

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Berkley West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1623 Arizona Avenue Santa Monica, CA 90404	

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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on observation, interview and record review, the facility failed to ensure indoor and outdoor visitations for all residents are in placed with no limitations of frequency and length of visits according to federal regulations.</p> <p>This deficient practice violated 33 out of 33 residents ' rights regarding visitation.</p> <p>Findings:</p> <p>A review of Resident 4 ' s Admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and pneumonia (lung infection that inflames air sacs with fluid or pus).</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 4/25/2024, indicated Resident 4's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were moderately impaired.</p> <p>During an interview with Resident 4 on 5/15/2024 at 10:51 a.m., Resident 4 stated, her family members can visit her (Resident 4) only on certain hours. Resident 4 further stated, visitors need to make an appointment prior to coming and can only come and visit for one hour.</p> <p>During an observation of the facility on 5/15/2024 at 9:49 a.m., observed posted signage outside the door of the facility that stated, Visiting Hours are from 11:00 a.m. to 6:00 p.m., Appointment Only!!! (highlighted) . Visits are one hour only at a time with only four visitors at a time in the facility.</p> <p>During an interview with Receptionist 1 (RC 1), on 5/15/2024 at 10:31 a.m., RC 1 stated, visitations have to be make via appointment and only during 11 a.m., to 6 p.m. and only 1 person at a time if inside the room. RC1 stated, family members are made aware of the visitation hours and limit.</p> <p>During an interview with Director of Nursing (DON), on 5/15/2024 at 2:10 p.m., DON stated, they are currently not on any COVID-19 (an infectious disease that can cause respiratory illness in humans) outbreak.</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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with Administrator (ADM) on 5/15/2024 at 3:04 p.m., ADM stated, visitation hours are posted outside the door which is from 11 a.m., to 6 p.m. because they don't want the visitors to interfere with morning residents' care.</p> <p>A review of the facility ' s undated policy and procedure (P&P) titled, Resident Rights, reviewed on 10/2023 indicated that federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: . communication with and access to people and services, both inside and outside the facility . visit and be visited by others from outside the facility.</p> <p>A review of Centers for Medicare & Medicaid Services (CMS), Quality, Safety & Oversight (QSO - oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers [including hospitals, nursing homes, home health agencies (HHAs), end-stage renal disease (ESRD) facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries], made available to beneficiaries, providers/suppliers, researchers and State surveyors information about these activities), reference letter: QSO-20-39-NH, revised on 5/8/2023 indicated that, facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the Public Health Emergency (PHE), facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.</p> <p>Based on observation, interview and record review, the facility failed to ensure indoor and outdoor visitations for all residents are in placed with no limitations of frequency and length of visits according to federal regulations.</p> <p>This deficient practice violated 33 out of 33 residents' rights regarding visitation.</p> <p>Findings:</p> <p>A review of Resident 4's Admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and pneumonia (lung infection that inflames air sacs with fluid or pus).</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 4/25/2024, indicated Resident 4's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were moderately impaired.</p> <p>During an interview with Resident 4 on 5/15/2024 at 10:51 a.m., Resident 4 stated, her family members can visit her (Resident 4) only on certain hours. Resident 4 further stated, visitors need to make an appointment prior to coming and can only come and visit for one hour.</p> <p>During an observation of the facility on 5/15/2024 at 9:49 a.m., observed posted signage outside the door of the facility that stated, Visiting Hours are from 11:00 a.m. to 6:00 p.m., Appointment Only!!! (highlighted) . Visits are one hour only at a time with only four visitors at a time in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on interview and record review, the facility failed to ensure a resident's notice of discharge or transfer was provided to the resident and/or resident's representative that included a right to appeal for one of one sampled resident, Resident 1.</p> <p>This had the potential to result in an unsafe discharge and or denying the resident of the right to appeal the discharge.</p> <p>Finding:</p> <p>A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus (DM - a chronic condition that affects the way the body processes blood sugar [glucose]), nontraumatic intracerebral hemorrhage (when blood suddenly bursts into brain tissue, causing damage to the brain) and history of falling.</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 4/19/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were intact and required moderate to maximal assistance from staff for activities of daily living (ADL-toileting hygiene, shower/bathing, repositioning from sit to stand, sit to lying and rolling left and right).</p> <p>A review of Resident 1 ' s Notice of Medicare Non-Coverage (NOMNC - a notice that indicates when your care is set to end from a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or hospice), dated 4/26/2024 indicated, the effective date coverage for current SNF services will end on 4/28/2024. Resident 1 ' s NOMNC form has a handwritten notes by SSD, that indicated the following:</p> <p>i. on 4/26/2024, SSD called Resident 1 ' s family member (FM) at 3.25 p.m., to informed her of NOMNC.