understand and make decisions. During a review of Resident 252's OSR, dated active as of 5/29/2024, the OSR indicated, a physician's order dated 5/23/2024 for enteral feeding: Jevity (calorically dense fiber-fortified therapeutic nutrition that provides complete balanced nutrition) 1.5 at 55 cc per hour for 20 hours via pump to provide 1100 CC/1320 kcal per day. The OSR indicated, an order dated 5/23/2024 to monitor GT patency every shift. During a review of Resident 252's MAR, dated 5/2024, the MAR indicated Resident 252 was receiving the enteral feeding during the day, evening, and night shifts. During an observation on 5/28/24 at 9:42 AM., Resident 25 was nonverbal and was sitting up on a wheelchair doing a coloring activity. Resident 25 was receiving Fibersource HN tube feeding via GT and the GT pump was beeping indicating Flow Error Clog in Line Downstream of Pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/28/2024 at 10:15 AM., with LVN 6, Resident 25's GT pump continued to beep indicating Flow Error Clog in Line Downstream of Pump. LVN 6 stated, it was important to respond to the GT pump when the pump was beeping because if the GT was pump beeped, Resident 25 was not getting his feeding and that could result in weight loss, could result in clogging up the GT and cause more complications [to Resident 25]. During an observation and interview on 5/28/2024 at 10:22 AM., with Certified Nursing Assistant (CNA) 7, Resident 252 was awake in bed and receiving Jevity tube feeding via GT. The GT pump was beeping indicating Flow Error Clog in Line Downstream of Pump. Resident 252 stated, the GT pump had been beeping a long time. The HFEN (Health Facilities Evaluator Nurse) had to asked CNA 7 to get a licensed staff to check the GT pump. During a concurrent observation and interview on 5/28/2024 at 10:30 AM., with LVN 2, Resident 252's GT pump was beeping indicating Flow Error Clog in Line Downstream of Pump. LVN 2 stated, it was important to respond to the GT pump alarm to ensure Resident 252 was getting his feeding. LVN 2 stated [not responding to a GT alarm] could [result in] the GT getting clogged, complications, and could result in the replacement of the GT. During an observation on 5/28/2024 at 10:41 AM., Resident 252's GT pump was beeping. During an observation on 5/28/2024 at 11:10 AM., Resident 252's GT pump continued to beep, HFEN had to get an unidentified staff to check the GT pump. During a review of the facility's P&P titled, Enteral Tube Feeding via Continuous Pump, date revised November 2018, the P&P indicated, to ensure the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or this facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based an observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 61) received proper respiratory (relating to breathing) care such as oxygen (02 [a colorless, odorless, tasteless gas essential for living]) therapy to meet Resident 61's needs and in accordance with the physician's order. This failure resulted in Resident 61 receiving 02 therapy at a lower level and had the potential to result in compromised respiratory status (the movement of air in and out of the lungs and exchange of carbon dioxide [a colorless, odorless gas] and 02 at the alveolar level [alveoli, the functional units of the lung with the overall task to warrant gas exchange, i.e., 02 supply and carbon dioxide removal from the body]) to Resident 61. Findings: During a review of Resident 61's Admission Record (AR), the AR indicated Resident 61 was admitted to the facility on [DATE] with multiple diagnoses including respiratory failure, unspecified with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), tracheostomy (a surgically created hole [stoma] in the windpipe [trachea] that provides an alternative airway for breathing) status and anoxic brain damage (when your brain loses oxygen supply). During a review of Resident 61's Care Plan (CP), titled, Respiratory Care, date initiated 3/1/2023, the CP indicated interventions that included Fi02: 2 LPM with humidifier via t-bar and monitor 02 saturation, titrate Fi02 to keep Sp02 greater than 92%. During a review of Resident 61's CP, titled, Resident is at risk for respiratory distress, date initiated 3/1/2023, the CP indicated, interventions included monitor oxygen saturation as needed/ordered, tritrate Fi02 to keep 02 greater than 92% and apply oxygen as needed/ordered, 2 LPM via t-bar. During a review of Resident 61's History and Physical (H&P), dated 8/26/2023, the H&P indicated, Resident 61 did not have the capacity to understand and make decisions. During a review of Resident 61's CP, titled, Oxygen date initiated 2/9/2024, the CP indicated, interventions included to check the rate of 02 flow every shift, monitoring of 02 saturation as ordered, oxygen therapy as ordered, and provided oxygen as ordered. During a review of Resident 61's Minimum Data Set (MDS, an assessment and screening tool), dated 5/14/2024, the MDS indicated, Resident 61's cognitive (ability to think and process information) skills were severely impaired (never/rarely made decisions). The MDS indicated, Resident 61 was receiving oxygen therapy and tracheostomy care. During a review of Resident 61's Order Summary Report (OSR), dated active as of 5/29/2024, the OSR indicated, a physician's order dated 8/8/2023 for the RT, [Respiratory Therapist] Fi02 (02 flow) [to follow]: 2 LPM (liters per minute) humidifier via T-bar (t-piece, a type of device used to deliver humidified oxygen to a tracheostomy tube) every 6 hours. The OSR indicated an order dated 8/7/2021 to titrate (adjust) the 02 to keep 02 saturation greater than 92% as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Casa Bonita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 E Bonita Avenue San Dimas, CA 91773	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/28/2024 at 8:43 AM., with the Respiratory Therapist Supervisor (RTS), Resident 61 was asleep in bed with a t-piece connected to the oxygen humidifier concentrator and with the 02-flow rate below the 1-liter mark. The RTS stated, RTS adjusted the rate, it should be 2 liters, could titrate it [flow rate]. During an interview on 5/28/2024 at 1:11 PM with Registered Nurse (RN) 6, RN 6 stated, it was important for residents to have the correct 02 flow rate because residents might have distress, difficulty breathing. RN 6 stated, it was the RT or licensed nurse who checked for the correct 02 flow rate. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, date revised 10/2010, the P&P indicated, to adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. During a review of the facility's P&P titled, Physician Orders and Telephone Orders, dated 1/2004, the P&P indicated, physician's orders are in effect for 45 days from the date of the physician's signature unless otherwise specified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 49) was administered an eye drop medication properly in accordance with the facility's policy and procedure (P&P). This failure had the potential for Resident 49 to not receive the full benefits of the eye drop medication. Findings: During a review of Resident 49's Admission Record (AR), the AR indicated, Resident 49 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including ventricular fibrillation (a life-threatening heart rhythm that results in a rapid, inadequate heartbeat), tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing) status, and gastrostomy (a surgical procedure used to insert a tube, often referred to as G-Tube [GT] through the belly that brings nutrition and/or medications directly to the stomach). During a review of Resident 49's Care Plan (CP) titled, Potential for alteration in visual function secondary to eye dryness, date initiated 4/21/2023, the CP indicated, one of the goals was for Resident 49's eye dryness will be relieved through appropriate interventions daily. The CP indicated one of the interventions was [administration of] Visine Dry Eye Relief Opthalmic Solution 1% instill 2 drops in both eyes three times a day. During a review of Resident 49's H&P, dated 11/28/2023, the H&P indicated, Resident 49 did not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS, an assessment and screening tool), dated 4/5/2024, the MDS indicated, Resident 49's vision was highly impaired (object identification in question, but eyes appear to follow objects) and Resident 49's cognitive (ability to think and process information) skills for daily decision making were severely impaired (never/rarely made decisions). During a review of Resident 49's Order Summary Report (OSR), dated active as of 5/29/2024, the OSR indicated a physician's order, dated 5/26/2024 for Visine Dry Eye Relief Ophthalmic (relating to the eyes) Solution 1%, instill 2 drops in both eyes three times a day for dry eye. During a review of Resident 49's Medication Administration Record (MAR), dated 5/2024, the MAR indicated, Resident 25 was administered Visine Dry Eye Relief Opthalmic Solution 2 drops in both eyes on 5/29/2024 at 9 AM. During a concurrent observation and interview on 5/29/24 at 9:17 AM. during the medication pass with Licensed Vocational Nurse (LVN) 7, LVN 7 administered 2 eye drops, one after the other, of Visine Dry Eye Relief Opthalmic Solution 1% in both of Resident 49's eyes. LVN 7 stated, LVN 7 did not know LVN 7 had to wait a few minutes in between eye drops and when administering multiple eye drops. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 11:21 AM. with the Director of Nursing (DON), the DON stated, for any eye drops, to wait 5 minutes between eye drop [application] even if the eye drop medication was for dry eyes. The DON stated, it was important to wait so the eye drop would be absorbed better, for optimal eye drop absorption, and for Resident 49 to get the full benefits of the eye drop medication. During a review of the facility's P&P titled, Specific Medication Administration Procedures: Eye Drop Administration, dated 4/2008, the P&P indicated, the purpose was to administer opthalmic solution into and around the eye in a safe and accurate manner. The P&P indicated, to wait at least five 5 minutes before applying additional medication to the eye.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36288 Based on interviews and record review, the facility failed to ensure irregularities in the monthly Medication Regimen Review (MRR, thorough evaluation a resident's medication regimen) was identified for one of one sampled resident (Resident 11) who was on psychotropic medications (used to treat mental health disorders, alter neurotransmitters [transmit messages from neurons to muscles] in the brain). The facility's Consultant Pharmacist (FCP) failed to identify and report inadequate monitoring of duloxetine (psychotropic medication used to treat depression [a mental disorder with persistently depressed mood or loss of interest in activities that interferes with daily life] during the MRR done on 5/14/2024 to 5/15/2024. This failure had the potential to cause a decline Resident 11's physical and psychosocial well-being related to the administration of unnecessary psychotropic medications. Findings: During a review of Resident 11' s Admission Record (AR), the AR indicated the facility admitted Resident 11 on 4/27/2024 with multiple diagnoses including Alzheimer's disease (progressive disease that destroys memory and other mental functions) and depression. During a review of Resident 11's History and Physical (H&P), dated 4/30/2024, the H&P indicated Resident 11 had worsening confusion and was very frail and weak. The H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 5/2/2024, the MDS indicated Resident 11 had severe impairment in cognition (ability to obtain and process information). During a review of Resident 11's Medication Administration Record (MAR) for 5/2024, the MAR indicated the following: 1. Order Date: 4/27/2024 - duloxetine hydrochloride (HCl) capsule delayed release particles 60 milligrams (mg, unit of measurement) give 1 capsule by mouth two times a day for depression as manifested by verbalization of feelings of poor self-worth/worthlessness. 2. Duloxetine HCl was administered to Resident 11 from 5/1/2024 through 5/15/2024. During a concurrent interview and record review on 5/29/2024 at 10:19 AM with Registered Nurse 4 (RN 4), Resident 11's AR 1, physician orders, MAR, nursing notes, and FCP's MRR for 5/2024 were reviewed. RN 4 stated there was no documented evidence [to show] duloxetine side effects for duloxetine were monitored 5/2024. RN 4 stated FCP reviewed Resident 11's medications, but FCP did not have any recommendations for the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024 at 4:22 PM, the Director of Nursing (DON) stated monitoring the side effects of the psychotropic medications was important in preventing any adverse effects to the residents. During a telephone interview on 5/30/2024 at 4:44 PM, the FCP stated monitoring the side effects of psychotropic medications was important to ensure appropriate medication dose was ordered without any adverse effects to Resident 11. The FCP stated, I might have missed it. During a review of facility's P&P, titled Psychotherapeutic Medications, dated 3/21/2024, indicated the following: 1. The resident's response to psychotropic medication therapy must be evaluated to determine that the medications are appropriate, and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. 2. The licensed nurse must assess the resident and ensure side effects of psychotropic medications are monitored and documented on the medication sheets. 3. The pharmacist must complete monthly drug regimen review and give recommendations as indicated, and the facility would follow up with the recommendations.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36288

Based on interviews and record review, the facility failed to ensure three of five sampled residents (Residents 11, 20, & 96) did not receive unnecessary psychotropic medications (medications used to treat mental health disorders that alter neurotransmitters [transmit messages from neurons to muscles] in the brain, affects brain activities associated with mental processes and behavior) by failing to:

A. Monitor the side effects upon administration of Resident 11's duloxetine (psychotropic drug used to treat major depressive disorder [depression, mental disorder with persistently depressed mood or loss of interest in activities that interfere with daily life].

