

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 07/26/2024
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>42342</p> <p>Based on interview and record review, the facility failed to assess for cellulitis (when bacteria enter through a crack in the skin and causes skin to become infected and may appear red, warm, and painful to the touch) in the left lower extremity (left leg) in one of three sampled residents, Resident 1.</p> <p>This deficient practice caused Resident 1 to sign out against medical advice (AMA-when a patient leaves a hospital or facility before the treating physician recommends discharge) and go the general acute care hospital (GACH) where Resident 1 was diagnosed with cellulitis of the lower extremity unspecified laterality, bilateral leg pain and at risk for bacteremia (blood stream infection). Resident 1 was given Daptomycin (antibiotic medication used to treat infection) 350 mg (milligram-unit of measurement) IV (intravenous- given through the veins) and subsequently required in-patient admission for continued antibiotic treatment.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 7/1/2024 with diagnoses including fusion of spine cervical region (the cartilage in between bones of the neck is removed allowing the bones to fuse together), intervertebral disc degeneration lumbar region, spinal stenosis (narrowing of the hole the spinal cord passes through), diabetes mellitus (DM- long term disease causing high blood sugar), asthma, hypertension (HTN- high blood pressure) and dysphagia (difficulty swallowing).</p> <p>A review of Resident 1's Minimum Data Set (MDS-a standardized assessment and care planning tool) dated 7/13/2024, indicated Resident 1's cognition (mental ability to make decisions for daily living) was intact. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair.</p> <p>A review of Resident 1's physician order dated 7/11/2024 indicated an order for duplex doppler (an ultrasound test that examines the blood flow in the major arteries and veins in the legs) of right lower extremity (RLE) for swelling.</p> <p>A review of Resident 1's right lower extremity arterial doppler dated 7/13/2024 indicated, mild right lower extremity arterial disease, there is no deep vein thrombosis (DVT- blood clot in vein).</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1's GACH History of Present Illness (HPI- a chronological description of the progression of the patient's present illness from the first sign and symptom to the present written by the examining physician) note dated 7/13/2024 indicated Resident 1 had recurrent cellulitis, presented with bilateral leg swelling and signed out AMA from facility due to not being checked for cellulitis.</p> <p>A review of Resident 1's GACH POC US Soft Tissue (ultrasound of leg done at bedside) of the right extremity dated 7/13/2024 indicated redness and cellulitis with no abscess (a confined pocket of infectious drainage).</p> <p>A review of Resident 1's GACH Emergency Department (ED) Summary dated 7/13/2024, indicated, overall [Resident 1] with redness, warmth anterior portion of legs bilaterally, bedside US done consistent with cobble stoning (a three-dimensional visual appearance of multiple, equally sized, round, raised lesions, resembling roads paved by multiple equal-sized cobble stones which indicates inflamed tissue)- cellulitis. Discussed with pharmacy about the plan for antibiotics.</p> <p>On 7/24/2024 the California Department of Public Health (CDPH) received a complaint alleging that Resident 1 noted left leg had become redder and more swollen and Resident 1 was concerned about recurrent cellulitis. Resident 1 informed the facility, and an ultrasound on the right leg was ordered. The complaint further alleged Resident 1 requested to see a physician and was told by a facility staff that Resident 1 would have to wait until Monday so Resident 1 decided to sign out AMA and go to the GACH for further evaluation.</p> <p>During a concurrent interview and record review on 7/26/2024 at 11:01 a.m. with the Licensed Vocational Nurse 1 (LVN 1), Resident 1's Nursing progress note dated 7/13/2024 was reviewed. The nursing progress note indicated that on 7/13/2024 at 11 a.m., Resident 1 expressed concern about the redness in Resident 1's LLE and suspected the beginnings of cellulitis. Resident 1 was increased edema (swelling) in both legs, was offered Lasix but refused. On 7/13/2024 at 1 p.m. Resident 1 was still concerned about the resident's leg possibly being infected and was considering going to the GACH. On 7/13/2024 at 3:30 p.m. Resident 1 told LVN 1 that Resident 1 wanted to go the GACH to have the LLE examined and did not want to wait for the duplex ultrasound results. LVN 1 stated the doppler ultrasound of the LLE was not ordered nor done.