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	11/10/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure residents Advance Directive (ACHD - a legal document indicating resident preference on end-of-life treatment decisions) form was accurately documented in the paper chart and electronic chart for one out of six sampled residents (Resident 147). This deficient practice had the potential to cause conflict with resident's wishes regarding health care. Findings: A review of Resident 147's Admission Record indicated Resident 147 was admitted to the facility on [DATE] with diagnoses including degeneration of nervous system due to alcohol (damage to the nerves due to the direct toxic effect of alcohol and the malnutrition induced by it), spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine) and alcohol dependence with withdrawal (a condition that occurs when someone stops or reduces their alcohol consumption after long-term use, it's characterized by a range of physical and mental symptoms that can be uncomfortable and distressing). A review of Resident 147's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/28/2024, indicated Resident 147's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired for daily decision-making. A review of Resident 147's Advance Directive Acknowledgement Form, dated 10/23/2024, the form indicated, I (Resident 147) have executed an Advance Directive. On the same form on the second page, indicated, if Advance Directive was available and reviewed, the form indicated, none. During concurrent interview and record review with Social Services Director (SSD) on 11/10/2024 at 10 a.m., SSD reviewed Resident 147's paper chart and electronic chart and stated, Resident 147's Advance Directive Acknowledgment Form was not accurate. SSD stated, Resident 147 did not have an ACHD, but the form indicated Resident 147 have an executed an ACHD. SSD stated, she should have correctly filled out the form. (continued on next page)

