

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  05/08/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50754</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure staff treated residents with respect and dignity to enhance quality of life for two of two residents (Resident 12 and 15) when the Certified Nursing Assistant (CNA) were observed standing over Resident 12 and 15 during mealtime.</p> <p>This failure had the potential to make Resident 12 and 15 to feel devalue and disrespected which could cause Resident 12 and 15 to distrust the health care provider and would negatively impact the treatment plan.</p> <p>Findings:</p> <p>a. During a review of Resident 12's Admission Record (contains demographic and medical information), undated, the Admission Record indicated, Resident 12 was admitted to the facility on [DATE], with diagnoses of anoxic encephalopathy (brain damage), dementia (a group of symptoms that affect memory), hypertension (high blood pressure), depression and anxiety, insomnia (sleeping problems), and dysphagia (difficulty swallowing).</p> <p>During an observation on March 5, 2025, at from 12:09 PM through 12:50 PM, in the activity/dining room, Resident 12 was observed sitting in a high back wheelchair next to a table while CNA 2 was standing over Resident 12 feeding her lunch.</p> <p>During an interview on March 5, 2025, at 1:10 PM, with CNA 2, CNA 2 stated No I did not sit while feeding [Resident 12] lunch meal. CNA 2 further stated, the reason to sit with the residents during mealtime is to make it more of a homely environment for the residents.</p> <p>b. During a Review of Resident 15's Admission Record, undated, the Admission Record indicated Resident 15 was admitted to the facility on [DATE], with diagnoses of dementia (brain condition that effects thinking memory and behavior), depression (mental health condition persistent feeling of sadness, hopelessness, and loss of interest), anemia (low red blood cells to carry oxygen throughout the body), anxiety (feeling of fear, dread and uneasiness), osteoporosis (bones become thin, weak, and fragile), and Parkinson's disease (a disorder of the central nervous system that affects movement, tremors).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on March 5, 2025, from 12:09 PM through 12:50 PM, in the activity/dining room, Resident 15 was observed sitting in a wheelchair next to a table while CNA 1 was standing over Resident 15 feeding her lunch.</p> <p>During an interview on March 5, 2025, at 12:50 PM, with CNA 1, CNA 1 stated, I am supposed to sit and have eye to eye contact and verbalized the importance to make sure the resident has a good experience and give them with dignity.</p> <p>During a concurrent interview and record review on May 6, 2025, at 4:45 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Assistance with Feeding SNF, undated, was reviewed. The P&amp;P indicated, Policy: [Facility Name] shall ensure that all residents who require assistance with eating receive appropriate support in a manner that maintains their dignity, independence, safety, and nutritional well-being . Engage with the resident calmly and respectfully . The DON stated it was unacceptable for CNAs to be standing while feeding Residents 12 and 15. The DON further stated the staff did not follow the P&amp;P and CNA 1 and CNA 2 should have made sure that they were seated and engage with Resident 12 and 15, calmly and respectfully.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51583</b></p> <p>Based on interview and record review, the facility failed to ensure residents or resident representatives (RP) were informed of psychotropic medication (medications that affect the mind, emotions, and behaviors) treatment for three of 12 sampled residents (Resident 2, 8, and 12) when:</p> <ol style="list-style-type: none"> <li>1. Resident 2's informed consent (document signed by resident or representative to give permission for a proposed psychotropic medication and possible risks and benefits expected) was not updated and obtained for Resident 2's new order of Trazodone Deseryl (Trazodone-antidepressant medication) 50 milligram (MG-unit of measurement) and NF-Aripiprazole Av PAK (Aripiprazole-antipsychotic medication which is used to treatment of a wide variety of mood and psychotic disorders) 2.5 MG.</li> <li>2. Resident 8's informed consent was not updated and obtained for Resident 8's new order of Risperidone (Risperdal-antipsychotic medication) 0.5 MG and Escitalopram (Lexapro-antianxiety medication to help you relax) 10 MG.</li> <li>3. Resident 12's informed consent for Abilify (medication for mental health condition such as depression)15 MG PO Every Evening for BPSD (for diagnosis behavioral psychological symptoms in dementia) Start date of January 29, 2025, prescribed by physician, Consent signed by representative (son) on November 21, 2024, medication states Abilify 2mg po QHS. The consent does not match the order.</li> </ol> <p>These failures resulted in Residents 2, 8, and 12's right to be violated. Residents 2, 8, 12 and their representatives were not informed of psychotropic medications risks, benefits, adverse reactions, and the right to refuse the administration of medications.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 2's Admission Record (clinical record with demographic information), undated, the Admission Record indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses which included depression (constant feeling of sadness and loss of interests), hyperlipidemia (elevated levels of fat in the blood), and hypertension (high blood pressure).</li> </ol> <p>A review of Resident 2's physician order, dated March 12, 2025, indicated Resident 2 had an order for Trazodone Desyre! 