California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060000117	A. BUILDING: _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONITA HILLS POST ACUTE	1233 WEST LA HABRA BOULEVARD LA HABRA, CA 90631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a staffing audit visit for 24 randomly selected days from 07/01/2021 to 09/30/2021. Representing the Department: J.D., Associate Governmental Program Analyst. Welfare and Institutions (W&I) Code section 14126.022 sets forth the Department's authority to conduct audits of direct caregiver nursing services provided to residents of skilled nursing facilities, and to establish procedures for conducting such audits through All Facility Letters (AFLs). <http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14126.022.&lawCode=WIC> AFL 21-11, setting forth the audit process and guidelines for facilities is available through the following link: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx> Health and Safety Code (HSC) 1337-1338.5, sets forth the requirements for Certified Nurse Assistants is available through the following link: <https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=2.&chapter=2.&lawCode=HSC&article=9> W&I section 14126.022 requires the Department to assess an administrative penalty to a SNF if the Department determines that the SNF fails to meet the DHPPD requirements pursuant to HSC sections 1276.5 or 1276.65. The Department shall assess an administrative penalty to any facility that fails to meet the applicable standard	A 000		1/3/25

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 1/9/25

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A 000	Continued From page 1	A 000		

for staffing requirements on any given day. The applicable standard is 3.5 DHPPD and 2.4 DHPPD (CNA), unless an approved Workforce Shortage or Patient Needs Waiver is granted.

The statute was not met as evidenced by the following findings:

Final Audit Result:

Total Distinct Non-Compliant Day(s) = 14

Date	3.5	2.4
07/01/2021	3.88	2.57
07/02/2021	3.87	2.62
07/05/2021	3.60	2.52
07/06/2021	3.58	2.42
07/08/2021	3.73	2.43
07/14/2021	3.63	2.41
07/20/2021	3.71	2.55
07/22/2021	*3.44*	*2.39*
07/23/2021	*3.41*	*2.31*
07/24/2021	*3.22*	*2.17*
07/30/2021	*3.34*	*2.26*
08/10/2021	*3.47*	*2.35*
08/13/2021	*3.00*	*2.26*
08/14/2021	*3.22*	*2.23*
08/22/2021	*3.21*	*2.23*
08/23/2021	*3.43*	*2.35*
08/25/2021	3.58	*2.39*
08/29/2021	3.57	*2.33*
08/30/2021	*3.42*	2.41
09/05/2021	*3.44*	*2.31*
09/06/2021	3.56	2.56
09/08/2021	3.90	2.43
09/16/2021	3.87	2.53
09/17/2021	3.61	*2.36*

x.xx = non-compliant date

1/3/25

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A 200	Continued From page 2	A 200		
A 200	HSC 1276.65(c)(1)(B) SAS - 3.5 Standard (B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9. This Statute is not met as evidenced by: Facility failed to meet 3.5 Direct Care Service Hours Per Patient Day (DHPPD), Pursuant to HSC 1276.65(c)(1)(B) for 11 of 24 days. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s). Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Employee(s) failed to delineate time spent providing nursing services to skilled nursing care patients, as defined in HSC section 1276.65 and CCR Title 22, section 72309, section 72311 and section 72315, while assigned to perform other duties other than direct care.	A 200		1/3/25

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A 200	Continued From page 3 The Director of Staff Development (DSD) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required to carry out the duties of the DSD position.	A 200		
A 205	HSC 1276.65(c)(1)(C) SAS - 2.4 Standard (C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B). This Statute is not met as evidenced by: Facility Failed to meet 2.4 Direct Care Service Hours Per Patient Day (DHPPD) performed by certified nurse assistants, pursuant to HSC 1276.65(c)(1)(C) for 13 out of 24 days. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s). Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees.	A 205		1/3/25
A 020	AFL 21-11 II.B SAS-Form 530	A 020		

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A 020	Continued From page 4 B. Facilities must use CDPH 530. Failure to use this CDPH required form will result in a finding of non-compliance for each audited day the form is not available. The facility is responsible for ensuring all entries are accurate and legible. This Statute is not met as evidenced by: Facility failed to use CDPH Form 530 per AFL 21-11, Section II, Guidelines, subsection B, and pursuant to W&I 14126.022.	A 020		
A 040	AFL 21-11 II.B SAS-Form 612 B. Facilities must use CDPH 612. Failure to use this CDPH required form will result in a finding of non-compliance for each audited day the form is not available. The facility is responsible for ensuring all entries are accurate and legible. This Statute is not met as evidenced by: Facility failed to use CDPH Form 612 per AFL 21-11, Section II, Guidelines, subsection B, pursuant to W&I 14126.022.	A 040		1/3/25

"Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility submitted CHOW ownership package and such was approved on 1/5/2024.' The audit was cited in 2021. The POC dates will include the current dates for the previous cited deficient practices that occurred well before the CHOW."