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

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 11/10/2024
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F 0578 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, Advance Directives revised on 1/2024, the P&P indicated, Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives . The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure that one out of six sampled resident (Resident 144) was free from physical restraint and use of bed siderails by failing to: a. Ensure the use of bilateral (relating to both sides) bed siderails consent was completed per individualized (Resident 144) assessment. b. Obtain a physician's order to use of bilateral bed siderails. These deficient practices had the potential to result in entrapment and injury and residents not being treated with respect and dignity with the use of restraints (bed siderails). Cross Reference F657 Findings: A review of Resident 144's Admission Record indicated Resident 144 was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right and left dominant side, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). A review of Resident 144's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/31/2024, indicated Resident 144's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired for daily decision-making and required maximal assistance to total dependent from staff for Activities of Daily Living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During the initial tour of the facility and observation of Resident 144 on 11/8/2024 at 7:05 p.m., Resident 144 was lying on a bed with bilateral bed siderails pulled up. During an observation of Resident 144 on 11/9/2024 at 9 a.m., Resident 144 was lying in bed with bilateral bed siderails pulled up. A review of Resident 144's medical chart on 11/9/2024 at 12:52 p.m., indicated, a Bed Side Rail Permission was documented with no information and option of the use of bed side rails. A review of Resident 144's Physician Order Summary Report as of 11/9/2024, indicated there was no physician order to use/apply bilateral bed siderails. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 1 (RN 1) on 11/10/2024 at 10:13 a.m., RN 1 stated, Resident 144 is utilizing bed siderails for mobility and protection since admission on 10/26/2024. RN 1 reviewed chart with surveyor and confirmed, the bed siderail permission form in the chart is incomplete and not accurate and there was no physician's order for the bilateral bed siderails. RN 1 further stated, there should be a physician's order and consent when they started using the bilateral siderails for Resident 144. A review of the facility's policy and procedures (P&P) titled, Bed Safety and Bed Rails revised on 1/2024, the P&P indicated, The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent . If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: . consultation with the attending physician . Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility staff failed to document the reason why one of three sampled residents (Resident 41) was discharged from the facility. This deficient practice resulted to incomplete information of reason Resident 41 was transferred to General Acute Care Hospital 1 (GACH 1). Findings: A review of Resident 41's Admission Record indicated Resident 41 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including nondisplaced fracture (a broken bone where the pieces of bone remain aligned and don't move out of place) of anterior wall of left acetabulum (the front part of the hip socket on the left side of the body) and spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine). The Admission Record indicated Resident 41 was discharged from the facility on 8/22/2024. A review of Resident 41's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/22/2024, indicated Resident 41's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. A review of Resident 41's Progress Notes as of 11/10/2024, the Progress Notes did not have any documentation and discharge summary notes to indicate where Resident 41 was discharged to and the reason why the resident was discharged . During a concurrent interview with Director of Nursing (DON) on 11/10/2024 at 1:36 p.m., DON stated, Resident 41 was transferred to GACH 1 on 8/22/2024 due to a problem with his nephrostomy tube (a thin, flexible tube that drains urine directly from the kidney into a bag outside the body). Concurrently, DON reviewed Resident 41's medical record. DON stated and confirmed, there was no documentation regarding Resident 41's discharge to GACH 1. DON stated, Resident 41 did not have proper discharge process. A review of the facility's policy and procedures (P&P) titled, Transfer or Discharge, Facility-Initiated, dated 1/2024, the P&P indicated, Sufficient preparation and orientation for the resident prior to an immediate facility-oriented transfer or discharge includes explaining to the resident where he/she is going and why, and taking steps to minimize his/her anxiety or depression (e.g., working with the resident, representative, or family to ensure that the resident's belongings will be taken care of and transferred to the new location as needed/requested, and ensuring that staff recognize characteristic resident reactions identified during assessment and care planning) . Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to complete a notice of bed-hold policy and return form when the resident was transferred to the general acute care hospital (GACH) for one of three sampled residents (Resident 41). This deficient practice had a potential to result in the resident's responsible party being unaware of the bed hold policy and can lead to a transfer of the resident to another skilled nursing facility not of the resident's or responsible party's preference. Findings: A review of Resident 41's Admission Record indicated Resident 41 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including nondisplaced fracture (a broken bone where the pieces of bone remain aligned and don't move out of place) of anterior wall of left acetabulum (the front part of the hip socket on the left side of the body) and spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine). The Admission Record indicated Resident 41 was discharged from the facility on 8/22/2024. A review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/22/2024, indicated Resident 41's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. A review of Resident 41's Progress Notes dated 8/12/2024, the Progress Notes indicated, Resident (Resident 41) pulled out right nephrostomy tube (a thin, flexible tube that drains urine directly from the kidney into a bag outside the body), Physician (MD) aware with new order transfer to GACH for further evaluation. During a record review of Resident 41's Medical Record, there was no Notification of Bed Hold recorded when Resident 41 was transferred to GACH. During a concurrent interview with Director of Nursing (DON) on 11/10/2024 at 1:36 p.m. and record review, DON stated, Resident 41 was transferred to General Acute Care Hospital 1 (GACH 1) on 8/12/2024 and 8/22/2024 due to a problem with her nephrostomy tube. DON reviewed Resident 41's medical record and stated and confirmed, there was no documentation if bed hold notice was provided to Resident 41 and to her legal representative. A review of the facility's policy and procedures (P&P) titled, Bed-Holds and Returns, reviewed 1/2024, the P&P indicated, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a federally mandated resident assessment tool) a comprehensive standardized assessment and screening tool) for significant change in status was completed within the required time frame for one of six sampled residents, Resident 41. This deficient practice had the potential to negatively affect the provision of necessary care and services. Findings: A review of Resident 41's Admission Record indicated Resident 41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including nondisplaced fracture (a broken bone where the pieces of bone remain aligned and don't move out of place) of anterior wall of left acetabulum (the front part of the hip socket on the left side of the body) and spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine). The Admission Record indicated Resident 41 was discharged from the facility on 8/22/2024. A review of Resident 41's MDS dated [DATE], indicated Resident 41's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. A review of Resident 41's Progress Notes as of 11/10/2024, the Progress Notes did not have any documentation and discharge summary notes where Resident 41 was discharged to and the reason why. A review of Resident 41's Situation Background Assessment Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) as of 11/10/2024, there was no SBAR documented on 8/22/2024. During a concurrent interview with Director of Nursing (DON) on 11/10/2024 at 1:36 p.m., DON stated, Resident 41 was transferred to General Acute Care Hospital 1 (GACH 1) on 8/22/2024 due to a problem with the nephrostomy tube (a thin, flexible tube that drains urine directly from the kidney into a bag outside the body). DON reviewed Resident 41's medical record. DON stated and confirmed, there was no documentation regarding a change of condition when Resident 41 A review of the facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status, dated 1/2024, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, for four of four sampled residents (Residents 28, 144, 147, and 201), the facility failed to ensure: 1. A care plan was developed for psychotropic (any drug that affects brain activities associated with mental processes and behavior) medications and the care plan for impaired renal (kidney) function was specific for Resident 201. 