50 MG at night for inability to sleep and NF-Aripiprazole Av PAK 2.5 MG at bedtime for psychosis (a state where someone loses touch with reality).</p> <p>During a review of Resident 2's Informed Consent, dated August 28, 2024, the Informed Consent indicated, Trazadone 25 MG as needed for insomnia and Aripiprazole 15 MG daily for psychosis were signed on August 28, 2024.</p> <p>During an interview on May 7, 2025, at 8:29 AM with a Licensed Vocational Nurse (LVN 2), LVN 2 stated she was unable to find an updated consent reflecting the dosage changes for Trazadone and Aripiprazole.</p> <p>(continued on next page)</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of Resident 8's Admission Record, undated, the Admission Record indicated, Resident 8 was admitted to the facility on [DATE], with diagnoses which includes behavioral and psychological symptoms of dementia (a combination of agitation, anxiety, hallucinations with episodes of mania or depression) and type 2 diabetes mellitus (high blood sugar).</p> <p>A review of Resident 8's physician order, dated April 29, 2024, indicated Resident 8 had an order for Escitalopram 10 MG every day for mood and Risperidone 0.5 MG daily for agitation, impulse control, and hypersexual behavior.</p> <p>During a review of Resident 8's Informed Consent, dated January 26, 2024, the Informed Consent indicated, Lexapro 5 MG at bedtime was signed on January 26, 2024.</p> <p>A follow-up review of Resident 8's Informed Consent, dated May 19, 2024, the Informed Consent indicated, Risperdal 0.5 MG BID twice daily was signed on May 19, 2024.</p> <p>During an interview on May 7, 2025, at 8:32 AM with LVN 2, LVN 2 stated she was unable to find an updated consent reflecting the dosage changes for Escitalopram and Risperidone.</p> <p>During further concurrent interview and record review, on May 8, 2025, at 08:00 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Informed Consent Psychotropic Medications SNF [Skilled Nursing Facility], undated, was reviewed. The P&amp;P indicated, .5. The Informed Consent is updated with any change in psychotropic medications . The DON stated the facility staff did not follow the policy.</p> <p>50754</p> <p>3. During a review of Resident 12's Admission Record, undated, the Admission Record indicated Resident 12 was admitted to the facility on [DATE], with diagnoses of anoxic encephalopathy (brain damage), dementia (a group of symptoms that affect memory), hypertension (high blood pressure), depression and anxiety, insomnia (sleeping problems), and dysphagia (difficulty swallowing).</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:35 AM, with LVN 2, Resident 12's Informed Consent for Abilify, dated November 21, 2024, was reviewed. The Informed Consent for Abilify indicated, Abilify 2 MG PO HS was noted and signed by RP 1. LVN 2 verified and confirmed Resident 12's informed consent.</p> <p>During a follow-up concurrent interview and record review on May 8, 2025, at 9:35 AM, with LVN 2, Resident 12's Physician Order for Abilify dated January 29, 2025, was reviewed. The Physician Order for Abilify indicated, Resident 12 was ordered 15 MG to be given HS, started on January 29, 2025, for BPSD. LVN 2 stated, the physician order for Abilify and consent did not match so it indicated that Resident 12 and RP 1 were not informed of the change in psychotropic medication.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on May 8, 2025, at 11:25 AM, with the DON, the P&amp;P titled, Informed Consent Psychotropic Medication SNF, undated, was reviewed. The P&amp;P indicated, . 5. The informed consent is updated with any change in psychotropic medications. 6. Up to date and appropriate consents are validated during the interdisciplinary care plan (IDCP) conference as needed . The DON verified and confirmed the P&amp;P. The DON stated, it is her expectation and written in the policy that residents' informed consent needs to be updated for any changes in psychotropic medications with residents, resident representatives, or power of attorney (POA). The DON further stated, residents, resident representatives, or power of attorney should be informed of the side effects of any changes in psychotropic medications.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50754</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive minimum data set (MDS-a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS]) assessment was completed and submitted to CMS in accordance with the required federal submission timeframe for one of eight sampled residents (Resident 12).</p> <p>This failure resulted in inadequate monitoring of progress or decline for Resident 12 and the lack of resident specific information to CMS for payment and quality measure monitoring.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (contains demographic and medical information), the Admission Record indicated Resident 12 was admitted to the facility on [DATE], with diagnoses of anoxic encephalopathy (brain damage), dementia (a group of symptoms that affect memory), hypertension (high blood pressure), depression and anxiety, insomnia (sleeping problems), and dysphagia (difficulty swallowing).</p> <p>During an interview on May 8, 2025, at 9:35 AM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she was responsible for the MDS staff to ensure the MDS assessments were completed correctly. LVN 2 stated, it is very important to have residents' diagnoses accurately reflect residents' current condition in the updated resident assessment instrument (RAI-a standardized assessment tool that measures health status on nursing home residents) to identify residents' needs and goals.