

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Beachwood Post-Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15th Street Santa Monica, CA 90404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>44253</p> <p>Based on interview and record review, the facility failed to report an allegation of physical abuse to the state survey agency within 2 hours for one of three sampled residents (Resident 1) in accordance with the facility's policy and procedures (P&P) titled, