

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure staff implemented its policy and procedures on Health Insurance Portability and Accountability Act (HIPAA- is a U.S. federal law that protects sensitive patient/resident/client health information (PHI) from unauthorized disclosure, ensuring privacy, security, and data integrity while also allowing for health insurance portability and administrative efficiency in healthcare) for one of one resident (Resident 52). This deficient practice violated the privacy and confidentiality rights of Resident 52. Findings: During record review, Resident 52's admission Record indicated the facility admitted Resident 52 on 12/7/2025 with diagnoses including Type 2 Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN-high blood pressure). During record review, Resident 52's Minimum Data Set (MDS-A resident assessment tool) dated 12/29/2025, indicated Resident 52 had intact cognitive skills (mental ability to make decisions of daily living). During an observation and concurrent record review on 01/05/2026 at 12:09 PM Resident 52 was observed in bed receiving a bag of Sodium Chloride Solution 0.9% (NS 0.9%- Is a saltwater solution used medically for fluid/electrolyte replacement, wound/eye irrigation, nebulization to loosen mucus, and in laboratories for cell washing) intravenous (IV-into a vein) infusion at 100 milliliters (mL-unit of measurement) per hour (hr) via dial flow (a manual IV administration set with a built-in dial to control the flow rate [mL/hour] of fluids or medications). A telephone physician's order was taped/attached on the NS 0.9% solution bag and had the following information: Resident 52's name, date of birth (DOB) and room number Date of 1/4/2026 at 3:36 PM Facility name, address, fax number, and phone number. Order ID Number. Order Summary: Sodium Chloride Solution 0.9% intravenous use at 100 mL/hour. Confirmed by Registered Nurse Supervisor (RNS) 1. During an observation, interview, and concurrent record review in the presence of the director of nursing (DON) on 01/05/2026 at 2:45 PM, RNS 1 stated that HIPAA protects residents from sharing information to others who should not have their personal information; RNS 1 observed and read the physician's order attached/taped on Resident 52's IV NS 0.9% solution bag. RNS 1 stated the physician's order included Resident 52's name and DOB. RNS 1 stated the NS 0.9% solution IV bag was taken directly from the facility's emergency kit (e-kit). RNS 1 stated that IV bags do not come with a labels and so she printed the physician's order and taped it on Resident 52's IV bag. During an interview on 01/07/2026 at 2:11 PM, RNS 1 stated HIPAA protects patient privacy and that private information is not seen by other residents, staff, family members, and/or visitors and that all staff/all health care workers must comply with HIPAA law. RNS 1 stated that residents can become upset and betrayed when their protected information is displayed for anyone to see and retrieve without their permission. During record review, the facility's policy and procedures (P&P) titled 'HIPAA Compliance' revised on 4/2025, indicated, POLICY. It is the intent of the facility to adhere to the Omnibus Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, Enforcement and Breach Notification Rules. Transaction Code Sets, Enforcement guidance and related requirements of the Health Insurance Portability and Accountability Act (HIPAA). It is our intent to assure that policies, procedures and practices are developed, implemented, staff trained breaches avoided and compliance monitored.2. The facility will adopt guidelines and procedures that are compliant with the HIPAA Privacy and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055136
		If continuation sheet Page 1 of 8

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Security Rules and other related HIPAA rules and the practices established by the Rule as well as other applicable federal and state laws.3. Policies and Procedures and training will include as a minimum: a. Access to PHI - manual and electronic; b. Accounting of Disclosures including faxes; c. Amendments; d. Breach and impact rules; e. Business Associates; f. Compliance, monitoring and reporting; g. Designated Record Set; h. Disclosure with and without Authorizations; i. Marketing and Financing; j. Minimum Necessary; k. Privacy Practices and Privacy Notice; 1. Sanctions; m. Security requirements. During record review, the facility's P&P titled Protected Health Information (PHI), Authorization for Use or Disclosure of Policy Statement All uses and disclosures of revised 3/2014, indicated that, Protected health information (PHI) beyond those otherwise permitted by current HIPAA law require a signed authorization.1. Policy Interpretation and Implementation The facility and its business associates have a limited right to use and/or disclose PHI health information for purposes of treatment, payment, or for the operations of the organization.2. For other uses, there must be written authorization to release protected health information unless the law permits or requires the facility to use or disclose this information without authorization.5. Uses and disclosures of PHI that require written authorization, except as permitted by law, include: a. Use or disclosure of psychotherapy notes; b. Use or disclosure of PHI for marketing purposes; or c. The sale of PH. Uses or disclosures of PHI that require an opportunity for the individual to agree or object include:a. Use or disclosure of certain information to maintain a facility directory; (1) The facility will inform individuals of the type of information that will be used in the directory and the persons to whom the information will be disclosed.(2) Individuals will be given the opportunity to restrict some or all of the information used or disclosed in a facility directory.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to provide daily wound treatment per physician's orders for one of one sampled residents (Resident 42) according to Physician's Orders dated 12/24/2025. This deficient practice had the potential to place Resident 42 at risk for worsening of the pressure injury. Findings: A review of the Resident 42's admission Record indicated the facility re-admitted the resident on 12/20/2025, with diagnoses that included stage 3 pressure ulcer (is tissue damage that results in full-thickness loss of skin and the layer of fat under the skin may be visible), encephalopathy (brain damage that causes severe confusion and forgetfulness) and dementia (a progressive state of decline in mental abilities). A review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 12/24/2025 indicated the resident had one stage 3 pressure wound (ulcer) upon admission. The MDS also indicated Resident 42 was dependent upon staff to shower, lower body dressing and toileting hygiene. A review of Resident 42's care plan on impaired skin integrity, initiated 12/21/2025, indicated the resident had a stage 3 pressure wound (ulcer). The goal was for Resident 42's wound to decrease in size to not develop skin breakdown. The care plan interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) included to cleanse the site with normal saline, apply Santyl ointment (medicine that removes dead tissue from wounds so they can start to heal) and cover with a foam dressing (wound care material) daily. A review of Resident 42's altered care plan on skin integrity, initiated 12/23/2025, indicated the resident had a pressure injury on the right lateral lower leg. The care plan indicated the goal was for the resident's skin to be free from signs and symptoms of redness, swelling and foul smelling drainage. The care plan indicated interventions included to check resident's skin condition for presence of skin breakdown and to provide the treatment as ordered. A review of Resident 42's Physician's Orders dated 12/24/2025, indicated the physician ordered the following treatment orders:- To treat the sacral pressure injury, staff were to apply Santyl (ointment used to remove damaged tissue from chronic skin ulcers and severely burned areas) to sacrum topically every day shift for stage 3 pressure injury. - To treat the right later lower leg wound, staff were to cleanse the area with normal saline (NS - is a mixture of salt and water), pat dry, apply Santyl then cover with an abdominal pad and wrap with kerlix (a bulky, crinkled gauze bandage used to cushion, absorb fluid, and protect wounds) daily. During a concurrent interview and record review on 1/7/2026 at 1:34 PM with Treatment Nurse (TN) 1, Resident 42's Treatment Administration Records (TAR - a log used by healthcare professionals of all treatments given to a resident) for the month of December 2025 and January 2026 were reviewed. TN 1 stated Resident 42 was admitted with a stage 3 sacral pressure ulcer and a Stage 3 right lateral leg pressure ulcer. TN 1 stated Resident 42's wounds are treated daily. TN 1 stated there was no documented evidence that Resident 42's wounds were treated on 12/27/25, 12/30/2025 and on 1/2/2026. TN 1 stated treatments are documented to prove that they were completed and wounds are treated in order to improve the wound. During an interview on 1/8/2026 at 11:45 AM the Director of Nursing (DON) stated, If treatments are not documented they (treatment) are not done. Importance of wound treatment is to make sure the wound is treated properly so it doesn't get worse or become infection. The goal is to heal the wound. A review of the facility's P&P titled, Charting and Documentation, revised 4/2025, indicated the following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 40), who had limited range of motion (ROM - the extent of movement of a joint) in the right hand, had a right hand splint applied per the physician's order. This deficient practice placed Resident 5 at increased risk for further decline and contracture formation to the right hand. A review of Resident 40's admission Record indicated the facility admitted the resident on 10/26/2024 and readmitted the resident on 2/6/2025 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, gait and mobility abnormalities and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 40's Quarterly Minimum Data Set (MDS - a resident assessment tool) dated 10/29/2025 indicated the resident had severely impaired cognitive skills for daily decision-making. The MDS indicated the resident moderate assistance with dressing, toileting hygiene and bathing. The MDS also indicated Resident 40 received had limited range of motion (ROM - extent of movement of a joint) on an upper extremity. A review of Resident 40's high risk for further contractures on right hand care plan, initiated 10/24/2025, indicated the resident needed a right hand splint. The care plan interventions included for RNA for right hand/wrist splint application up to 4 hours as tolerated every day five times a week and to check for further contracture of the hands and fingers during care. A review of Resident 40's Physician Orders, dated 12/11/2025 indicated the resident was to receive Restorative Nursing Aide (RNA, assistant that help residents to maintain their function and joint mobility) for right hand /wrist splint application up to four hours every day five times a week. During an observation on 1/6/2026 at 9:52 AM, at Resident 40's bedside, Resident 40 was observed sleeping in bed. Resident 40 was not wearing a right hand splint. During an observation on 1/6/2026 at 12:18 PM, inside the dining Room. Resident 40 was observed eating lunch with his left hand. Resident 40 was not wearing a right hand splint. During an interview and observation on 1/6/2026 at 12:38 PM, Resident 40 stated the last time he wore the splint was in early December 2025. Resident 40 stated he would like to wear the splint. Resident 40 also stated he did not know why the splint isn't being applied. During a concurrent interview and record review on 1/6/2026 at 1:36 PM Restorative Nurse Aide (RNA) 1 stated Resident 40's right hand contracture and Resident 40 had an order to apply a splint to Resident 40's right hand for four hours a day. RNA 1 stated Resident 40's splint has been missing for around 20 days. RNA 1 further stated they did not know if a new splint had been ordered. During a concurrent review of the RNA log book for January 2026, RNA 1 stated there was no log for Resident 40. RNA 1 further stated it was important for Resident 40 to wear the splint to prevent his right hand contracture from worsening. A review of the facility's policy and procedures (P&P) titled, Resident Mobility and Range of Motion, revised 4/2025, indicated Residents will not experience an avoidable reduction in range of motion (ROM) and residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.		

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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. Based on interview and record review, the facility failed to provide urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) care every shift per the resident's physician order for one of four sampled resident's (Resident 12). This deficient practice had the potential to result in the development of a urinary tract infection (UTI- an infection in any part of the urinary system, the kidneys, bladder or urethra).A review of Resident 12's admission record indicated the facility admitted Resident 12 on 11/28/2025 with diagnoses that included lumbar vertebral fracture (a broken bone in the lower back), urinary retention (inability to completely empty one's bladder) and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 12/5/2025, indicated the resident's cognition (ability to acquire and understand knowledge) was intact. The MDS also indicated the resident had an indwelling urinary catheter and was not part of a toileting program. The MDS further indicated the resident was dependent upon staff for toileting hygiene, bathing and dressing. A review of the physician orders, dated 6/10/2025, indicated Resident 12 was to receive the following care:Foley Catheter size 16 French (Fr - measurement of the catheter's outer diameter) with 10 milliliter (m-unit of measurement) bulb. Monitor for placement and function as neededCatheter care for indwelling catheter every shift. Cleanse area every shift monitor for redness, irritation, swelling, signs and symptoms of urinary tract infection (UTI). A review of Resident 12's care plan on Has Indwelling Catheter, initiated 12/8/2025, indicated Resident 12 had a urinary catheter due to urinary retention. The care plan indicated a goal was for the resident to not exhibit signs or symptoms of urinary infection. The interventions included to monitor for signs/symptoms of UTI which included pain, burning, blood tinged urine. During an interview on 1/07/2026 at 1:55 