</p> <p>During a follow-up concurrent interview and record review on May 8, 2025, at 9:40 AM, with LVN 2, Resident 12's MDS with an assessment reference date (ARD-the last day of the observation period used for an assessment) on February 12, 2025, was reviewed. The MDS indicated, Resident 12 was assessed as NONE for depression and dementia. LVN 2 verified and stated Resident 12's MDS was incorrectly assessed. LVN 2 confirmed and stated, Resident 12 was on a psychotropic (mind altering) medication and the MDS did not accurately reflect Resident 7's current condition.</p> <p>During a review of Resident 12's Physician Order for ablify (medication for mental health condition such as depression), dated of document, the Physician Order for ablify indicated, Resident 7 was ordered 15 milligram (mg-unit of dosing medication) to be given at bedtime (HS), started on January 29, 2025, for BPSD (behavioral and psychological symptoms of dementia).</p> <p>During an interview on May 08, 2025, at 11:25 AM, with the Director of Nursing (DON), the DON stated that the MDS should have been completed accurately and reflected the current condition of residents.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on May 8, 2025, at 11:26 AM, with the DON, the facility's policy and procedure (P&amp;P) titled, Resident Assessment Instrument (RAI), undated, was reviewed. The P&amp;P indicated .RAI assessment process will be conducted for all SNF [Skill Nursing Facility] residents as an ongoing process to appropriately assess each resident's functional mobility and health status and in a timely fashion, to identify and address any potential significant change in status . PROCEDURE: (2) (2.3) states A Quarterly review will be conducted within 92 days of the ARD of the previous assessment. Not less than once every three months and (7) states the completed MDS will be transmitted electronically to [Name of electronic system] system within 14 days. (7) (7.1) further states Validation reports for transmitted MDS will be retained in the DON office . The DON verified and stated the MDS staff did not follow the RAI policy in correctly filling out the RAI so the RAI did not provide an accurate picture of the residents. The DON further stated, the MDS staff should have had the diagnosis, and their assessment documented accurately and in a timely manner.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51583</p> <p>Based on interview and record review, the facility failed to ensure the quarterly Resident Assessment Instrument/Minimum Data Set (RAI/MDS- a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS] every 3 months or quarterly) was completed in accordance with federal submission timeframes, for two of four residents (Residents 16 and 19) when:</p> <ol style="list-style-type: none"> <li>1. Resident 16's quarterly RAI/MDS assessment was completed on March 18, 2025 (52 days late).</li> <li>2. Resident 19's quarterly RAI/MDS assessment was not completed on March 13, 2025 (92 days late)</li> </ol> <p>These failures had the potential to result in a delay in determining the resources necessary to competently care for the residents during the day-to-day operations and emergencies for Residents 16 and 19.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 16's History and Physical (H&amp;P -contains resident's medical history, physical examination and reason for admission to the facility), dated July 2024, the H&amp;P indicated, Resident 16 was admitted to the facility on [DATE], with diagnoses which included hypertension (a condition where the heart is working harder to pump blood), type 2 diabetes mellitus (high blood sugar), and cerebrovascular accident (blood flow to the brain is blocked).</li> </ol> <p>During an interview on May 8, 2025, at 9:09 AM, with the Director of Nursing (DON), the DON stated one of her duties is to complete the resident's MDS. The DON further stated the expectation for the quarterly assessment is that it must be completed within 92 days from the prior quarterly assessment.</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:15 AM, with the DON, Resident 16's quarterly MDS assessment data, dated December 2024, was reviewed. The DON stated the last quarterly assessment was completed on December 18, 2024. The DON further stated she did not complete the quarterly assessment that was due on March 18, 2025 (52 days late).</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:19 AM, with the DON, the facility's policy and procedure (P&amp;P) titled, Resident Assessment Instrument (RAI), dated February 2017, was reviewed. The P&amp;P indicated, .2.3 A Quarterly review will be conducted within 92 days of the ARD of the previous assessment. Not less than once every three months . The DON stated the policy was not followed and should have because it provides accurate reimbursement for the facility and care planning for the residents.</p> <p>47332</p> <p>(continued on next page)</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of Resident 19's H&amp;P, dated September 6, 2024, the H&amp;P, indicated, Resident 19 was admitted to the facility on [DATE], with diagnoses of dementia (a progressive decline in mental ability, impacting memory, thinking, language, and behavior, to the point where it affects daily life).</p> <p>During an interview on May 8, 2025, at 9:09 AM, with the DON, the DON stated one of her duties is to complete the residents MDS. The DON further stated that the expectation for the quarterly assessment is that it must be completed within 92 days from the prior quarterly assessment.