B. Provide a documented rationale for the continuation of Resident 20's as needed (PRN) Ativan (generic name lorazepam, psychotropic medication to treat anxiety [excessive and persistent feelings of worry, fear, dread, and uneasiness that interfere with daily life]) physician orders.

C. Ensure Resident 96's order for PRN Lorazepam (psychotropic medication used for the treatment of anxiety), started on 4/22/2024, was limited to 14 days. The facility also failed to ensure Resident 96's primary care physician (PCP) documented the rational for extending the PRN order for Lorazepam on 5/23/2024 in accordance with the facility's policy and procedure (P&P) titled, Psychotherapeutic Medications, updated 3/21/2024.

These failures had the potential to cause adverse effects (unwanted, uncomfortable, or dangerous effects that a resident may have due to a medication) to Residents 11, 20, and 96 related to the possible administration of unnecessary psychotropic medications.

(Cross Reference with F636)

Findings:

A. During a review of Resident 11' s Admission Record (AR), the AR indicated the facility admitted Resident 11 on 4/27/2024 with multiple diagnoses including Alzheimer's disease (progressive disease that destroys memory and other mental functions), depression, and anxiety disorder (a mental health disorder characterized by feelings of fear, anxiety, or fear that are strong enough to interfere with daily activities).

During a review of Resident 11's History and Physical (H&P), dated 4/30/2024, the H&P indicated Resident 11 had worsening confusion and was very frail and weak. The H&P indicated Resident 11 did not have the capacity to understand and make decisions.

During a review of Resident 11's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 5/2/2024, the MDS indicated Resident 11 had severe impairment in cognition (ability to obtain and process information).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's Medication Administration Record (MAR) for 5/2024, the MAR indicated the following: 1. Order Date: 4/27/2024 - duloxetine hydrochloride (HCl) capsule delayed release particles 60 milligrams (mg, unit of measurement) give 1 capsule by mouth two times a day for depression as manifested by verbalization of feelings of poor self-worth/worthlessness. 2. Duloxetine HCl was administered to Resident 11 from 5/1/2024 through 5/15/2024. During a concurrent interview and record review on 5/29/2024 at 10:19 AM with Registered Nurse 4 (RN 4), Resident 11's physician orders, MAR, and nursing notes were reviewed. RN 4 stated there was no documented evidence to show side effects for duloxetine were monitored 5/2024. During an interview on 5/30/2024 at 4:22 PM, the Director of Nursing (DON) stated monitoring the side effects of the psychotropic medications was important in preventing any adverse effects to the residents. During a review of the National Library of Medicine's (NLM's) guidance, titled Duloxetine, dated 2024, the NLM's guidance indicated, but not limited to, the following potential side effects of duloxetine: nausea, vomiting, constipation, diarrhea, weight changes, heartburn, stomach pain, decreased appetite, dry mouth, increased urination, sweating, dizziness, headache, tiredness, drowsiness, muscle pain or cramps, sexual problems, and uncontrollable shaking of a part of the body, unusual bleeding or bruising, pain in the upper right part of the stomach, dark colored urine, fever, rash, hives, and difficulty breathing. https://medlineplus.gov/druginfo/meds/a604030.html#side-effects During a review of facility's P&P, titled Psychotherapeutic Medications, dated 3/21/2024, the P&P indicated the licensed nurse must assess the resident and ensure the side effects of psychotropic medications are monitored and documented on the medication sheets. B. During a review of Resident 20's AR, the AR indicated the facility admitted Resident 20 on 2/6/2023 with multiple diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with daily activities). During a review of Resident 20's H&P, dated 2/9/2024, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had severe impairment in cognition. During a review of Resident 20's MARs dated from 3/2024 through 5/2024, the MARs indicated the physician's order, dated 2/27/2024, to administer Ativan 0.5 mg by mouth every 8 hours PRN for anxiety for 90 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/29/2024 at 10:19 AM with RN 4, Resident 20's admission record, MDS, physician orders, physician notes, MAR, and nursing notes were reviewed. RN 4 stated there was no documented rationale from the HCP, who prescribed the PRN Ativan beyond 14 days