</p> <p>ii. SSD called FM at 11:45 p.m., on Saturday to remind her (FM) of NOMNC last coverage date of 4/28/2024, discharge on 4/28/24.</p> <p>During an interview with Social Services Director (SSD) on 5/15/2024 at 11:30 a.m., SSD stated, they received the NOMNC letter on 4/26/2024 and she attempted to talk to Resident 1 ' s FM regarding the last covered date. SSD stated, she was not able to talk to Resident 1 ' s FM directly so she left a message on 4/26/2024 and 4/27/2024. SSD stated, she did not provide the NOMNC information to Resident 1. SSD further stated, there was no information given to Resident 1 and Resident 1 ' s FM regarding how to submit an appeal. SSD further stated, she did not document any of this information in Resident 1 ' s Progress Notes in Electronic Health Record (EHR) and she did not send a copy of the NOMNC via mail.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s policy and procedure (P&P) titled, Medicare Denial Process Beneficiary Notices, effective date 11/27/2023 indicated, the facility will ensure that the communication of the Generic Notice to the representative occurs as follows: the beneficiary ' s appeal rights must be explained to the representative. The P&P also indicated, when direct phone contact cannot be made, send a copy of the Generic Notice to the representative by certified mail, return receipt requested.</p> <p>A review of the facility ' s P&P titled, Resident Rights, revised on 10/2023 indicated, The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>Based on interview and record review, the facility failed to ensure a resident's notice of discharge or transfer was provided to the resident and/or resident's representative that included a right to appeal for one of one sampled resident, Resident 1.</p> <p>This had the potential to result in an unsafe discharge and or denying the resident of the right to appeal the discharge.</p> <p>Finding:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus (DM - a chronic condition that affects the way the body processes blood sugar [glucose]), nontraumatic intracerebral hemorrhage (when blood suddenly bursts into brain tissue, causing damage to the brain) and history of falling.</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 4/19/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were intact and required moderate to maximal assistance from staff for activities of daily living (ADL-toileting hygiene, shower/bathing, repositioning from sit to stand, sit to lying and rolling left and right).</p> <p>A review of Resident 1's Notice of Medicare Non-Coverage (NOMNC - a notice that indicates when your care is set to end from a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or hospice), dated 4/26/2024 indicated, the effective date coverage for current SNF services will end on 4/28/2024. Resident 1's NOMNC form has a handwritten notes by SSD, that indicated the following:</p> <p>i. on 4/26/2024, SSD called Resident 1's family member (FM) at 3.25 p.m., to informed her of NOMNC.</p> <p>ii. SSD called FM at 11:45 p.m., on Saturday to remind her (FM) of NOMNC last coverage date of 4/28/2024, discharge on 4/28/24.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on observation, interview and record review, the facility failed to refer and provide podiatry service as ordered by physician for one of four sampled residents, Resident 1.</p> <p>This deficient practice placed the resident at risk of injury and complications.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus (DM - a chronic condition that affects the way the body processes blood sugar [glucose]), nontraumatic intracerebral hemorrhage (when blood suddenly bursts into brain tissue, causing damage to the brain) and history of falling.</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 4/19/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were intact and required moderate to maximal assistance from staff for activities of daily living (ADL-toileting hygiene, shower/bathing, repositioning from sit to stand, sit to lying and rolling left and right).</p> <p>A review of Resident 1 ' s Order Summary Report, dated 4/15/2024, indicated, physician ordered podiatry services for treatment of mycotic hypertrophic toenails (infection of the nails causing thickening of the nails and may become curled) and/or other foot problems - diabetic (a person who has DM) or vascular disease (any condition that affects your circulatory system, or system of blood vessels).</p> <p>A review of Resident 1 ' s Care Plan for at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to type II DM, created on 4/17/2024, indicated an intervention to provide good foot care.</p> <p>During a concurrent observation and interview with Resident 1 on 5/15/2024 at 10:58 a.m., Resident 1 stated, she had requested for a podiatry appointment for his foot and toes, and she was told that the Podiatrist will come but she still has not been seen by a Podiatrist. Resident 1 stated her toenails are long and it makes her very uncomfortable. Resident 1 stated, she is having a hard time putting on her socks because of how long her toenails are. Resident further stated, she is being seen by her Podiatrist frequently when she was at home. Resident 1 was noted to have long, thick, sharp toenails on both feet.</p> <p>During an interview with Licensed Vocational Nurse 1 (LVN1) on 5/15/2024 at 11:07 a.m., LVN1 stated, Podiatrist services are managed by the Social Services department, and they are the one who makes sure that residents are seen by Podiatrist. LVN1 observed Resident 1 ' s toenails on both feet and stated, her nails are really long and mycotic. LVN1 stated, Resident 1 also has heel ulcer (localised injury to the heel as result of pressure sometimes in association with other factors). LVN1 further stated, this puts her at risk of injury and makes her uncomfortable.</p> <p>(continued on next page)</p>

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