</p> <p>During a concurrent interview and record review, on May 8, 2025, at 9:15 AM, with the DON, Resident 19's quarterly MDS assessment dated [DATE], was reviewed, the DON stated the last quarterly assessment was completed on December 04, 2024, the DON further stated she did not complete the quarterly assessment that was due on March 13, 2025 (92 days late).</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:19 AM, with the DON, the facility's P&amp;P titled, Resident Assessment Instrument (RAI), dated February 2017, was reviewed. The P&amp;P indicated, 2.3 A Quarterly review will be conducted within 92 days of the ARD of the previous assessment. Not less than once every three months . The DON stated that policy was not followed and should have been because it provides accurate reimbursement for the facility and care planning for the residents.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51583</b></p> <p>Based on interview and record review, the facility failed to ensure the quarterly (every 3 months) Resident Assessment Instrument/Minimum Data Set (RAI/MDS- a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS]) was transmitted (submitted) to CMS in accordance with federal submission timeframes, for three of four residents (Resident 5, 12, and 16) reviewed for resident assessment when:</p> <ol style="list-style-type: none"> <li>1. Resident 5's quarterly RAI/MDS assessment completed on February 14, 2025, has not been transmitted as of May 8, 2025 (69 days late).</li> <li>2. Resident 16's quarterly RAI/MDS assessment dated [DATE], was transmitted on January 8, 2025 (7 days late) and quarterly MDS assessment due March 18, 2025, was not transmitted (37 days late from the due date).</li> <li>3. Resident 12's comprehensive RAI/MDS assessment was due on March 30, 2025 but was not transmitted (81 days late)</li> </ol> <p>These failures resulted in inadequate monitoring of Residents 5, 12, and 16's progress or decline and the lack of resident specific information to CMS for payment and quality measure monitoring.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 5's History and Physical (H&amp;P -contains resident's medical history, physical examination and reason for admission to the facility), dated June, 2023, the H&amp;P indicated, Resident 5 was admitted to the facility on [DATE], with diagnoses which included schizencephaly (birth defect in the brain) and spastic quadriplegia (severe condition affecting movement and posture).</li> </ol> <p>During an interview on May 8, 2025, at 9:09 AM, with the Director of Nursing (DON), the DON stated one of her duties is to transmit the resident's MDS once completed. The DON further stated the expectation for the quarterly assessment is to be submitted within 14 days of completion.</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:11 AM, with the DON, Resident 5's quarterly MDS assessment data, dated February 2025, was reviewed. The DON stated the quarterly assessment was completed on February 14, 2025, and was supposed to be submitted by February 28, 2025 (69 days late) but was not.</p> <ol style="list-style-type: none"> <li>2. During a review of Resident 16's H&amp;P, dated July 2024, the H&amp;P indicated, Resident 16 was admitted to the facility on [DATE], with diagnoses which included hypertension (a condition where the heart is working harder to pump blood), type 2 diabetes mellitus (high blood sugar), and cerebrovascular accident (blood flow to the brain is blocked).</li> </ol> <p>During an interview on May 8, 2025, at 9:09 AM, with the DON, the DON stated one of her duties is to transmit the resident's MDS once completed. The DON further stated the expectation for the quarterly assessment is to be locked and submitted within 14 days of completed.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on May 8, 2025, at 9:15 AM, with the DON, Resident 16's quarterly MDS assessment data, dated December 2024 and March 2025, were reviewed. The DON stated the quarterly assessment for December 2024 was completed on December 18, 2024. The DON confirmed that the quarterly assessment should have been submitted by January 1, 2025, but it was submitted on January 8, 2025 (7 days late). The DON stated the quarterly assessment for March 2025 completed and transmitted on March 18, 2025, and should have been transmitted by April 1, 2025 (37 days late).</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:19 AM, with the DON, the facility's P&amp;P titled, Resident Assessment Instrument (RAI), dated February 2017, was reviewed. The P&amp;P indicated, . The completed MDS will be transmitted electronically to CMS QIES-ASAP system within 14 days . The DON stated the policy was not followed and should have been because it provides accurate reimbursement for the facility and care planning for the residents.</p> <p>47332</p> <p>3. During a review of Resident 12's H&amp;P, dated March 3, 2022, the H&amp;P indicated, Resident 12 was admitted to the facility on [DATE], with diagnoses of Severe disability post anoxic encephalopathy (a medical emergency that occurs when the brain doesn't receive enough oxygen, even when blood flow is adequate. It can lead to lifelong brain damage).</p> <p>During an interview on May 8, 2025, at 9:09 AM, with the DON, the DON stated one of her duties is to transmit the resident's MDS once completed. The DON further stated the expectation for the quarterly assessment is to be submitted within 14 days of completion.</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:11 AM, with the DON, Resident 12's Comprehensive MDS assessment data, dated February 12, 2025, was reviewed. The DON stated comprehensive assessment was completed on February 12, 2025. The DON further stated she completed the assessment but did not submit, it was due on March 30, 2025 (81 days late).</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:19 AM, with the DON, the facility's P&amp;P titled, Resident Assessment Instrument (RAI), dated February 2017, was reviewed. The P&amp;P indicated, . The completed MDS will be transmitted electronically to CMS QIES-ASAP system within 14 days . The DON stated the policy was not followed and should have been because it provides accurate reimbursement for the facility and care planning for the residents.</p>		

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NAME OF PROVIDER OR SUPPLIER  Bear Valley Community Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  41870 Garstin Rd Big Bear Lake, CA 92315	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50754</p> <p>Based on interview, and record review, the facility failed to develop and implement comprehensive person-centered care plan (an individualized plan that includes residents' health problems, preferences and goals) for one of three residents (Resident 12) when Resident 12 did not have a care plan developed or implemented to address an ongoing psychotropic (mind altering) medication.</p> <p>This failure had the potential for Resident 12 to have unidentified medical needs, delay in treatment and lack of coordinated care related to psychotropic drugs which can negatively affect Resident 12's mental state.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (contains demographic and medical information), the Admission Record indicated Resident 12 was admitted to the facility on [DATE], with diagnoses of anoxic encephalopathy (brain damage), dementia (a group of symptoms that affect memory), hypertension (high blood pressure), depression and anxiety, insomnia (sleeping problems), and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 12's Physician Order for Abilify (medication for mental health condition such as depression), dated January 29, 2025, the Physician Order for abilify indicated, Resident 12 was ordered 15 milligram (mg-unit of dosing medication) to be given at bedtime (HS), started on January 29, 2025 for BPSD (behavioral and psychological symptoms of dementia).</p> <p>During a concurrent interview and record review on May 8, 2025, at 9:35AM, with Licensed Vocational Nurse (LVN 2), Resident 12's care plan, undated, was reviewed. There was no documented evidence addressing Resident 12's dementia. LVN 2 verified and confirmed, there was no care plan for Resident 12's dementia. LVN 2 stated, they should have coded it correctly for depression and dementia instead being coded as none.</p> <p>During a concurrent interview and record review on May 8, 2025, at 11:25 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Nursing Care Plan-SNF [Skilled Nursing Facility], undated, was reviewed. The P&amp;P indicated, [Facility Name] will develop and implement a person-centered comprehensive Care Plan for each resident that includes measurable goals and timeframes to meet the resident's medical, nursing and mental/psychological needs that are identified on the comprehensive assessment. The person-centered Care Plan Policy states (4) will address many areas in (4.1) states Psychotropic medicated used will be addressed in the person-centered Care Plan. A person-centered comprehensive Care Plan is updated with any change to the resident's care needs. (6) the Care Plan is updated with any change to the resident's care needs . The DON acknowledged and confirmed that the staff did not follow the care plan policy. The DON stated that the nurses should have developed a care plan to address dementia diagnosis.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51583</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure safe oxygen administration was provided in accordance with the facility's policy and procedure (P&amp;P) for one of two sampled residents (Resident 8) when Resident 8's oxygen tubing (a device which delivers oxygen) was not labeled to indicate the date it was changed.</p> <p>This failure had the potential to result in a respiratory infection leading to a decline in Resident 8's health status.</p> <p>Findings:</p> <p>During a review of Resident 8's clinical records, Progress Note, April 2025, the Progress Note indicated, Resident 8 was admitted on [DATE], with diagnoses which included dementia (loss of ability to think or remember), diabetes (high blood sugar), and osteoarthritis of multiple joints (a condition that causes the hands, legs, hips to become stiff and painful).</p> <p>During an observation on May 5, 2025, at 11:09 AM, Resident 8 was in his room, lying in bed, and receiving oxygen via oxygen tubing running at three liters per minute. The oxygen tubing was not labeled to indicate the last time it was changed.</p> <p>During a concurrent observation and interview on May 5, 2025, at 11:15 AM, with a Licensed Vocational Nurse (LVN 1) in Resident 8's room, LVN 1 inspected Resident 8's oxygen tubing and stated it did not have a label or date on it. LVN 1 further stated the oxygen tubing was supposed to be changed weekly and the date must be written on it.</p> <p>During a concurrent interview and record review on May 6, 2025, at 4:06 PM, with the Director of Nursing (DON), the facility's P&amp;P titled, Oxygen Use in the SNF [Skilled Nursing Facility], undated, was reviewed. The P&amp;P indicated, .3. All oxygen humidifier bottles, and tubing shall be changed every Sunday night by the Licensed Nurse . 3.1. A label shall be attached to both the humidifier bottle and oxygen tubing noting the date and time these were changed with the Licensed Nurse's initials . The DON stated oxygen tubing should be changed and labeled every Sunday and further stated the facility staff did not follow the policy.