on 2/27/2024, to indicate the reason Ativan was ordered beyond 14 days. During an interview on 5/30/2024 at 12:58 PM, the facility's Consultant Pharmacist (FCP) stated it was important to limit the duration of PRN Ativan to 14 days because this would be the evaluation period to ensure the dosage was appropriate for the resident's (in general) diagnosis. The FCP stated if PRN Ativan was no longer needed, the HCP's order would automatically be discontinued after the 14 days. The FCP stated if PRN Ativan was still needed, the FCP stated the HCP had to review the resident's behavior manifestations and any side effects of the medication and document the rationale/s why the PRN Ativan had to be continued. The HCP would need to reorder and specify the duration of the PRN Ativan. During a review of facility's P&P, titled Psychotherapeutic Medications, dated 3/21/2024, indicated the following: 1. The resident's response to the psychotropic medication therapy must be evaluated to determine that the medications are appropriate, and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. 2. The PRN antianxiety order must be limited to 14 days unless the PCP evaluates and documents the rationale for extension. 44027 C. During a review of Resident 96's AR, the AR indicated Resident 96 was admitted to the facility on [DATE] with severe dementia with agitation, hypertension (high blood pressure), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 96's MDS, dated [DATE], the MDS indicated Resident 96 was severely impaired with cognitive skills. The MDS indicated Resident 96 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting and dressing. The MDS indicated Resident 96 received psychotropic medications at the facility. During a concurrent interview and record review on 5/29/2024 at 3:22 PM with the DON, Resident 96's physician orders, dated 4/22/2024 and 5/23/2024 were reviewed. The physician orders both indicated Resident 96 had a medication order for Lorazepam 0.5 milligram (MG, a unit of measurement) give 1 tablet (tab) by mouth (PO) every 12 hours as needed (PRN) for anxiety manifested by (m/b) restlessness causing anger. The physician order dated 4/22/2024 indicated Resident 96's PRN order for Lorazepam was active for 30 days. The physician order dated 5/23/2024 indicated Resident 96's PRN order for Lorazepam was active for 30 days. The DON stated Resident 96's PRN order for Lorazepam needed to be written for 14 days. The DON sated the orders for Lorazepam were written for 30 days. The DON stated Resident 96's PRN order for Lorazepam was renewed on 5/23/2024. The DON stated Resident 96's PCP did not document in Resident 96's medical record the rational for extending Resident 96's PRN order for Lorazepam to 30 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's Order Summary Report dated 5/29/2024, the Order Summary Report indicated Resident 96 had a physician's order, dated 5/23/2024, for Lorazepam oral tablet 0.5 MG give 1 tab by mouth every 12 hours PRN for anxiety m/b restlessness causing anger. The medication order was started on 5/23/2023 and had an end date of 6/22/2024 (longer than 14 days). During a review of the facility's P&P titled, Psychotherapeutic Medications, updated 3/21/2024, the P&P indicated, antianxiety medications are psychotropic medications. The P&P indicated, The licensed nurse will assess resident to ensue: H.PRN psychotropic orders: 1. NO PRN antipsychotic unless the prescribe have evaluated resident and documented the rational/benefits; PRN antipsychotic will be limited to 14 days unless the primary care provider evaluate the rational and documents the rational for extension 2. PRN hypnotic order will be limited to 14 days unless the primary care provider evaluates and documents the rationale for extension 3. PRN antianxiety order will be limited to 14 days unless the primary care provider evaluates and documents the rationale for extension .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 38108 Based on observation, interview and record review, the facility failed ensure three of four sampled glasses of milk/mocha mix were served at 40 degrees Fahrenheit (F, a unit used to measure temperature) or lower as indicated in the facility's policy. This deficient practice had the potential to compromise the residents' taste by serving unfresh or spoiled milk/mocha mix to the residents. Findings: During an observation with the Dietary Supervisor (DS) and Kitchen Aid 1 (KA 1), in the facility kitchen, on 5/29/2024 at 12:27 PM, several 8 ounces of glasses of milk were on the trays ready to be served with the residents' lunch. Three of the four glasses of milk