2. A care plan was developed specifically for mouth breathing and oral care for Resident 28. Cross Reference F657 and F677. 3. A care plan was developed when Resident 147 showed signs of high risk of elopement (leaving the facility unsupervised and without staff knowledge). Cross Reference F689 4. A care plan was developed for Resident 144's use of bilateral bed siderails. These failures had the potential to negatively affect the delivery of care and services for (Residents 28, 144, 147, and 201). Findings: 1. During a review of Resident 201's Admission Record dated 11/10/24 indicated, Resident 201 was admitted to the facility on [DATE], with diagnoses including, anxiety, insomnia (trouble falling or staying asleep), chronic obstructive pulmonary disease (COPD - a chronic/ongoing lung disease causing difficulty in breathing), and end stage renal disease (ESRD - irreversible kidney failure). During a review of Resident 201's Physician Progress Note, dated 10/20/24, indicated the resident had the capacity to understand and make decisions. During a review of Resident 201's MDS dated [DATE], indicated the resident had moderate memory problems, and had trouble falling and staying asleep. During a review of Resident 201's physician's orders, indicated an order for Buspirone oral tablet 15 micrograms (mcg) two times a day for anxiety disorder dated 10/17/24, and Trazodone oral tablet 50 milligrams (mg) by mouth as needed for insomnia at bedtime dated 10/17/24. During a concurrent interview and record review with Registered Nurse 1 (RN) 1 on 11/10/24 at 3:02 pm, Resident 201's care plans were reviewed. RN 1 verified there were no care plans for the two psychotropic medications ordered and stated not having a care plan could not monitor the interventions for the medications. Further review of the resident's care plan indicated a care plan initiated on 10/18/24 for impaired renal function related to (specify) - no reason specified in the care plan. RN 1 verified the care plan did not specify a reason for the impaired renal function and stated is it supposed to be for ESRD but is not complete. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 28's Admission Record dated 11/10/24, indicated, Resident 28 was admitted to the facility on [DATE], with diagnoses including; Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), disorder of the muscles, Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), gastrostomy tube (Gtube - a surgical opening fitted with a device to allow feedings/medications/hydration to be administered directly to the stomach common for people with swallowing problems) and dysphagia (difficulty swallowing). During a review of Resident 28's MDS dated [DATE], indicated Resident 28 was rarely/never understood, with severely impaired cognition rarely/never made decisions, had short and longer term memory problems, was unable to eat by mouth, and was dependent on staff for oral hygiene, toileting, showering/bathing, dressing, personal hygiene and bed mobility. During observation with concurrent interview with the facility administrator (ADM) on 11/10/24 at 7:48 a.m. Resident 28 was observed in bed with his mouth wide open and crusty buildup of yellow-brown dried secretions in this oral cavity. The AMD stated the resident mouth-breathes and builds up dried secretions quickly in the mouth shift to shift. During a review of Resident 28's care plans, indicated there was no specific care plan developed/created for oral hygiene and mouth-breathing that resulted in dry oral cavity and build up of dried secretions in Resident 2's mouth. 43454 3. A review of Resident 147's Admission Record indicated Resident 147 was admitted to the facility on [DATE] with diagnoses including degeneration of nervous system due to alcohol (there is damage to the nerves due to the direct toxic effect of alcohol and the malnutrition induced by it), spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine) and alcohol dependence with withdrawal (a condition that occurs when someone stops or reduces their alcohol consumption after long-term use, it's characterized by a range of physical and mental symptoms that can be uncomfortable and distressing). A review of Resident 147's MDS 10/28/2024, indicated Resident 147's cognition was moderately impaired for daily decision-making. A review of Resident 147's elopement (when a patient leaves a healthcare facility without permission and may be a danger to themselves or others) risk/wanderer related to disoriented to place, impaired safety awareness, initiated on 11/8/2024, had a goal of resident's safety will be maintained and resident will not leave facility unattended through the review date. A review of Resident 147's Elopement Screening, dated 11/5/2024 indicated a score of 13 (high risk for elopement). A review of Resident 147's care plan as of 11/9/2024 indicated, there was no care plan developed when Resident 147 was screened to be at high risk of elopement. During an observation of the facility on 11/8/2024 at 7:28 p.m., Resident 147 was not observed inside her room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up observation of Resident 147's room on 11/8/2024 at 8:50 p.m., Resident 147 was not seen inside her room and inside the facility. During an interview with Resident 27 on 11/8/2024 at 7:28 p.m., Resident 27 stated, Resident 147 left the facility today and Resident 27 did not know where Resident 147 went. Resident 27 stated, Resident 147 has been wanting to leave the facility, that Resident 27 saw Resident 147 walk out of her [Resident 147] room and that Resident 147 had two luggages. During an interview with Administrator (ADM) on 11/9/2024 at 10:29 a.m., ADM stated, Resident 147 left the building yesterday (11/8/2024). ADM stated that when they (facility) found out that Resident 147 was not in the resident's room, ADM called Resident 147's cellphone but Resident 147 did not want to say where she [Resident 147] was initially and that Resident 147 was not going to come back to the facility. ADM stated, they (facility) then called Resident 147's family member and that the facility finally was able to track Resident 147. ADM stated, that on 11/8/2024 night, the Director of Nursing (DON) picked up Resident 147 at a location at a location the resident was at. ADM stated, Resident 147 left against medical advice (AMA) and that Resident 147 leaving the facility was not an elopement case. When asked if Resident 147 was given a documentation and explanation of leaving AMA, ADM stated no. When asked then why Resident 147 is back in the facility if she left AMA, ADM did not answer. During an interview with Resident 147 on 11/9/2024 at 10:29 a.m., Resident 147 stated, Resident 147 left the facility without staff's knowledge, and walked on her own to Hotel 1. Resident 147 stated, she was not provided with any discharge AMA letter or documentation that indicated Resident 147 wanted to leave AMA. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 11/9/2024 at 10:47 a.m., LVN 2 stated, Resident 147 is able to walk on her own with no assistive device. LVN 2 stated, Resident 147 was anxious to go home, and staff would see Resident 147 carrying the resident's two luggage. LVN 2 stated, Resident 147 would verbalize, where is the garage, I want to grab my car and go home while carrying two luggage with her and Resident 147 would verbalize that she wants to leave the facility and go home several times in a day. During a follow-up interview with ADM on 11/9/2024 at 2:30 p.m., ADM stated, Resident 147 did not elope and that she left AMA. ADM was asked if any of the staff observed and saw Resident 147 leaving the facility and walked out of the door, ADM stated, no. ADM further stated that surveyors were not informed while surveyors were in the facility on 11/8/2024 and the State Department was not notified when Resident 147 left the facility without staff's knowledge. 4. A review of Resident 144's Admission Record indicated Resident 144 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right and left dominant side, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). A review of Resident 144's MDS dated [DATE], indicated Resident 144's cognition action or process, was severely impaired for daily decision-making and required maximal assistance to total dependent from staff for Activities of Daily Living. (continued on next page)

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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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial tour of the facility and observation of Resident 144 on 11/8/2024 at 7:05 p.m., Resident 144 was in bed, lying on a bed with a bilateral bed siderails up. During an observation of Resident 144 on 11/9/2024 at 9 a.m., Resident 144 was lying in bed with a bilateral bed siderails up. A review of Resident 144's medical chart on 11/9/2024, indicated, there was no care plan developed for the use of bilateral side rails for Resident 144. A review of Resident 144's Physician Order Summary Report as of 11/9/2024, indicated there was no physician order for the bilateral bed siderails. During an interview with Registered Nurse 1 (RN 1) on 11/10/2024 at 10:13 a.m., RN 1 stated, Resident 144, is utilizing bed siderails for mobility and protection since admission on 10/26/2024. RN 1 stated, a care plan should have been developed and initiated upon the use of bilateral side rails. A review of the facility's policy and procedures titled Care plans, Comprehensive Person-Centered', revised on 1/2024, indicated, a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident . describes the services that are to be furnished . includes the resident's stated goals upon admission . reflects currently recognized standards of practice for problem areas and conditions.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley West Healthcare Center	1623 Arizona Avenue Santa Monica, CA 90404

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview, and record review, the nursing staff failed to revise a care plan for at risk for falls for one of four sampled residents (Resident 24), who sustained a fall and injury after the resident was found on the floor on 12/3/2023 and on 8/9/2024. This deficient practice had the potential to place Resident 24 at increased risk for recurrent falls. Cross Reference F604 Findings: A review of Resident 24's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including Parkinsonism (a general term for a range of conditions that cause movement problems similar to Parkinson's disease, such as tremors, slowness, and stiffness), spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine) and history of falling. A review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/5/2024, indicated Resident 24's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired for daily decision-making. The MDS also indicated Resident 24 required maximal assistance to total dependence from staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 24's Morse Fall Risk Screen (MFRS- assessment tool for risk for fall) dated 8/9/2024 indicated, Resident 24 scored 75 (MFRS score of 46 or higher indicates a high risk of falling). - A review of Resident 24's Progress Notes indicated the following: i. Dated 12/3/2023, a caregiver reported to a nurse that Resident 24 had a fall from bed, found resident sitting position with back against the bed, upon head to toe assessment, noted skin tear to right elbow. ii. Dated 8/9/2024 at 11:00 a.m., Resident 24 was found sitting on the floor, on injury. A review of Resident 24's care plan (CP) for high risk of fall and injury, initiated on 12/2/2023, the CP goal indicated Resident (24) will be able to adjust to a change in the usual environment and routine to prevent falls and injury through the next review date. A revision of this CP was made on 11/9/2024, indicated Resident 24 had an actual fall on 8/9/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 11/10/2024 at 3:51p.m., RN 1 reviewed Resident 24's CP. RN 1 stated Resident 24 had an actual fall on 12/3/2023 and on 8/9/2024 and that the CP was not revised for Resident 24's high risk of fall and injury. RN 1 stated, the CP should have been revised when Resident 24 had an actual fall to prevent another fall incident and injury. A review of the facility's policy and procedures (P&P) titled, Falls and Fall Risk, Managing, revised 1/2024, the P&P indicated, if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . The staff will monitor and document each resident's response to interventions intended to reduce falling of the risks of falling . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the Attending Physician will help the staff reconsider possible causes that may not previously have been identified.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview, and record review, the facility failed to provide oral care to two of five sampled residents (Residents 20 and 28). This failure had the potential to result in infection, illness and effect the resident's self-esteem and quality of life. Cross reference with F790 and F656 Findings: A review of Resident 20's Admission Record dated 11/10/24, indicated the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), malnutrition, disorder of the muscle, abnormalities of gait and mobility gastrostomy tube (Gtube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and dysphagia (difficulty swallowing). A review of Resident 20's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/22/24, the MDS indicated, Resident 20 had severely impaired cognition (ability to think, understand and make daily decisions). The same MDS indicated Resident 20 required substantial/ maximal assistance with helper for eating, and was dependent on staff for oral hygiene, toileting, bathing, dressing and bed mobility. During an observation with concurrent interview on 11/10/24 at 7:50 a.m., with facility Administrator (ADM), Resident 20 was observed with a buildup of pasty yellow film on her mouth, the ADM stated the resident has that issue (gets a yellow buildup on her mouth) probably from the night shift and the Certified Nursing Assistant (CNA) should provide oral care. During a review of Resident 28's Admission Record dated 11/10/24 indicated, Resident 28 was admitted to the facility on [DATE], with diagnosis including; Alzheimers disease (a disease characterized by a progressive decline in mental abilities), disorder of the muscles, Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), gastrostomy tube (Gtube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and dysphagia (difficulty swallowing). During a review of Resident 28's MDS dated [DATE], indicated the resident was rarely/never understood, with severely impaired cognition rarely/never made decisions, had short- and long-term memory problems, was unable to eat by mouth, and was dependent on staff for oral hygiene, toileting, showering/bathing, dressing, personal hygiene and bed mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation with concurrent interview with the facility administrator (ADM) on 11/10/24 at 7:48 a.m., Resident 28 was observed in bed with his mouth wide open and crusty buildup of yellow-brown dried secretions in this oral cavity. The AMD stated the resident does mouth-breath and has buildup in his mouth of the dried secretions quickly shift to shift, the CNA should have done oral care on the night shift. During observation with concurrent interview on 11/10/24 at 8:17 a.m. with CNA 3. Resident 28's mouth was observed wide open with the same crusty buildup of yellow-brown dried secretions in this oral cavity CNA 3 was providing oral care and stated the buildup in his mouth was tarter. The CNA was unable to clear the mouth of the crusty buildup with the oral sponge on a stick and toothbrush and toothpaste. She further stated she didn't know if the resident had been seen by a dentist. During a review of the facility's policy and procedure (P&P) titled Mouth Care revised January 2024 indicated, the purpose of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent oral infection.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 147) was properly supervised to prevent elopement (leaving the facility unsupervised and without staff knowledge) by failing to: a. Ensure to evaluate and analyze hazard(s) and risk(s) of elopement when Resident 147 verbalized of wanting to leave the facility and made attempt of leaving as she was observed walking out of her room with her two luggage with her multiple times in a day. b. Examine Resident 147 for injury, complete and file an incident report and document relevant information in the resident's medical record when Resident 147 was returned back to the facility per facility's policy and procedure titled, Wandering and Elopement. These deficient practices resulted in Resident 1 eloping on 11/8/2024, walked outside unsupervised and without notifying the staff. Cross reference to F656. Findings: A review of Resident 147's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including degeneration of nervous system due to alcohol (there is damage to the nerves due to the direct toxic effect of alcohol and the malnutrition induced by it), spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine) and alcohol dependence with withdrawal (a condition that occurs when someone stops or reduces their alcohol consumption after long-term use, it's characterized by a range of physical and mental symptoms that can be uncomfortable and distressing). A review of Resident 147's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/28/2024, indicated Resident 147's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired for daily decision-making. A review of Resident 147's elopement risk/wanderer related to disoriented to place, impaired safety awareness, initiated on 11/8/2024, had a goal of resident's safety will be maintained and resident will now leave facility unattended through the review date. A review of Resident 147's Elopement Screening, dated 10/22/2024 indicated a score of 5 (low risk). A review of Resident 147's Elopement Screening, dated 11/5/2024 indicated a score of 13 (high risk). During an observation of the facility on 11/8/2024 at 7:28 p.m., Resident 147 was not observed inside her room. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up observation of Resident 147's room on 11/8/2024 at 8:50 p.m., Resident 147 was not seen inside her room and inside the facility. During an interview with Resident 27 on 11/8/2024 at 7:28 p.m., Resident 27 stated, Resident 147 left the facility today and she doesn't know where she went. Resident 27 stated, Resident 147 has been wanting to leave the facility and she saw her walked out of her room with her two luggage with her. During an interview with Administrator (ADM) on 11/9/2024 at 10:29 a.m., ADM stated, Resident 147 left the building yesterday (11/8/2024). When they found out that Resident 147 was not in her room, he called her on her cellphone and Resident 147 did not want to say where she was initially and that she was not going to come back. ADM stated, they then called Resident 147's daughter and they finally was able to track Resident 147. ADM stated, the Director of Nursing (DON) picked her up on her location that night (11/8/2024). ADM stated, Resident 147 left against [NAME] advice (AMA) and it was not an elopement case. When asked if Resident 147 was given a documentation and explanation of leaving AMA, ADM stated no. When asked then why Resident 147 is back in the facility if she left AMA, ADM did not answer. During an interview with Resident 147 on 11/9/2024 at 10:29 a.m., Resident 147 stated, she left the facility without staff's knowledge, and she walked on her own to Hotel 1. Resident 147 stated, she was not provided with any discharge AMA letter or documentation if she wants to leave AMA. During an interview with Licensed Vocational Nurse (LVN) 2 on 11/9/2024 at 10:47 a.m., LVN 2 stated, Resident 147 is able to walk on her own with no assistive device. LVN 2 stated, Resident 147 was anxious to go home, and she would be seen carrying her two luggage with her. LVN 2 stated, Resident would verbalize, where is the garage, I want to grab my car and go home while carrying two luggage with her and she would verbalize that she wants to leave the facility and go home several times in a day. During a follow-up interview with ADM on 11/9/2024 at 2:30 p.m., ADM stated, Resident 147 did not elope and that she left AMA. ADM was asked if any of the staff observed and saw Resident 147 leaving the facility and walked out of the door, ADM stated, no. ADM further stated that surveyors were not informed while surveyors were in the facility on 11/8/2024 and the State Department was not notified when Resident 147 left the facility without staff's knowledge. A review of Resident 147's electronic and paper charting as of 11/10/2024, there was no documentation of the incident and relevant information and assessment of injury when Resident 147 was returned back to the facility on the night of 11/8/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Berkley West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1623 Arizona Avenue Santa Monica, CA 90404	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedures (P&P) titled, Wandering and Elopement, revised on 1/2024, the P&P indicated, If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; and c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.). When the resident returns to the facility, the director of nursing services or charge nurse shall: a. examine the resident for injuries; b. contact the attending physician and report findings and conditions of the resident; c. notify the resident's legal representative (sponsor); d. notify search teams that the resident has been located; e. complete and file an incident report; and f. document relevant information in the resident's medical record. During a review of facility's P&P titled, Discharging a Resident without a Physician's Approval, revised on 1/2024, the P&P indicated, If the resident or representative (sponsor) requests discharge without the approval of the attending physician, the resident and/or representative (sponsor) will be asked to sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility staff failed to ensure resident received appropriate treatment and services to prevent urinary tract infections urinary tract infection (UTI- an infection in the bladder/urinary tract) for one of two sampled residents (Resident 144) by failing to ensure Resident 144's indwelling urinary (foley) catheter (a hollow tube inserted into the bladder to drain or collect urine) was placed below the level of the bladder at all times. This deficient practice had the potential to result or resulted in urinary tract infections for the resident. Findings: A review of Resident 144's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right and left dominant side, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). A review of Resident 144's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/31/2024, indicated Resident 144's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired for daily decision-making and required maximal assistance to total dependent from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 144's Order Summary Report, dated 10/27/2024 indicated, Foley catheter balloon connected to drainage bag. During an observation of Resident 144 on 11/8/2024 at 7:05 p.m., observed Resident 144's foley catheter with the drainage bag hanging on the side of the bed, placed above the level of Resident 144's bladder and was tied to the right moveable bed side rails. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1 on 11/8/2024 at 7:19 p.m., in Resident 144's room, LVN 1 observed Resident 144's foley catheter and stated, the foley catheter drainage bag was placed high up. LVN 1 stated, the foley catheter drainage bag should be placed below resident's bladder so that the urine won't back up which places them at risk of complications and infection. LVN 1 was then observed untying the foley catheter drainage bag and tied to a non-movable frame of the bed, below Resident 144's bladder. A review of Resident 144's Care Plan for at risk for high risk for developing complications including UTI due to use of foley catheter related to urinary retention, initiated on 11/9/2024, with a goal of Resident (144) will not develop any complications associated with catheter usage and Resident (144) will be free from signs and symptoms of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN)1 on 11/10/2024 at 10:22 a.m., RN 1 stated, Resident 144 is on foley catheter and all foley catheter drainage should be placed below the bladder on a non-movable frame of the bed. RN 1 stated, if the FC was placed above the bladder, it places resident at risk for infection. RN 1 stated, license staff, certified nurses and supervisors are all responsible on making sure that the FC are placed correctly. During a review of the facility's policy and procedures (P&P) titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, reviewed on January 2024, the P&P indicated, The following catheter-associated urinary tract infections (CAUTI) prevention strategies have been adopted and are to be followed by clinical staff: Maintain unobstructed urine flow . keep drainage bag below the level of the bladder at all times.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to properly assess resident's pain for one of three sampled residents (Resident 196) during a medication pass observation. This deficient practice had the potential to negatively affect the residents' physical comfort and psychosocial well-being and had the potential to increase the pain level and result in an unmanageable pain level. Findings: A review of the Admission Record indicated Resident 196 was admitted to the facility on [DATE] with diagnosis including spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine), low back pain, and disorder of muscle. A review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/1/2024, indicated Resident 196's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate to maximal assistance from staffs for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 196's Order Summary indicated physician ordered the following: i.Dated 11/5/2024, Oxycodone (an opioid used in the management of moderate to severe pain) oral tablet five milligram (mg - unit of measurement) - give one tablet by mouth four times a day for pain. ii.Dated 11/2/2024, Tylenol I(it can treat minor aches and pains, and reduces fever) extra strength 500 mg - give 1000 mg by mouth three times a day for pain management During an observation of medication pass with Licensed Vocational Nurse (LVN) 2 on 11/9/2024 at 9:48 a.m. , LVN 2 was observed administering Resident 196's Tylenol and Oxycodone medication without assessing and asking resident's pain level prior to giving the medications. During an interview with LVN 2, on 11/9/2024 at 9:52 a.m., LVN 2 stated, she forgot to assess Resident 196's pain level prior to giving his pain medications. During an interview with Registered Nurse (RN) 1 on 11/10/2024 at 10:35 a.m., RN 1 stated, the pain level should be assessed by asking resident's their pain level prior to giving their pain medications. RN 1 stated, pain assessment must be done first so that they know which pain medications and other interventions to provide to make sure the pain will be managed. (continued on next page)