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51583</p> <p>Based on interview and record review, the facility failed to maintain accurate records of controlled medications (medications that are controlled by the government because it may be abused or cause addiction) for one of two medication carts (Medication Cart 1).</p> <p>This failure had the potential for drug diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff in a highly vulnerable population of 21 residents.</p> <p>Findings:</p> <p>During a concurrent interview, and record review on May 7, 2025, at 6:20 AM, with a Licensed Vocational Nurse 2 (LVN 2), at the nurse's station, the Medication Cart 1's Controlled Medication Shift Count (CMSC-form used by the facility to verify counting of controlled medications at the change of shift by oncoming and off going licensed nurses), dated April 23 2025, through May 4, 2025, was reviewed. The CMSC indicated that there were two missing signatures on April 26, 2025, for the night shift (7:00 PM to 7:00 AM). LVN 2 confirmed two missing signatures and stated the expectations for the CMSC to be counted by two nursing staff, filled out, and signed every shift change.</p> <p>During a concurrent interview and record review on May 7, 2025, at 10:15 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Controlled Drugs, undated, was reviewed. The P&amp;P indicated, .2.3. Skilled Nursing narcotic counts are conducted at shift change by verification with two licensed nurses . The DON stated the policy was not followed and should have been to find out if there are any discrepancies.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>51583</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&amp;P) for drug storage for one of one medication refrigerator in the medication storage room when the daily medication temperature log for the refrigerator was missing two staff signatures for two shifts.</p> <p>This failure had the potential for medications to be less effective due to the temperature of the medications being out of range.</p> <p>Findings:</p> <p>During a concurrent observation and interview on May 07, 2025, at 9:30 AM, with the Director of Nursing (DON), in the medication storage room, across from the nursing station, one medication refrigerator was observed with a document titled, Daily Temperature Log for Refrigerator, with two missing signatures. The DON verified there were missing signatures for the refrigerator temperature checks on March 12, 2025, and March 30, 2025.</p> <p>During a concurrent interview and record review on May 07, 2025, at 10:32 AM, with the DON, the facility's P&amp;P titled, Drug Storage Temperatures, undated, was reviewed. The P&amp;P indicated, . All refrigerators used for the storage of vaccines shall be monitored twice daily . The DON stated the policy was not followed because there was no proof of staff monitoring the refrigerator's temperature and further stated the medications need to be kept at the correct temperatures for the safe use of the medications.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47332</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored to conserve nutritive value (measure of a well-balanced diet) and maintain professional standards of food safety for all 21 residents admitted in the facility when:</p> <ol style="list-style-type: none"> <li>1. There was an unlabeled bag of minced beef in the refrigerator.</li> <li>2. There was an open and unlabeled bag of tortilla flour in the refrigerator.</li> </ol> <p>These failures had the potential to cause unsafe food consumption for all 21 vulnerable residents in the facility from possible allergenic substances in food products and consume food beyond the use date (expired date), which can negatively affect resident's health from allergic reaction or foodborne illness (illness caused by ingestion of contaminated food or beverages).</p> <p>3. For Resident 7, a serving of pureed cauliflower was not palatable or had comparable taste to regular serving of cauliflower.</p> <p>This failure had the potential to cause Resident 7, who was on pureed texture diet order, to experience a decrease in food intake which could lead to unintentional weight loss, malnutrition (not having enough food to eat), and resulting in actual physical harm.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on [DATE], at 11:07 AM, with the Executive Chef (EC), the shelf to the left side of the refrigerator had a bag of minced beef with no label. The EC stated the bag of minced beef should have been labeled and dated.</li> <li>During a concurrent interview and record review on [DATE], at 11:45 AM, with the Director of Nutrition Services (DNS), the facility's policy and procedure (P&amp;P) titled, Food Storage, dated [DATE], was reviewed. The P&amp;P indicated. Procedure:13. Refrigerated food storage: f. All food should be covered, labeled and dated and routinely monitored to assure that food (including leftovers) will be consumed by their use by dates, to frozen (where applicable) or discarded The DNS verified and confirmed that the facility staff did not follow the P&amp;P. The DNS stated that the bag of minced beef in the refrigerator should have been labelled and dated. The DNS further stated that not labeling and dating the bag of minced beef increases the risk of foodborne illness.</li> <li>2. During a concurrent observation and interview on [DATE], at 11:10 AM, with the EC, the shelf to the left side of the refrigerator was observed to have an open unlabeled bag of flour tortillas without, open date, beyond the use date, or description of product. The EC stated the bag of flour tortilla should have been labeled and dated with a description of the product.