

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Bear Valley Community Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 41870 Garstin Rd Big Bear Lake, CA 92315	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure resident was treated with respect and dignity for one resident (Resident 1) when the facility staff spoke to Resident 1 using language and tone as if one might address a child and refused Resident 1 to receive a shower at his preferred time. This failure resulted in Resident 1 feeling put down and embarrassed which could potentially affect his care from his lack of trust or doubt with the facility staff to participate in treatment plan. Findings: During a review of a Medical Doctor (MD) Progress Note, dated August 27, 2024, the MD progress note indicated Resident 1 has history of congestive heart failure (a serious condition in which the heart doesn't pump blood through the body as efficiently as it should), seizure disorder (a sudden burst of electrical activity in the brain and can cause changes in behavior, movements, feelings and levels of consciousness), stroke (a serious medical emergency that happens when blood flow to the brain is interrupted, either by a blockage or a rupture of a blood vessel), hypothyroidism (when the thyroid gland isn't producing enough thyroid hormones and many bodily functions slow down), and hypertension (when the force of the blood pushing on the blood vessel walls is too high and the heart has to pump harder). During a review of the facility's document title, Report of Suspected Dependent Adult/Elder Abuse (SOC 341-a form that the facility is required to report suspected abuse), dated June 11, 2025, the SOC 341 indicated that there was potential for verbal abuse from a Certified Nurse Assistant (CNA1) towards Resident 1. The SOC 341 also indicated that a CNA spoke to a resident in a belittling and demeaning manner, using language and tone comparable to how one might address a child. This occurred after the resident requested a shower in the evening, having declined one earlier in the day. During an interview on June 20, 2025, at 10:51 AM, with Resident 1, Resident 1 stated I wanted a shower, and [CNA1] was Snooty. [CNA1] said I tried to get you to the shower earlier and I said I'm sorry. I just didn't want to shower in am and would rather know what I did for [CNA1] to yell at me like that. [CNA1] came down like a cat out hell. She was mean and vulgar. Resident 1 stated that CNA1 yelled at him in front of the facility staff and other residents which made him feel not too good. During an interview on June 20, 2025, at 11:52 AM, with RN1, RN1 stated Resident 1 did not want to shower at the scheduled time and CNA1 responded in a very unprofessional tone and was brazen with him. During an interview on June 20, 2025, at 12:17 PM, with the Director of Nursing (DON), the DON stated that Resident 1 live here, and CNA1 was rude and didn't need to be. During an interview on July 7, 2025, at 11:22 AM, with CNA2, CNA2 stated Resident 1 asked about a shower and CNA1 scolded [Resident 1] like a child because he was asking for a shower and CNA1 asked 'why are you asking me now, it's late.' CNA2 further stated It was disturbing. It didn't sit right. CNA2 added, He was aware of her behavior, and he asked, 'why are you talking to me like that'. CNA2 stated, He was completely silent after that. I think he got embarrassed and left [the area]. It was embarrassing to him because other people were around. I wouldn't want to be treated like putting me down with others around. During a concurrent interview and record review on July 7, 2025, at 11:42 AM, with the Assistant Director of Nursing (ADON) and DON, the facility's policy and procedure (P&P) titled, Resident Rights, undated, was reviewed. The P&P indicated, POLICY: [The facility] will assure that all residents are treated with respect and dignity in a manner and environment that promotes their quality of life while promoting their right to self-determination whereby their care choices are respected . PROCEDURE: .3. The right to be assisted by all staff in maintaining and enhancing their self-esteem and self-worth .15. The right to choose their own schedule and have their needs accommodated in relation to: .15.3. Their bathing times and schedule . The ADON and DON acknowledged that the right to be treated with dignity and respect as well as the right to make his own schedule was not followed.</p>		