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 11/10/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled, Pain Assessment and Management, revised on 1/2024, the P&P indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure: A.The policy and procedure for medication administration was followed for one of three sampled residents (Resident 26). On 11/9/2024 at 9:26 a.m., Licensed Vocational Nurse 2 (LVN 2) was observed crushing Apixaban (anticoagulant used to reduce the risk of stroke and blood clots), lisinopril (can treat high blood pressure and heart failure), Vitamin D (a fat-soluble vitamin that helps the body absorb calcium and perform other important functions) and multivitamin (used to treat or prevent vitamin deficiency due to poor diet, certain illnesses). This deficient practice placed resident at risk for physical and chemical incompatibilities between medications, loss of effectiveness, and worsening of medical conditions. B. The Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR) for one of one sampled resident (Resident 196). This deficient practice had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug). Findings: A.A review of the Admission Record indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and Parkinson's disease (a chronic brain disorder that causes movement problems, and can also affect mental health, sleep, and pain). A review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/20/2024, indicated Resident 26's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was mildly impaired. The MDS indicated Resident 26 required moderate to maximal assistance from staffs for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation of medication pass with Licensed Vocational Nurse (LVN) 2 on 11/9/2024 at 9:26 a.m. LVN 2 was observed crushing the following four medications: i. Apixaban 5 milligram (mg - unit of measurement) oral tablet ii. Lisinopril (medication for high blood pressure) 10 mg oral tablet iii. Vitamin D oral tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	iv. Multivitamin-minerals oral tablet LVN 2 placed all four pills in a plastic pouch used for medications which was then placed in a pill crusher (a metal tool used to crush pills at the same time). LVN 2 then placed all crushed medication together in a medicine cup and mixed an apple sauce with it. During an interview with LVN 2, on 11/9/2024 at 9:35 a.m., LVN 2 stated, she crushed all four medications then put them all together in a cup and added an apple sauce with it. LVN 2 stated, this was her process on administering medications and it is acceptable to put mix all medications together after crushing it. During an interview with Registered Nurse (RN) 1, on 11/10/2024 at 10:35 a.m., RN 1 stated, medications that were crushed must be given one by one and separated on each medication cup so that the licensed nurse will know which medications is which and that if resident refuses any of the medications, then she will be able to distinguish each medication. During a review of facility's policy and procedure (P&P) titled Medication Administration - General Guidelines, effective 10/2017, the P&P indicated, Crushed medications should not be combined and given all at once, either orally or via feeding tube. B. A review of the Admission Record indicated Resident 196 was admitted to the facility on [DATE] with diagnosis including spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine), low back pain, and disorder of muscle. A review of the MDS dated [DATE], indicated Resident 196's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate to maximal assistance from staffs for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 196's Order Summary, indicated physician ordered the following: i. Oxycodone (an opioid used in the management of moderate to severe pain) oral tablet five milligram (mg - unit of measurement) - give one tablet by mouth four times a day for pain. ii. Oxycodone 5 mg tablet - give one tablet by mouth every 4 hours as needed for moderate pain. iii. Oxycodone 5 mg tablet - give 2 tablets by mouth every 4 hours as needed for severe pain. A review of Resident 196's MAR indicated the following: i. Oxycodone 5 mg - give one tablet four times a day: indicated administered to Resident 196 from 11/5/2024 to 11/9/2024 (at 9 a.m., 1 p.m., 5 p.m., and 9 p.m.) ii. Oxycodone 5 mg tablet - give one tablet every 4 hours as needed for moderate pain: the MAR indicated; Resident 196 has not received this medication as ordered by physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	iii. Oxycodone 5mg tablet - give two tablet every 4 hours as needed for severe pain: the MAR indicated; Resident 196 received three doses of this medication from 11/1/2024 to 11/4/2024). A review of Resident 196's bubble pack for the following indicated: i. Oxycodone 5 mg four times daily - 28 tablets remaining ii. Oxycodone 5 mg - one tablet for moderate pain: 30 tablets remaining iii. Oxycodone 5 mg - two tablets for severe pain: 11 tablets remaining During an interview with LVN 2, on 11/9/2024 at 9:52 a.m., LVN 2 stated, when giving Oxycodone medication to Resident 196, they don't look at the bubble pack and they don't compare it from physician's order. LVN 2 stated, the narcotic count is not accurate because they the remaining tablets is not the same as the count in each CDR. During a concurrent interview and record review of Resident 196's MAR, CDR and bubble pack with Registered Nurse 1 (RN 1) on 11/10/2024 at 10:35 a.m., RN 1 stated, the MAR, CDR and bubble pack for Resident 196's oxycodone medication orders are not accurate when matched. RN 1 stated, the nurses must remove the medication from the correct bubble pack and document on the correct CDR. During a review of facility's P&P, titled, Controlled Substances, revised on 1/2024, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications . The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to administer medications appropriately to two of four sampled residents, (Residents 26 and 196) observed during the medication pass observation. During medication pass observation, there were four medication errors for Resident 26 and two medication errors for Resident 196 for a total of six medication errors out of 25 opportunities. These medication administration errors resulted to a medication error rate of 24%. Cross Reference: F755 and F697 Findings: A. A review of the Admission Record indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and Parkinson's disease (a chronic brain disorder that causes movement problems, and can also affect mental health, sleep, and pain). A review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/20/2024, indicated Resident 26's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was mildly impaired. The MDS indicated Resident 26 required moderate to maximal assistance from staffs for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation of medication pass with Licensed Vocational Nurse (LVN) 2 on 11/9/2024 at 9:26 a.m. LVN 2 was observed crushing the following four medications: i. Apixaban (medication to prevent blood clots) 5 milligram (mg - unit of measurement) oral tablet ii. Lisinopril (medication for high blood pressure) 10 mg oral tablet iii.Vitamin D oral tablet iv.Multivitamin-minerals oral tablet LVN 2 placed all four pills in a plastic pouch used for medications which was then placed in a pill crusher (a metal tool used to crush pills at the same time). LVN 2 then placed all crushed medication together in a medicine cup and mixed an apple sauce with it. During an interview with LVN 2, on 11/9/2024 at 9:35 a.m., LVN 2 stated, she crushed all four medications then put them all together in a cup and added an apple sauce with it. LVN 2 stated, this was her process on administering medications and it is acceptable to put mix all medications together after crushing it. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN) 1, on 11/10/2024 at 10:35 a.m., RN 1 stated, medications that were crushed must be given one by one and separated on each medication cup so that the licensed nurse will know which medications is which and that if resident refuses any of the medications, then she will be able to distinguish each medication. During a review of facility's policy and procedure (P&P) titled Medication Administration - General Guidelines, effective 10/2017, the P&P indicated, Crushed medications should not be combined and given all at once, either orally or via feeding tube. B. A review of the Admission Record indicated Resident 196 was admitted to the facility on [DATE] with diagnosis including spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine), low back pain, and disorder of muscle. A review of the MDS dated [DATE], indicated Resident 196's skills for daily decisions was intact. The MDS indicated Resident 1 required moderate to maximal assistance from staffs for ADLs. A review of Resident 196's Order Summary indicated physician ordered the following: i. Dated 11/5/2024, Oxycodone (an opioid used in the management of moderate to severe pain) oral tablet five milligram (mg - unit of measurement) - give one tablet by mouth four times a day for pain ii. Dated 11/2/2024, Tylenol I(medication to treat minor aches and pains, and reduces fever) extra strength 500 mg - give 1000 mg by mouth three times a day for pain management During an observation of medication pass with LVN 2 on 11/9/2024 at 9:48 a.m., LVN 2 was observed administering Resident 196's Tylenol and Oxycodone medication without assessing and asking resident's pain level prior to giving the medications. During an interview with LVN 2 on 11/9/2024 at 9:52 a.m., LVN 2 stated, she forgot to assess Resident 196's pain level prior to giving his pain medications. During an interview with RN 1 on 11/10/2024 at 10:35 a.m., RN 1 stated, the pain level should be assessed by asking resident's their pain level prior to giving their pain medications. RN 1 stated, pain assessment must be done first so that they know which pain medications and other interventions to provide to make sure the pain will be managed. During a review of the facility's P&P titled, Pain Assessment and Management, revised on 1/2024, the P&P indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of residents in the facility by failing to esnure: A. Proper disposal of one open sterile intravenous (IV- inside the vein) administration set sterile intravenous medication tubing (used for delivering fluids or medications though and IV), eight expired sterile collection swabs, seven expired specimen collection tubes, and 10 expired specimen collection kits. B. Medication cart and pill cutter were clean and sanitized at all times. These deficient practices had the potential to compromise the safety and effectiveness of medications and sterile supplies which can result in medication administration error and risk for unsafe, improper medication administration use. Findings: During a concurrent observation and interview on [DATE] 6:45 p.m., with Infection Preventionist Nurse (IPN), the medication storage closet was reviewed for expired supplies. One open sterile IV administration set, eight expired sterile collection swabs (expiration date [DATE]), seven expired specimen collection tubes (expiration date [DATE]), and 10 expired specimen collection kits (expiration date [DATE]) were observed, IPN verified the expiration dates of the supplies, gathered them to throw out and stated they may not be accurate (since expired). During a review of the facility's policy and procedures (P&P), titled Medication Labeling and Storage, reviewed on [DATE], the P&P indicated, the nursing staff is responsible for maintaining the medication storage and preparation areas in a clean, safe, and sanitary manner. B. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3 on [DATE] at 4:09 p.m., observed Medication Cart 1 (East Station). Medication Cart 1's medication bottles plastic container was observed with brown and black spots that were not easily removed. Inside the cart, a pill cutter was also observed with whitish particles. LVN 2 stated the medication bottle containers should be cleaned and the pill cutter should be cleaned and sanitized after each use, so it does not cause of mixing with medications. During a review of the facility's P&P titled, Medication Labeling and Storage, revised on [DATE], the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. During a review of facility's P&P titled Medication Administration - General Guidelines, effective ,d+[DATE], the P&P indicated, Medications are crushed between two souffle cups/or in a plastic pouch . A tablet-splitter is used to avoid contact with the tablet.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview, and record review, the facility failed to provide a routine dental visit to one of two residents sampled (Resident 28) as per physician's orders dated 9/23/24. This failure had the potential to result in pain, infection, illness and effect the resident's self-esteem and quality of life. Cross reference with F677 Findings: During a review of Resident 28's Admission Record dated 11/10/24 indicated, Resident 28 was admitted to the facility on [DATE], with diagnosis including; Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), disorder of the muscles, Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), gastrostomy tube (Gtube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and dysphagia (difficulty swallowing). During a review of Resident 28's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 10/15/24, indicated the resident was rarely/never understood, with severely impaired cognition (ability to think, read, learn, remember, reason, express thoughts, and make decisions), rarely/never made decisions, had short- and long-term memory problems, was unable to eat by mouth, and was dependent on staff for oral hygiene, toileting, showering/bathing, dressing, personal hygiene and bed mobility. During observation and concurrent interview on 11/10/24 at 8:17 a.m. with Certified Nursing Assistant 3 (CNA 3). Resident 28's mouth was observed wide open with crusty buildup of yellow-brown dried secretions in the resident's oral cavity. CNA 3 was providing oral care and stated the buildup in the resident's mouth was tarter (plaque that has become hardened). CNA 3 was unable to clear the mouth of the crusty buildup with the oral sponge on a stick and toothbrush and toothpaste. CNA 3 stated she did not know if the resident had been seen by a dentist. During a concurrent interview and record review with Registered Nurse (RN) 1 on 11/10/24 at 10:06 a.m., Resident 28's physician's orders, dated 9/23/24 were reviewed. The orders indicated dental evaluation/consult as needed, RN 1 stated she did not know if the resident had a dental evaluation. RN 1 stated Social Services usually dealt with dental evaluations. During an interview with Social Services Director (SSD) on 11/10/24 at 10:20 a.m., the SSD stated Resident 28 had not been seen by a dentist at the facility. The SSD confirmed there was a dentist that went to the facility and was able to perform all dental services. During a review of the facility's policy and procedures (P&P) titled Dental Services revised January 2024, indicated routine and emergency dental services were available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38740 Based on observations, interviews, and record reviews, the facility failed to ensure kitchen staff were competent in safe and effective food preparation and handling practices. By failing to: 1.Ensure [NAME] 1moniotored cooked roast pork for safe cool down process and storage (hot food cooled down within a certain time frame to prevent harmful bacterial growth). 2. Ensure [NAME] 1 knew the concentration strength of the chlorine sanitizer (a substance or product that is used to reduce or eliminate pathogenic agents on surfaces) used for food contact surfaces and did not follow the sanitizer solution procedures and preparation per the facility policy. These deficient practices had the potential to result in unsafe and unsanitary food production that could lead to foodborne illness (Infectious organisms or their toxins are the most common causes of food poisoning with symptoms that may include cramping, nausea, vomiting or diarrhea and death) in 42 out of 46 residents who received food from the facility kitchen. Findings: 1. During a concurrent observation and interview in the kitchen on 11/8/2024 at 6:18 p.m., one cooked roast pork was observed set on the kitchen counter. The roast pork was in a plastic bag in a large deep pan and was covered with ice. Cook1 stated she did not document the time the roast was taken out of the oven. [NAME] 1 stated the thought she removed the roast pork from the oven at 5 p.m. and she set it on the counter to cool down. Cook1 stated after the roast cooled down it will be stored in the refrigerator for Sunday lunch. Cook1 checked the temperature of the roast pork using the facility thermometer and the temperature registered at 191.3 degrees Fahrenheit (F) in the middle section of the roast and 188.4 degrees F on the side of the roast. [NAME] 1 stated she would put the roast in the refrigerator before she went home at 7:30 p.m. Cook1 did not know at what temperature to place the roast pork in the refrigerator. Cook1 sated she put ice on the roast to cool the roast down. Cook1 did not know how else to cool down the roast pork and when asked if the temperature of the roast should be monitored in the refrigerator Cook1 did not answer. During a concurrent observation and interview with cook1 and the Dietary Supervisor (DS) on 11/9/2024 at 11:05 a.m. The DS stated the facility policy was to hold cold food at 41 degrees or lower. The DS stated when improper holding temperature occurred, bacteria could grow and cause illness. The DS stated when cooking large pieces of meat ahead of time, during the cool down process, the large piece of meat should be cut into smaller pieces to cool down faster. The DS stated cook1 should have cut the roast into smaller pieces to cool down faster. DS stated cook1 should have documented the time the pork was removed from the oven and started the monitoring of the cool down process. The DS then discarded the pork. During a review of in-service records for kitchen staff on cool down process dated 5/23/24, Cook1 was not present during the in-service. (continued on next page)