A200
Corrective Action To Correct Deficiency:
On 1/3/25, DSD reviewed the last 60 days of DHPPD data to ensure that facility is meeting the requirement and reviewed all active staff to ensure adequate staff is available to meet the requirement based in the current and anticipated census data.
On 1/3/2025, Payroll separated licensed nurse functioning as DSD hours while performing nursing care vs. DSD duties.
Identify Any Other Residents Who May Have Been Affected By the Deficient Practice:
On 1/3/2025, DSD performed rounds of the facility and interviewed all interviewable residents to ascertain if there had been any delays in care as it pertains to CNA staffing. There were 0 concerns identified.
On 1/3/2025, DON interviewed all alert and interviewable residents to ascertain if they have experienced any issues by the facility not ensuring clear separation of the DSD functioning as DSD vs. direct care staff. There were 0 other issues identified.
Systemic Change To Prevent Recurrence:
On 1/3/2025, DSD provided education to individuals responsible for staffing the facility regarding the current regulatory requirements and interventions and escalation required should the available staff to meet the requirement is lacking.
On 1/3/25, Admin provided inservicing to DSD and her designee regarding the importance of separating nursing house vs. hours associated with DSD job duties.
Monitoring And Evaluation Plan:
Beginning 1/3/25, Admin/DSD will meet weekly to go over current staffing needs and review the week prior of DHPPD data to ensure facility is adequately staffed per the regulatory requirement. These focused meetings will continue for 3 months or until substantial compliance is obtained. Any ongoing issues or noncompliance will be reported by Admin at the monthly QA meeting.
Beginning 1/3/25, DSD will audit her time sheets weekly to ensure that the hours are properly recorded and relegated to the tasks she was completing on that particular shift. These audits will continue for 3 months or until substantial compliance is obtained. Any ongoing issues or noncompliance will be reported by Admin at the monthly QA meeting.

A205
Corrective Action To Correct Deficiency:
On 1/3/25, Payroll/DSD audited all active employee personnel and payroll files to ensure that they are current, complete, and accurate.
Identify Any Other Residents Who May Have Been Affected By the Deficient Practice:
On 1/3/25, DSD performed rounds and interviews of all in house alert and interviewable residents to ensure there have been no concerns with care and that staff is competent and able to complete their duties. There were 0 other issues identified.
Systemic Change To Prevent Recurrence:

On 1/3/25, Admin provided inservicing to DSD/Payroll regarding the importance of maintaining current, complete, and accurate personnel records for all employees.
Monitoring And Evaluation Plan:
Beginning 1/3/25, DSD will review all new hire employee personnel files weekly to ensure they are current, complete, and accurate. These reviews will continue for 3 months or until substantial compliance is obtained. Any ongoing issues or noncompliance will be reported by Admin at the monthly QA meeting.

A020
Corrective Action To Correct Deficiency:
On 1/3/25, the CMS 530 Form was made available by Payroll for use by salaried staff should they be providing direct care to residents.
Identify Any Other Residents Who May Have Been Affected By the Deficient Practice:
On 1/3/25, DSD audited the nursing hours to ascertain if any residents were affected by this deficient practice due to inadequate hours. There were 0 other issues identified.
Systemic Change To Prevent Recurrence:
On 1/3/25, Payroll provided inservicing to the DSD and designee regarding the CDPH 530 Form per AFL 21-11 and the proper utilization to ensure adequate tracking of hours.
Monitoring And Evaluation Plan:
Beginning 1/3/25, Payroll will perform audits of staffing sign in sheets weekly to ensure that any employees that should have a 530 Form utilized to track their hours has one properly filled out and in place. These audits will continue for 3 months or until substantial compliance is obtained. Any ongoing issues will be reported by Payroll at the monthly QA meeting.

A040
Corrective Action To Correct Deficiency:
On 1/3/2, the CDPH 612 Form was made available for use by staff by Admin.

Identify Any Other Residents Who May Have Been Affected By the Deficient Practice:
On 1/3/25, DSD audited the nursing hours to ascertain if any residents were affected by this deficient practice due to not using the required CMS 612 Form. There were 0 other issues identified.
Systemic Change To Prevent Recurrence:
On 1/3/25, DSD provided inservicing to the Payroll regarding the CDPH 612 Form per AFL 21-11 and the proper utilization to ensure adequate tracking of hours.
Monitoring And Evaluation Plan:
Beginning 1/3/25, Payroll will perform audits of staffing sign in sheets weekly and the postings to ensure that the 612 Form is utilized for posting and is accurate. These audits will continue for 3 months or until substantial compliance is obtained. Any ongoing issues will be reported by Admin at the monthly QA meeting.