STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055136	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley West Healthcare Center	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)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on interview and record review the facility failed to involve an interdisciplinary team (IDT, is a group of professionals from different disciplines who work together to achieve a common goal for residents), resident and/or resident representative in developing a discharge plan and assist the resident and/or resident representatives in selecting a post-acute care provider for one of three sampled resident, (Resident 1). This deficient practice caused the resident and resident representative to be uninformed regarding the discharge plan and placed Resident 1 at risk potentially going to a facility that does not meet her needs. Findings: A review of Resident 1's Admission Record indicated the facility admitted this [AGE] year-old-female on 4/15/2024 with diagnoses including non-traumatic intracerebral Hemorrhage (bleeding in the brain unrelated to trauma), diabetes Mellitus type 2, Cirrhosis (long term liver damage) of the liver, abnormal gait (an unusual walking pattern), pressure ulcer of left and right heel (open wounds due to the pressure of the feet resting on the bed), Hypertension (high blood pressure), Anemia (low red blood cells), history of falls, Glaucoma (pressure in the eyes) and Hyperlipidemia (high cholesterol). A review of Resident 1's Multidisciplinary Care Conference Note dated 4/18/2024 indicated the director of social services (DSS) spoke with the family member (FM) regarding discharge planning and the FM stated she will need placement, she is not safe to live alone at home, DSS will continue to follow up. Further indicates Resident 1 has no barriers, can walk with a front wheel walker and standby assistance. Resident 1 is confused per rehab at times des not want to participate with walking or exercise. Per FM she is working with staff at GACH for placement and will inform DSS of outcome. DSS will assist with finding a placement memory care for resident. DSS will also refer to placement agent (PA) to assist with finding memory care facility. Resident 1 was able to take 3 steps on a front wheel walker with maximal assistance of two people. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/19/2024 indicated Resident 1's cognition (the mental ability to make decisions of daily living)was moderately impaired. Resident 1 required maximal assistance (helper does more than half the effort) with transfers (moving from bed to chair), toileting and hygiene. The resident and family are active participants in the discharge process. The resident has a goal to discharge to the community and active discharge planning has occurred. No referrals have been made to the local contact agency due to referral not wanted. A review of Resident 1's discharge care plan dated 5/2024 indicated Resident 1 was to return to the community to a daily living shelter. Interventions included to assist with obtaining community resources for discharge, social services will meet with resident or family to begin discharge planning, give family list of resources needed. A review of Resident 1's physician order dated 4/24/2024 indicated discharge Resident 1 home on 4/29/2024 with home health, physical therapy, occupational therapy, and a registered nurse. (DME-durable medical equipment) hospital bed and wheelchair. On 5/8/2024 the California Department of Public Health (CDPH) received a complaint alleging the facility was not assisting with placement of Resident 1 after discharge from the facility. During an interview on 5/22/2024 at 10:30 a.m. the social worker (SW) from the general acute care hospital (GACH) stated, we intermittently assist with short term resident's placement. My colleague spoke with the DSS at the facility regarding Resident 1's discharge and was told the GACH was helping with the discharge and that is not correct because we don't do that. We then spoke with the FM who stated the facility was not helping with the discharge planning process and Resident 1 was still in the facility. I then tried to reach the DSS at the facility several times and never heard back . (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2024 at 1:45 p.m. the FM stated, On 4/29/2024 I spoke with the facility, and they informed me that I would be responsible to pay 100 dollars a day for Resident 1's stay there after this date and I told them immediately that I could not afford that, and they should start working on getting her a new place. I also told them she was not safe to go home because I travel for work. Initially the DSS told me it was not her job to assist with the discharge . So, on 5/8/2024, I called the GACH, and they gave me a referral to an agency to assist with getting Resident 1 on an assist living waiver program (ALWP-designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility) to help cover the cost of her stay at a new place. No one from the facility said to me that they would start looking for a new place for her so there was no clear