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Berkley West Healthcare Center	1623 Arizona Avenue Santa Monica, CA 90404

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of job description for cook indicated, the cook, prepare food in accordance with sanitary regulations as well as established policies and procedures. A review of facility policy and procedures titled Cooling and reheating of potentially hazardous or time/temperature Control for Safety Food dated 2023 indicated, when cooked PHF or TCS food will not be served right away it must be cooled as quickly as possible the method is: cool cooked food form 140 degrees (F) to 70 degrees (F) within two hours, then cool from 70 degrees F to 41 degrees F or less in an addition four hours for total cooling time of six hours. Methods of cooling Food 1) placing the food in shallow pans; 2) separate into smaller or thinner portions. 2. During an observation in the kitchen on 11/9/2024 at 9:00 a.m. [NAME] 1 was observed cleaning the food contact surfaces with a cloth that was stored in a sanitizer solution in the red bucket. When asked to test the sanitizer solution, Cook1 proceeded to demonstrate how to prepare the sanitizer solution using chlorine disinfectant. Cook1 filled the bucket with two liters of water then added a capful (1 tablespoon) of chlorine in the water. Cook1 then proceeded to test the solution and it was at 200 PPM (parts per million sanitize concentration) The recommended concentration level for chlorine sanitizer is between 50-100 parts per million (ppm). During a concurrent interview with Cook1 and DS on 11/9/2024 at 9:15 a.m., Cook1 stated the normal range for the sanitizer solution is 200 PPM, Cook1 pointed to the sanitizer testing log and stated every day we check and its 200PPM. The DS stated the normal range for the chlorine sanitizer was 200PPM. The DS stated the kitchen staff did not use Quaternary ammonia (another type of sanitizer) in the kitchen and only chlorine sanitizer was used. The DS stated the chlorine sanitizer was used to clean the kitchen counters, meal carts and equipment. During a concurrent interview with DS and review of facility policy for chlorine sanitizer solution, the DS verified that the normal concentration of the chlorine solution had to be 100 parts per million. During an interview with Registered Dietitian (RD) and the DS on 11/9/2024 at 1:40 p.m., the DS sated kitchen staff were not mixing the solution of the choline sanitizer correctly because they were not following facility policy. The DS stated the correct range for an affective chlorine sanitizer is 100 PPM as per policy. The RD stated too much chlorine could result in a potential of chemical cross contamination of food. A review of facility policy and procedures titled Sanitizers or Germicides (dated 2023) indicated, if Chlorine is used a bactericidal agent, the concentration of the solution must be 100PPM. One tables of bleach diluted with 1 gallon (a unit of volume) or (3.7 liters) of water and will yield 100 parts per million.