PM, Treatment Nurse (TN) 1 stated Resident 12 had a urinary catheter due to decreased urine output. TN 1 stated urinary catheter care is provided by nursing staff every shift. TN 1 further stated there was no documentation that catheter care was provided to Resident 1 on 1/2/2026 during the day shift or on 1/3/2026 during the night shift. TN 1 stated a potential of outcome of not providing catheter care was that Resident 12 could develop an infection. During an interview on 1/8/2026 at 11:42, the Director of Nursing (DON) stated if a treatment is not documented it was not done. The DON further stated it was important to provide catheter care every shift in order to prevent the resident from developing an infection. A review of the facility's policy and procedures (P&P) titled, Catheter Care, Urinary, revised 4/2025, indicated, The purpose of this procedure is to prevent catheter-associated urinary tract infections. A review of the facility's P&P titled, Charting and Documentation, revised 4/2025, indicated: 2. The following information is to be documented in the resident medical record:a. Objective observations;b. Medications administered;c. Treatments or services performed;		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review the facility failed to ensure insulin (a hormone that regulates blood sugar) for single-patient use (meant for multiple uses for one individual patient/resident) for Resident 34 was ordered and delivered to the facility timely for one of six residents (Resident 34).As a result, on 1/6/2026 at 11:15AM, licensed vocational nurse (LVN) 2, dispensed 2 units (unit of measure) insulin pen (portable medical device used for injecting doses of insulin) that was already in use/circulation and prescribed specifically for Resident 46 and administered/injected Resident 34 with the same insulin therefore decreasing/reducing the intended time and doses of the insulin prescribed for Resident 46. Cross Reference F880 Findings: During a concurrent observation and interview of medication administration on 1/6/2026 at 11:15AM, LVN 2 injected Resident 34 with 2 units of insulin per sliding scale (chart with prescribed pre-established doses) via insulin pen for a blood sugar test result of 204. An observation/review of a label on the insulin pen, the label indicated that the insulin was prescribed for Resident 46. During an interview LVN 2 apologetically stated she accidentally used Resident 46's insulin pen to administer insulin to Resident 34. LVN 2 further stated Resident 34's insulin pen was in the medication cart, however upon inspection, there was no insulin found of the medication cart and the medication refrigerator for Resident 34. During a concurrent interview and record review on 1/6/2026 at 11:46 AM, the Director of Staff Development (DSD) stated a renewal order for Resident 34's insulin pen was completed yesterday (1/5/2026) during the night shift, the DSD stated facility contracted pharmacy had not delivered Resident 34's ordered insulin medication to the facility. During an interview on 1/8/2026 at 2:45PM, the Director of Nursing (DON) stated sharing a single-patient insulin pen on any resident other than on the resident that the insulin was prescribed for, can lead to reduced intended time use of the prescribed dose for the intended Resident placing residents at risk for serious skin and blood borne diseases that can result in poor outcomes including death. A review of the facility's policy and procedures (P&P) titled Medication Administration-General Guidelines dated 04/2025 indicated, Prior to administration, the medication . the Resident's medication administration record (MAR) is compared with the medication label. Medications supplied for one resident are never administered to another resident. A review of the facility Licensed Vocational Nurse Job Description dated 2003, subtitle Drug Administration Functions indicated, Ensure that prescribed medication for one resident is not administered to another.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 8's medical records did not contain abbreviations not approved by the facility in accordance with the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Charting and Documentation with a revision date of 7/2017. This deficient practice had the potential to result in miscommunication between medical and nursing staff causing delay in providing medical care and services to Resident 8. Findings During a review of Resident 8's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 8 was admitted to the facility on [DATE] with the following diagnoses: hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), dysphagia (difficulty swallowing), and acute on chronic diastolic heart failure (a sudden worsening of long-term stiffness in the heart's main pumping chamber (left ventricle), making it hard to relax and fill with blood, leading to fluid backup, shortness of breath, fatigue, and swelling, requiring urgent treatment). During a review of Resident 8's Hospice (is medical care for people who are expected to live six months or less) Comprehensive Assessment (identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process) with benefit period dates of 10/17/2025 through 1/14/2026 indicated, Resident 8 was under hospice care. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool) dated 10/23/2025, indicated, Resident 8 had moderately impaired cognition (make poor decisions, cues and supervisions required) and was dependent on all activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 8's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) with a focus on declining health status, initiated on 10/18/2025, indicated the CP goal is to keep Resident 8 comfortable and pain will be controlled. The CP intervention included to observe/report increase pain rate and re-evaluate medication as needed through hospice. However, the same CP indicated that a staff used the abbreviation PIC but failed to indicate/spell out what PIC stood for/means. During a review of Resident 8's Hospice Visit Note Report dated 12/30/2025 indicated, Resident 8 had a recent decline in functional status in feeding, bathing, toileting, ambulation, transfers, feeding, and was now bedbound (someone confined to bed for most or all of their day due to illness, injury, or physical limitations, requiring assistance). During a review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) dated 1/09/2026 indicated, Several staff were educated on avoiding abbreviations in patient documentation. During a review of the facility's Abbreviations and Symbols with a revision date of 9/2013, the document did not include the abbreviation PIC as part of the facility approved abbreviations. During a review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Charting and Documentation with a revision date of 7/2017 indicated, To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure insulin (a hormone that regulates blood sugar) for single-patient use (meant for multiple uses for one individual patient/resident) for Resident 34 was ordered and delivered to the facility timely for one of six residents (Resident 34). This deficient practice placed both Resident 34 and 46 at high risk for infection and transmission of bloodborne pathogens, including hepatitis B (HBV-a viral infection of the liver), hepatitis C (HCV-a viral infection causing liver inflammation), and human immunodeficiency virus (HIV- a virus that attacks the body's immune system).Cross Reference F760 Findings: During a concurrent observation and interview of medication administration on 1/6/2026 at 11:15AM, LVN 2 injected Resident 34 with 2 units of insulin per sliding scale (chart with prescribed pre-established doses) via insulin pen for a blood sugar test result of 204. An observation/review of a label on the insulin pen, the label indicated that the insulin was prescribed for Resident 46. During an interview LVN 2 apologetically stated she accidentally used Resident 46's insulin pen to administer insulin to Resident 34. LVN 2 further stated Resident 34's insulin pen was in the medication cart, however upon inspection, there was no insulin found of the medication cart and the medication refrigerator for Resident 34. During a concurrent interview and record review on 1/6/2026 at 11:46 AM, the Director of Staff Development (DSD) stated a renewal order for Resident 34's insulin pen was completed yesterday (1/5/2026) during the night shift, the DSD stated facility contracted pharmacy had not delivered Resident 34's ordered insulin medication to the facility. During an interview on 1/8/2026 at 2:45PM, the Director of Nursing (DON) stated sharing a single-patient insulin pen on any resident other than on the resident that the insulin was prescribed for, can lead to reduced intended time use of the prescribed dose for the intended Resident placing residents at risk for serious skin and blood borne diseases that can result in poor outcomes including death. A review of the facility's policy and procedures (P&P) titled Infection Prevention & Control Program dated 04/2025 indicated, An infection and control program (IPCP) is established . to help prevent the development and transmission of communicable diseases and infections. Prevention of infection includes educating staff and ensuring that they adhere to proper techniques and procedures. A review of the facility's P&P titled Medication Administration-General Guidelines dated 04/2025 indicated, Prior to administration, the medication . the Resident's medication administration record (MAR) is compared with the medication label. Medications supplied for one resident are never administered to another resident. A review of the facility Licensed Vocational Nurse Job Description dated 2003, subtitle Drug Administration Functions indicated, Ensure that prescribed medication for one resident is not administered to another.		