direction or plan for her discharge. On 5/9/2024 I heard from a representative from the ALWP, and they said they would assist with the waiver to find placement for Resident 1 . I communicated this to the DSS at the facility and she did not ask for the number or offer to follow up as I travel for work and may or may not be available . I then got a call from the PA offering potential facilities however that was not helpful because they did not accept Medi-Cal. I informed them Resident 1 was in the process of applying for the ALWP and once she was approved, we could find a place . The PA did not provide a list of any facilities that accept the ALWP. The DSS did not call back after I spoke with the placement center nor offer a list of facilities that accept the ALWP . I called the agency from GACH yesterday to follow up on the ALWP because I had not heard back from them nor the DSS at the facility and I was told that someone would go to visit Resident 1 after she had been at the facility for 60 days to evaluate her for the ALWP, so I provided them with the contact information for the facility . I felt like the DSS should have been making these phone calls and following up not me I am not a medical professional, and my work schedule is very hectic with travel . During a concurrent interview and record review on 5/23/2024 at 2:00pm with the DSS, the DSS progress note dated 5/8/2024 was reviewed. The progress note indicated the FM called to follow up with discharge planning and stated she did not have a plan. The DSS offered to assist as needed with placement. The DSS will refer to PA to reach out to FM and help find memory care for facility for Resident 1. DSS will keep daughter posted. The DSS stated, the last conversation I had with the FM was on 5/8/2024. The FM told me She was getting help from somewhere to apply for the ALWP and they would contact me . I am not familiar with that program, but I do have a list of facilities that accept the waiver program . I did not provide the FM with that list . I have not been contacted by anyone regarding the ALPW for Resident 1 and I did not follow up with the FM regarding the ALWP . I did reach out to another associated at another facility to see if they could accept Resident 1 but I never heard back from them . I did not communicate that to the resident nor the FM . The DSS stated, I have not followed up with the FM regarding discharge planning since 5/9/2024, I usually follow up when I have time after I have ordered DME for my other residents . Lastly, the DSS stated, we have one initial discharge care plan meeting with the family and the team and any communication after that is usually between me and the family . During an interview on 5/23/2024 at 4:26 p.m. the Administrator (Adm) stated, When the FM stated she would find placement I expected the DSS to follow up and ask if she needed any resources to find assisted living facilities. The role of the DSS is to exhaust all means to find placement which means contacting a minimum of three facilities to see if they could accept Resident 1. The DSS should have provided the list of facilities that accept the ALWP to the FM so she could choose places then faxed Resident 1's paperwork to those places for possible placement and kept the FM informed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P &P) titled, Interdisciplinary Team (IDT) Discharge (DC) Planning , revised 10/2023 indicated: This facility shall provide Discharge Planning for all resident/patients according to federal and state regulatory requirements. This facility shall complete a comprehensive assessment of the resident/patient's needs, strengths, goals, life history and preferences utilizing the resident assessment instrument to assist with the process of discharge planning. This facility's discharge planning process shall apply all resident/patients and shall consist of four (4) stages: Screening all residents/patients to determine which are at risk of adverse health consequences post-discharge if they lack discharge planning. Evaluation of the post-discharge needs of resident/patients identified in the first stage, or of resident/patients who request an evaluation, or whose physician requests one. Development of a discharge plan if indicated by the evaluation or at the request of the resident/patient's physician. Initiation of the implementation of the discharge plan prior to the discharge of a resident/patient A registered nurse, social worker or other qualified staff shall oversee the development of the discharge plan. The resident/patient/significant other/family must be informed of the resident/patient's freedom to choose among participating providers for post-hospital care services. A list of participating medical skilled nursing facilities that are available and in the geographic area requested by the resident/patient shall be included in the discharge plan. Resident/patient education shall be a major focus of discharge planning activities, as many aftercare needs are met through education provided by the interdisciplinary team (IDT). Resident/patient education is documented in both the plan of care and medical record.