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review on [DATE], at 11:30 AM, with the DNS, the facility's P&amp;P titled, Food Storage, dated [DATE], was reviewed. The P&amp;P indicated. Procedure:13. Refrigerated food storage: f. All food should be covered, labeled and dated and routinely monitored to assure that food (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded The DNS verified and confirmed that the facility staff did not follow the P&amp;P. the DNS stated that the bag of flour tortilla in the refrigerator should have been labeled and dated. The DNS further stated that not labeling and dating the bag of flour tortilla increases the risk of foodborne illness.</p> <p>3. During a review of Resident 7's Admission Record(contains demographic and medical information), the Admission Record indicated, Resident 7 was admitted to the facility on [DATE], with the diagnoses of chronic obstructive pulmonary disease (COPD-a group of lung disease that block airflow and make it difficult to breathe) and dementia (a progressive decline in mental ability, impacting memory, thinking, language, and behavior, to the point where it affects daily life).</p> <p>During a review of Resident 7's Physician Order for diet, dated February 23, 2022, the Physician Order indicated, Resident 7 had an order for a regular diet with pureed texture.</p> <p>During an observation on [DATE], at 11:40 AM, with a Kitchen Staff (Cook 1) and the DNS, cook 1 was observed preparing the pureed cauliflower in blender by using only hot water.</p> <p>During a concurrent observation and interview on [DATE], at 12:06 PM, with the EC, the sample taste trays of regular diet (no restriction on food) and pureed diet for lunch were observed and tested for palatability (the taste of food), texture and temperature. The sample trays consisted of cilantro chicken, refried beans, Spanish rice, cauliflower and tres leche cake. The regular diet vegetables tasted buttery flavor and were not comparable to the pureed vegetable served. The EC stated that the pureed cauliflower tasted watery and bland and did taste like the regular diet cauliflower.</p> <p>During an interview on [DATE], at 1:00 PM with [NAME] 1 and the DNS, [NAME] 1 stated that she only added hot water to make cauliflower pureed, I should have followed the recipe and should have added small amount of gravy sauce, vegetable juice, water, fruit juice, milk or half &amp; half to meet desired taste and consistency. The DNS further stated that the pureed diet meals should taste like regular diet meals for the residents and [NAME] 1 did not follow the recipe.</p> <p>During a concurrent interview and record review on [DATE], at 9:08 AM, with the DNS, the facility's P&amp;P titled, The Dining Experience, dated February 2023, and PU4 Cauliflower (fzn) (P4U Cauliflower) recipe, undated, were reviewed. The P&amp;P indicated, .Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutrition and/or special dietary needs and food preferences and are served at a safe and appetizing temperature . The P4U Cauliflower recipe indicated, .Measured desired # of servings into food processor. Blend until smooth. Use Drip Test and Spoon Tilt Test to confirm texture is within IDDSI (International Dysphagia Diet Standardization Initiative) Level 4 Specifications. Add small amounts of gravy, sauce, vegetable juice, water, fruit juice, milk, or half &amp; half to meet desired consistency. Drain &amp; Discard excess fluid that has separated from solid food pieces The DNS stated, the pureed cauliflower should taste the same as regular diet textured cauliflower, we did not follow our facility's policy and procedure to provide each individual with nourishing and palatable meal.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47332</b></p> <p>Based on observation, interview, and record review, the facility failed to provide special assistive devices during mealtimes for three of 21 sampled residents (Resident 3, 7 and 15) when:</p> <ol style="list-style-type: none"> <li>1. Residents 3 and 7 were not provided with a plate guard (a clip onto the edge of a plate to prevent spilling of food) and [NAME] Anti Spill Cup (KCup-allows the cup to be easily filled, once the lid is screwed on, the liquid will not slip even if the cup is turned completely upside down) during lunch.</li> <li>2. Resident 15 was not provided with KCup as ordered.</li> </ol> <p>These failures had the potential to cause Resident 3, 7, and 15 to experience a decrease in food intake without appropriate assistive devices which could lead to unintentional weight loss (not having enough food to eat) and resulting in actual physical harm and medical complications.</p> <p>Findings:</p> <p>1a. During a review of Resident 3's Admission Record (contain demographic and medical information), undated, the Admission Record indicated, Resident 3 was admitted to the facility on [DATE], with the diagnoses which included hemiplegia (a condition characterized by severe or complete paralysis on one side of the body), and right side hemiparesis (muscle weakness or partial paralysis on one side of the body).</p> <p>During a review of Resident 3's Physician Order for diet, dated April 25, 2022, the physician order indicated, Resident 3 had an order for a plate guard and KCup.</p> <p>1b. During a review of Resident 7's Admission Record, undated, the Admission Record indicated, Resident 7 was admitted to the facility on [DATE], with the diagnoses which included chronic obstructive pulmonary disease (COPD-a group of lung disease that block airflow and make it difficult to breathe) and dementia (a progressive decrease in mental ability, impacting memory, thinking, language, and behavior, to the point where it affects daily life).