</p> <p>During a concurrent interview and record review on 7/26/2024 at 11:01 a.m. with LVN 1, Resident 1's Situation Background Assessment and Recommendation (SBAR a form used to communicate between the nursing team and the physician) dated 7/13/2024 was reviewed. Resident 1's SBAR indicated Resident 1 complained of redness to the left lower extremity (LLE) and a duplex doppler had been taken that morning, but no results were available. The SBAR form indicated LVN 1 notified the attending physician who ordered a venous doppler of the LLE to be done the previous day and Lasix (a medication that relieves the body of fluid buildup) however Resident 1 refused the medication. The SBAR form indicated Resident 1 contacted the resident's own physician and decided to sign out AMA because the resident's left leg was showing early signs of cellulitis. LVN 1 confirmed and stated Resident 1 had swelling and redness on the right leg the day before (7/12/2024) and that is why the US of the right leg was ordered. LVN 1 stated the US took a while to get it done. LVN 1 further stated the US of the RLE was not done until the morning of 7/13/2024 when Resident 1 complained about the LLE. LVN 1 stated Resident 1 left the facility before the US result for the RLE was obtained and before the US of the LLE could be ordered. LVN 1 stated, I should have asked for an US of both legs when the right leg was ordered that is why [Resident 1] called her own doctor and left.</p> <p>(continued on next page)</p>		

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<p>F 0641</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 7/26/2024 at 1 p.m., with the Director of Nursing (DON), Resident 1's SBAR dated 7/13/2024 was reviewed. Resident 1's SBAR indicated Resident 1 complained of redness to the left lower extremity (LLE) and a duplex doppler had been taken that morning, but no results were available. The SBAR form indicated LVN 1 notified the attending physician who ordered a venous doppler of the LLE to be done the previous day and Lasix (a medication that relieves the body of fluid buildup) however Resident 1 refused the medication. Lastly, the form indicated Resident 1 contacted her own physician and decided to sign out AMA because the left leg was showing early signs of cellulitis. The DON stated, if Resident 1 complained about the left leg, then it should have been assessed and reported to the physician so the US could be ordered for the left leg. The DON further stated, I do not see an assessment of either leg documented.</p> <p>During a concurrent interview and record review on 7/26/2024 at 1:15 p.m. with the DON, Resident 1's nursing progress notes dated 7/11/2024, 7/12/2024, 7/13/2024 and the medical records were reviewed. Resident 1's nursing progress notes dated 7/11/2024 -7/13/2024 did not indicate any assessments for the RLE nor the LLE. Resident 1's medical record did not indicate an any SBAR related to RLE redness nor monitoring or RLE nor LLE redness or swelling. The DON stated when there is a change in condition (COC- clinically important deviation from a patient's. baseline in physical, cognitive, behavioral, or functional domains) the resident should be assessed, and findings should be communicated to the physician. The DON stated if the physician gives orders, the orders should be carried out and the resident should be monitored for any further changes.</p> <p>A review of the facility's policy and procedures titled, Change in a Resident's Condition or Status, (n.d.) indicated, 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an):</p> <ol style="list-style-type: none"> a. accident or incident involving the resident. b. discovery of injuries of an unknown source. c. adverse reaction to medication. d. significant change in the resident's physical/emotional/mental condition. e. need to alter the resident's medical treatment significantly. f. refusal of treatment or medications two (2) or more consecutive times). g. need to transfer the resident to a hospital/treatment center. h. discharge without proper medical authority; and/or i. specific instruction to notify the Physician of changes in the resident's condition. <p>2. A significant change of condition is a major decline or improvement in the resident's status that:</p> <ol style="list-style-type: none"> a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). <p>(continued on next page)</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. A representative of the business office will notify the resident, his/her family, or representative (sponsor), when: a. There is a change in the resident's billing. b. There is a change in the resident's level of care status. c. There is a change in resident rights under federal or state law or regulations; and/or d. There is a change in the rules of the facility that affects the rights or responsibilities of the resident.		