were randomly selected and observed to have a temperature higher than 41F. The first glass measured at 42 F, the third glass measured at 44 F and the fourth glass measured at 51 F. During an interview with KA 1, on 5/29/2024 at 12:29 PM, KA 1 stated the milk temperature should be below 41 F because above 41F is the danger zone (the temperature range between 40F and 140F in which bacteria can grow rapidly) and the residents could get the sick from consuming those milk/mocha mix. During an interview with the DS on 5/29/2024 at 12:38 PM, the DS stated milk should be under 41 degrees F because if not, bacteria may grow or the milk/moca mix can be unfreshed or spoiled. A review of the facility's policy titled, Meal Service, updated on 3/21/2024, indicated food temperature will be taken to insure foods are at the proper serving temperature. The policy indicated cold beverages, desserts will be served no more than 40 degrees F.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to provide a snack to one of one sampled resident (Resident 48) in accordance with the facility's Policy and Procedure (P&P) titled, Frequency of Meals. This deficient practice had the potential for Resident 48 to be hungry and to negatively affect his feeling of well-being. Findings: During a review of Resident 48's Admission Record (AR), the AR indicated Resident 48 was admitted to the facility on [DATE] with spinal stenosis (the spaces in the spine narrow and create pressure on the spinal cord and nerve roots), post laminectomy syndrome (a condition in which the patient continues to feel pain after undergoing a laminectomy [back surgery] or another form of back surgery), and type 2 diabetes mellitus (a chronic [long standing] condition that affects the way the body processes blood sugar). During a review of Resident 48's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/6/2024, the MDS indicated Resident 48 had no impairment with cognitive skills (ability to make daily decisions). The MDS indicated Resident 48 was dependent (helper does all the effort) on staff for toileting, showering, and dressing. During an interview on 5/28/2024 at 10:52 AM with Resident 48, Resident 48 stated Resident 48 got hungry at night and Resident 48 asked facility staff for a snack at night, but the facility staff did not provide Resident 48 with a snack. During an interview on 5/29/2024 at 7:19 AM with Registered Nurse (RN) 1, RN 1 stated facility staff took snacks from the snack carts and gave the snacks to residents (in general) whenever they requested snacks. RN 1 stated residents (in general) could have snacks during the afternoon and during the night shift. RN 1 stated sometimes we [the facility] ran out of snacks. RN 1 stated there was a time when RN 1 did not have a snack for Resident 48 when Resident 48 requested for a snack during the night shift. RN 1 stated RN 1 told Resident 48, Resident 48 had to wait until the kitchen provided breakfast in the morning to have a snack. During an interview on 5/29/2024 at 10:03 AM with the Dietary Supervisor (DS), the DS stated kitchen staff provided snack trays to the facility units and were distributed during the evening and night shifts. The DS stated nursing staff informed the DS, about a month ago, that there were not enough snacks available for residents during the night. During a review of Resident 96's care plan titled Resident has Alteration in Nutritional Status ., dated 5/1/2024, the care plan indicated to offer snacks to Resident 48. (continued on next page)

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 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Bonita Convalescent Hospital	535 E Bonita Avenue San Dimas, CA 91773

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Frequency of Meals, revised July 2017, the P&P indicated, Nourishing snacks will be available for residents who need or desire additional food between meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38108 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen as indicated in the facility's policy when one of one sampled Registered Dietician (RD 1) did not wear a beard cover, while working in the kitchen food preparation area. This deficient practices had the potential for the RD's beard/facial hair to fall into the residents food and contaminate the residents' food. Findings: During an observation in the facility kitchen, on 5/29/2024 from 11:49 AM to 12:44 PM, the Registered Dietician (RD), who had visible beard, was observed walking around the kitchen while the residents' lunch was being prepared. The RD walked from the cold drinks preparation area to the food assembly tray line