</p> <p>During a review of Resident 7's Physician Order for diet, dated April 23, 2022, the physician order indicated, Resident 7 had an order for a plate guard and KCup.</p> <p>During a concurrent observation and interview on May 5, 2025, at 12:15 PM, with a Certified Nursing Assistant (CNA 2), in the residents' dining room, Resident 3 and 7 were not given a plate guard and KCup for eating during lunch. Resident 3 and 7 had meal tickets which indicated a plate guard and KCup were ordered to be used during mealtimes. CNA 2 verified and confirmed that Resident 3 and 7 did not have a plate guard and KCup during the entire lunch time. CNA 2 further stated that Resident 3 and 7 should have a plate guard and KCup during meal and snack time.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on May 8, 2025, at 9:08 AM, with the Director of Nutrition Services (DNS), the facility's policy and procedure (P&amp;P) titled, Assistance with Feeding SNF [Skilled Nursing Facility], undated, was reviewed. The P&amp;P indicated, . [Facility Name] shall ensure that all residents who require assistance with eating receive appropriate support in manner that maintains their dignity, independence, safety, and nutritional well-being . The DNS stated, Resident 3 and 7 should have been provided with a plate guard and KCup, the facility staff did not follow the P&amp;P.</p> <p>50754</p> <p>2. During a review of Resident 15's Admission Record, undated, the Admission Record indicated, Resident 15 was admitted to the facility on [DATE], with diagnoses which included dementia (brain condition that effects thinking memory and behavior), depression (mental health condition persistent feeling of sadness, hopelessness, and loss of interest), anemia (low red blood cells to carry oxygen throughout the body), anxiety (feeling of fear, dread and uneasiness), osteoporosis (bones become thin, weak, and fragile), and Parkinson's disease (a disorder of the central nervous system that affects movement, tremors).</p> <p>A review of Resident 15's Physician Order, dated February 20, 2025, indicated Resident 15 had an order for KCup three times a day with meals.</p> <p>During an observation on May 5, 2025, at 12:09 PM, in the dining room, Resident 15 was observed sitting at one of the dining tables without a KCup. Resident 15's meal ticket, at the bottom, indicated KCup should be on Resident 15's meal tray.</p> <p>During a follow-up concurrent observation and interview on May 5, 2025, at 12:50 PM, with CNA 1, Resident 15 was observed without a KCup, and CNA 1 assisted Resident 15 with meal. Resident 15 drank supplement drink and water through a straw. CNA 1 confirmed and stated that Resident 15 did not have a KCup and should have.</p> <p>During a concurrent interview and record review, on May 6, 2025, at 4:39 PM, with the Director of Nursing (DON), the facility's P&amp;P, undated, was reviewed. The P&amp;P indicated, .Subject: Assistance with Feeding SNF [Skilled Nursing Facility], Policy: [Facility Name] shall ensure that all residents who require assistance with eating receive appropriate support in a manner that maintains their dignity, independence, safety, and nutritional well-being . The DON confirmed Resident 15 should have had her KCup with her meal to encourage the patient to become stronger and CNA 1 should have made sure Resident 15 had her KCup. The [NAME] stated that the P&amp;P was not followed by CNA 1.</p>

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50754</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed for all 21 residents in the facility when two cups with brown liquid were found on the folding table/desk in the laundry room.</p> <p>This failure had the potential to result in spilling which can cause contamination to from uncleaned cloths and wetness can create mold and mildew to further compromised all 21 vulnerable residents in the facility.</p> <p>Finding:</p> <p>During a concurrent observation and interview on March 7, 2025, at 7:01 AM, with an Environment Service (EVS) and Environment Service-Trainee (EVS-T), the laundry room across from the Nurse's station in Unit B was observed. There was a brown cup with a sippy lid and a clear cup, containing brown liquid inside, located on the folding table. EVS and EVS-T acknowledged the two brown liquid cups on the folding table inside the laundry room. EVS stated he was informed that the coffee cup was allowed.</p> <p>During an interview on March 7, 2025, at 8:10 AM, with the Director of Facilities (DOF), the DOF stated they are not supposed to have personal drinks/beverages in the laundry room. The DOF confirmed yes, it is an infection control issue. The DOF stated it is important to not have personal drinks in the facility areas, this prevents infections and contamination.</p> <p>During a concurrent interview and record review on May 8, 2025, at 11:53 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Infection Prevention- Skilled Nursing Facility (SNF), dated June 25, 2015, was reviewed. The P&amp;P indicated, . [Facility Name] shall promote the maintenance of a safe environment for both residents and employees and provides appropriate care for residents to prevent the spread of infection. The skilled Nursing Facility provides care to residents of varying ages and disease processes. When infections occur, they can be devastating to residents as well as staff members. Staff and health care providers play a crucial role in protecting themselves and our residents . The DON confirmed the P&amp;P was not followed and should have been. The DON stated drinks should not have been in the laundry care area in the staff personal area or in the break area.</p>		