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NAME OF PROVIDER OR SUPPLIER: Berkley West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1623 Arizona Avenue Santa Monica, CA 90404	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 11/9/2024 when: 1.Facility failed to follow lunch menu and portion sizes as written for residents on pureed diet. Four residents on pureed diet received 1/2 cup of pureed Salisbury steak instead of 2/3 of cup per the food portion and serving guide. This deficient practice had the potential to result in decreased nutritional intake and weight loss for Four residents who were on puree diet. Findings: According to the facility lunch menu for pureed diet on 11/9/2024, the following items will be served: Salisbury Steak All American Gravy #6 scoop (5 1/3 ounces (oz)); Twice baked mashed potato #8 scoop (1/2 cup); Confetti corn pureed #12 scoop (1/3 cup); pureed wheat roll, margarine; apples with caramel sauce pureed and milk. During an observation of the tray line service for lunch on 11/9/2024, at 11:45 a.m., for residents who were on pureed diet the cook served pureed Salisbury steak using 4oz. ladle, instead of 5 1/3 oz. per menu. During a review of the menu and interview with Cook2 and DS on 11/9/2024 at 12:30 pm. Cook2 stated she served the pureed meat with using the wrong spoon and served less protein to residents who were on pureed diet. Cook2 sated when serving less food to residents, the resident could lose weight. The dietary supervisor (DS) stated cooks should always follow the menu and the serving guide to serve the correct amount according to the planned menu. A review of facility menu and spreadsheet (portion and serving guide) on 11/9/2024 indicated serve pureed Salisbury steak using #6 scoop yielding 5 1/2 ounces. A review of facility Policy titled Menu Planning indicated, The menus are planned to meet nutritional needs of residents in accordance with .the most recent recommended dietary allowances of the Food and Nutrition Board of the national Research Council National Academy of Sciences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure 1 of 12 sampled residents (Resident 37) was served the food preferences listed on the lunch meal ticket (physician ordered diet with resident food preferences). By serving Resident 37 who had lactose intolerance (lactose a sugar found in dairy products such as milk) regular milk during lunch, despite lactose being listed as an intolerance on resident's lunch meal ticket/tray card. This Deficient practice had the potential to result in decreased meal satisfaction, decrease caloric intake and experience symptoms associated with lactose intolerance. Findings: A review of Resident 37's admission record indicated the facility admitted the resident on 9/28/2024 with diagnoses that included dysphagia (difficulty swallowing), prediabetes (condition in which blood sugar levels are higher than normal), and severe protein-calorie malnutrition. A review of Resident 37's diet order dated 11/7/2024 at 7:58 am, indicated a diet order for regular large portions diet minced and moist texture, thin liquids consistency. A review of Resident 37's care plan for risk for significat weight changes and/or malnutrition, indicate the residnet was to recive the diet as ordered. A review of Resident 37's Nutritional Risk assessment dated [DATE] indicated Resident 37 was allergic to corn syrup and lactose. A review of the Dietary Profile dated 10/8/2024 indicated Resident 37's diet was regular diet mechanical soft texture. The dietary profile indicated resident preferred lactose free milk, eats eggs, and eats cheese occasionally. A review of resident 37's meal ticket (physician ordered diet with resident food preferences and intolerances) for lunch dated 11/9/2024 indicated resident food intolerances included lactose intolerance. During an observation in the kitchen on 11/9/2024 at 11:45 a.m., beverages and milk were prepared for service, cups were sealed with a plastic wrap and the type of beverage written on the wrapper with a marker. Dietary Aide 2 (DA2) was observed serving a regular cup of milk to resident 37. During a concurrent observation and interview with DS on 11/9.2024 at 11:50 a.m. The dietary supervisor (DS) stated beverages were marked by the type of milk and the consistency of milk or juice. The DS stated facility served lactose free milk, or non-dairy milk such as almond or soy and there was texture modified (thickened) beverages as well. The DS stated as staff prepared the beverages, staff would mark the beverage and then serve accordingly. The DS stated when there was no writing on the wrapper of the milk it meant the beverage was regular milk. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley West Healthcare Center	1623 Arizona Avenue Santa Monica, CA 90404