that served food to the residents. The RD did not wear a beard cover. The RD wore a surgical mask. The RD's beard was uncovered from the mid of the RD's left and right cheeks to the RD's ear. The RD's goatee beard (a small, pointed beard) was protruding under the RD's chin, outside of the RD's surgical mask. During an interview with the Dietary Supervisor (DS), on 5/29/24 at 12:38 PM, The DS stated kitchen staff needed to covered his beard with a beard net/cover while they are working in the kitchen for sanitary purposes. During an interview with the Registered Dietician (RD), on 5/29/24 at 12:44 PM, The RD stated kitchen staff needed to wear a beard net if they had a beard due to facial hair could fall into the residents' food. A review of the facility policy titled, Sanitation and Infection Control, dated 3/21/24, food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. The policy indicated beards and/or mustaches should be closely trimmed or must be covered at all times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36288 Based on observation, interview, and record review, the facility failed to follow infection prevention and control practices and implement interventions to prevent and control the spread of infections in the facility for one of five sampled residents (Resident 41) in accordance with the facility's policy and procedure (P&P) on Enhanced Standard Precautions (ESP, approach for preventing the transmission on Multidrug-Resistant Organisms [MDROs, germs resistant to many antibiotics] in skilled nursing facilities [SNFs]). This failure had the potential to result in the increased spread of infections throughout the facility. Findings: During a review of Resident 41's Admission Record (AR 1), AR 1 indicated the facility admitted Resident 41 on 9/29/2020 with multiple diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with daily activities), type 2 diabetes mellitus (disorder causing elevated sugar level in the blood), and presence of gastrostomy (surgical opening into the stomach for the introduction of food). During a review of Resident 41's History and Physical (H&P), dated 4/29/2024, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 4/30/2024, the MDS indicated Resident 41 had severely impaired cognitive skills (ability to obtain and process information) for daily decision-making. The MDS indicated Resident 41 had impairment in both sides of the upper and lower extremities. The MDS indicated Resident 41 was dependent on staff for all self-care activities. The MDS indicated Resident 41 was frequently incontinent of urine and bowel (unintentional passing of urine or feces). The MDS indicated Resident 41 had a feeding tube (medical device used to deliver liquid nutrition formula directly into the digestive system). During an observation on 5/28/2024 at 1:36 PM, Certified Nursing Assistant 6 (CNA 6) was wearing gloves but no gown while CNA 6 changed Resident 41's adult brief in Resident 41's bed. During an interview on 5/28/2024 at 1:41 PM, CNA 6 stated Resident 41 was not on ESP. CNA 6 stated CNA 6 did not wear a gown, because Resident 41 was not on isolation [to stay away/kept away from others). CNA 6 stated ESP was implemented for residents with known infectious organisms and to prevent the transmission of infections. During an interview on 5/28/2024 at 1:51 PM, Registered Nurse 3 (RN 3) stated all residents must be placed on ESP due to the risk of infection transmission by bodily fluids and required the use of gown and gloves when providing resident care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Casa Bonita Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 535 E Bonita Avenue San Dimas, CA 91773	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024 at 4:22 PM, the Director of Nursing (DON) stated ESPs must be implemented for high-risk residents who had indwelling medical devices (device inserted into the body) such as gastrostomy tube and/or wounds to prevent the transmission of MDROs. The DON stated all staff must wear gowns and gloves during high-contact care activities. During a review of the facility's policy and procedure (P&P), titled Enhanced Standard Precautions, dated 4/2023, the P&P indicated the following: 1. ESP must be used as an infection prevention and control intervention to reduce the spread of MDRO acquisitions. 2. ESP employ target gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities include dressing, providing hygiene, changing linens, changing briefs, or assisting with toileting. 4. ESP are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 5. ESP remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.