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with DA2 on 11/9/2024 at 12:20 p.m. DA2 stated no lactose means no dairy products such as milk. DA2 stated the facility offered lactose free milk and would write the type of milk on the wrapper on top of the cup. DA2 stated when someone with no lactose intolerance received regular milk they would have stomach problems. During a dining observation on 11/9/2024 at 1:00 p.m., Resident 37's tray was observed on the bedside table with regular milk on the tray. During a concurrent interview with resident 37 and resident's spouse, resident 37 stated she has lactose intolerance, and she usually gets lactose free milk. Resident 37's spouse stated he is at the facility every day and usually the cup of milk is marked with writings on the wrapper indicating lactose free milk, but today there was no writing on the wrapper that is why resident 37 did not drink it until we verify it is lactose free. Resident 37's family member 1 (FM 1) stated when resident 37 drank regular milk the resident would have stomachaches. FM 1 stated the resident took lactase when at home (medication helps digest the milk) to prevent the symptoms. During an interview with the DS and the registered dietician (RD) on 11/9/2024 at 1:30 p.m., the DS stated he verified that resident 37 received the regular milk instead of lactose free milk. The DS stated DA2 made a mistake and served the wrong milk. The DS stated giving Resident 37 regular milk had the potential for the resident to have a stomachache. The RD stated she would provide an in-service on monitoring the trays and checking them twice. A review of facility policy titled Food Preferences (dated 2023) indicated, Resident's food preferences will be adhered .Substitutes for all foods disliked will be given from the appropriate food group.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in accordance with professional standards to ensure food service safety. By failing to: 1.Ensure cut watermelon and cantaloupe stored in the reach in refrigerator did not exceed storage periods for ready to eat food. 2. Ensure dietary aide 1 (DA1) adhered to sanitary practices. DA 1 on 11/8/2024 at 6:45 p.m. was observed cleaning the kitchen, leaving the kitchen, returning to the kitchen with the dinner cart with the dishes, putting on a clean apron and proceeded to remove clean and sanitized dishes from the dish machine without washing hands. 3. Ensure DA 1 and DA 2 did not use a kitchen/dish towel to dry the cooking pots, pans, and utensils instead of letting them air dry. 4. Ensure previously cooked roast beef was monitored for safe cool down process (hot food cooled down within a certain time frame to precent harmful bacterial growth) These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 42 out of 46 residents who received food from the facility. Findings: 1.During an observation in the kitchen on 11/8/2024 at 6:00 p.m. there was one medium size bowl of cut watermelon and cantaloupe stored in the reach in refrigerator with a date of 11/3/24 and use by date of 11/5/2024. The fruits in the bowl looked wilted. On the same shelf there was a quarter of a cantaloup wrapped with plastic wrap with dates 11/6/2024 and half of a watermelon wrapped with plastic with dates 11/6/2024. The cantaloupe looked wilted and not fresh. During a concurrent observation and interview with [NAME] 1 on 11/8/2024 at 6:10 p.m., Cook1 stated the fruits in the bowl were old and should have been discarded. Cook1 stated the quarter cantaloupe did not look fresh, and half the watermelon was old. [NAME] 1 removed the fruits from the reach in refrigerator to discard the fruits. A review of facility policy titled Procedure for Refrigerated Storage (dated 2023) indicated, Produce will be delivered frequently and rotated in the order it is delivered to assure that a fresh product is used, free of any wilting or spoilage. 2.During an observation in the kitchen on 11/8/2024 at 6:45 p.m., DA1 was observed cleaning and wiping the food cart that was in the kitchen, DA then left the kitchen and returned with another food cart. DA1then put on a cloth apron, rinsed hands in the dishwashing area sink with water and proceeded to remove clean and sanitized dishes from the dishwasher without washing hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with DA1 and the Dietary Supervisor (DS) on 11/8/2024 at 6:50 p.m., DA1 stated she did not wash hands when returned to the kitchen. DA1 stated my hands are contaminated, and I touched the clean and sanitized dishes. DA1 stated she should wash hands in the hand washing sink using soap and water after entering the kitchen and before removing clean and sanitized dishes from the dishwashing machine. The DS stated dishes could be contaminated and would be rewashed. The DS asked DA1 to wash their hands before returning to the task. A review of facility policy and Procedure titled Hand Washing Procedure (dated 2023) indicated, Hand washing is important to prevent the spread of infection. Use warm running water and soap .wet hands and forearms first. Add soap and rub hands for 20 seconds. rinse thoroughly and dry hands .When hands need to be washed: before starting work in kitchen, before and after doing housekeeping procedures. 3.During an observation in the kitchen on 11/8/2024 at 7:00 p.m., DA1 was observed removing the clean and sanitized dishes from the dishwashing machine and drying them with a kitchen cloth before storing them. During a concurrent observation and interview with DA1 and DS on 11/8/2024 at 7:15 p.m., The DS stated staff should not use kitchen towels to dry dishes because of the potential for contaminating the dishes with the cloth. The DS stated DA1 should have allowed the dishes to air dry. During an interview with the Registered Dietitian (RD) on 11/9/2024 at 1:40 p.m., the RD stated staff should not use kitchen /dish cloths to dry dishes in the facility kitchen. The RD stated all the kitchen cloth towels would be removed from the kitchen, so staff is not tempted to use them and provide in-services to kitchen staff. During a review of facility policy and procedures titled Dishwashing (dated 2023) indicated, Dishes are to be air dried in racks before stacking and storing. A review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment and Utensils, Air-Drying Required. Code 4-901.11 indicated, Items must be allowed to drain and to air-dry before being stacked or stored .Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. 4.During an observation in the kitchen on 11/8/2024 at 6:18 p.m. a cooked roast pork was observed set on the kitchen counter. The cooked roast pork was in a plastic bag in a large deep pan and was covered with ice. Cook1 stated she believed the roast pork was removed from the oven at 5 p.m. and was set on the counter to cool down. Cook1 stated after cooling down the roast would be stored in the refrigerator for Sunday lunch. Cook1 stated she did not document the time the roast was taken out of the oven. Cook1 checked the temperature of the roast pork using the facility thermometer and the temperature registered at 191.3 degrees Fahrenheit (F) in the middle section of the roast and 188.4 degrees F on the side of the roast. [NAME] 1 stated she would put the roast in the refrigerator before she went home at 7:30 p.m. When asked if the temperature of the roast should be monitored in the refrigerator Cook1 did not answer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in the kitchen on 11/9/2024 at 11:00 a.m. previously cooked roast pork was in the reach in refrigerator. The roast pork was still in the plastic bag and stored in a large pan. Cook1 checked the temperature of the roast pork using the facility thermometer and the temperature ranged from 42.8 to 42.4 degrees F. Cook1 stated the temperature should have been 41 degrees or less. During a concurrent observation and interview with cook1 and the DS on 11/9/2024 at 11:05 a.m. The DS stated the facility policy was to hold cold food at 41 degrees or lower. The DS stated when food was held at improper temperatures bacteria could grow and cause illness. The DS stated when cooking large pieces of meat ahead of time and during the cool down process, the large piece of meat should be cut into smaller pieces to cool down faster. The DS stated cook1 should have cut the roast into smaller pieces to cool down faster. The DS stated cook1 should have documented the time the pork was removed from the oven and started the monitoring of the cool down Process. The DS stayed late at night and put the pork in the refrigerator. The DS stated the pork was not monitored for cool down per policy. The DS then discarded the pork. During an interview with the RD on 11/9/2024 at 11:15 a.m., the RD stated the facility policy was to hold cold food at 41 degrees or lower. The RD stated she will provide Inservice on proper cool down process. A review of facility policy and procedure titled Cooling and reheating of potentially hazardous or time/temperature Control for Safety Food (dated 2023) indicated, when cooked PHF or TCS food will not be served right away it must be cooled as quickly as possible the metho is: cool cooked food form 140 degrees (F) to 70 degrees (F) within two hours, then cool from 70 degrees F to 41 degrees F or less in an addition four hours for total cooling time of six hours. Methods of cooling Food 1) placing the food in shallow pans; 2) separate into smaller or thinner portions. A review of the 2022 U.S. Food and Drug Administration Food Code titled Time/temperature control for safety food, hot and cold holding Code 3-501.16 indicated, except during preparation, cooking or cooling, time/temperature control for safety food shall be maintained at 135degrees F or above, and at 41 degrees F or below.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses, PPE may include respirators, gloves, overalls, boots, disposable gowns, and goggles) when providing care to one of four sampled residents (Resident 144) who was on enhanced barrier precautions (utilized to prevent the spread of multi-drug resistant organisms) room. This deficient practice had the potential to result in the spread of disease and infection to all 46 residents, visitors, and staffs. Findings: A review of Resident 144's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right and left dominant side, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). A review of Resident 144's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/31/2024, indicated Resident 144's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired for daily decision-making and the resident required maximal assistance and was totally dependent on staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 144's Care Plan for at risk for high risk for developing complications including UTI (Urinary tract Infection: an infection in any part of the urinary system including the kidneys [organs in the body that filter waste materials out of the blood and pass them out of the body as urine, regulates blood pressure and the levels of water, salts, and minerals], and ureters [Tube/s that carry urine from the kidneys to the bladder and urethra]) due to use of foley catheter (a hollow tube inserted into the bladder to drain or collect urine) related to urinary retention, initiated on 11/9/2024, with a goal of Resident (144) will not develop any complications associated with catheter usage and Resident (144) will be free from signs and symptoms of UTI. During an observation of Resident 144 on 11/8/2024 at 7:05 p.m., Resident 144's foley catheter was observed with the drainage bag hanging on the side of the bed, placed above the level of Resident 144's bladder. The foley catheter drainage bag was observed tied to the right moveable bed side rails. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 11/8/2024 at 7:19 p.m., in Resident 144's room, LVN 1 was observed going inside Resident 144 without putting on full PPE. LVN 1 was observed putting on gloves, did not hand sanitize before putting on new gloves, and then moved the foley catheter to a non-movable frame of the bed. After moving the foley catheter, LVN 1 then removed the soiled gloves, went outside the room, did not hand sanitize after exiting the room and was still holding the soiled gloves in both hands. During an interview with LVN 1 on 11/8/2024 at 7:23 p.m., LVN 1 stated, Resident 144 was on an enhanced barrier precautions. LVN 1 confirmed by stating, she did not wear full PPE before touching resident's indwelling catheter because she was about to give another resident's medications. LVN 1 stated, she should have worn full PPE for infection control. During an interview with Registered Nurse 1 (RN 1) on 11/10/2024 at 10:22 a.m., RN 1 stated staff needed to wear full PPE before touching indwelling catheter or giving care to residents who were on enhanced barrier precautions. RN 1 stated wearing full PPE was for infection control and prevention. A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions (EBP) dated 1/2024, the P&P indicated, EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray . Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing).

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F 0919

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure that a working call system is available in each resident's bathroom and bathing area.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46843

Based on observation, interview, and record review, the facility failed to ensure that call light (a device with a button or touch pad a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) were within reach for one of six sampled residents (Resident 199).

This deficient practice had the potential to result in staff delay in meeting Resident 199's needs for hydration, toileting, and activities of daily living.

Findings:

A review of Resident 199's Admission Record indicated Resident 199 was admitted to the facility on [DATE], with medical diagnoses that included: Muscle weakness (a lack of physical or muscle strength, throughout the body). Hypertension (HTN-high blood pressure). Acute Kidney Failure (A condition in which the kidneys suddenly can't filter waste from the blood).

A review of Resident 199's Minimum Data Set (MDS - a federally mandated resident assessment tool) was intact. The MDS indicated the resident was able to make decisions regarding daily care. The MDS indicated the resident required minimal assistance from staff for toileting, hygiene, bathing, lower body dressing, and personal hygiene).

During observation on 11/8/2024 at 7:01 pm, Resident 199 was observed lying in bed, with the call light was hanging off the wall, behind the resident's bed and out of reach of Resident 199.

During an interview on 11/8/2024 at 7:03 pm Resident 199 stated she did not know where her call light was. Resident 199 stated that if she needed help, she would yell for help.

During an interview on 11/8/2024 at 7:08 pm with Certified Nurse Assistant (CNA) 2, CNA 2 stated that Resident 199 did not have the call light within reach; however, it was okay because CNA 2 was always checking on her residents. CNA 2 stated the residents usually had the call light within reach if the call light was not within reach the resident would not be able to get help if needed because the residents would not be able to call for help.

During an interview on 11/8/2024 at 07:27 p.m., with the Director of Nursing (DON), the DON stated that while the residents were in bed call lights were to remain within easy reach of the resident. The DON stated staff were to perform room checks periodically to ensure resident safety was maintained and that call lights were within reach of each resident.

During a review of the facility's policy and procedures titled, Answering the Call Light date revised January 2024, indicated the purpose of the policy was The purpose of this procedure is to ensure timely response to the resident's requests and needs.

General Guidelines

(continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Upon admission and periodically as needed, explain, and demonstrate use of the call light to the resident. 2.Ensure that the call light is accessible to the resident.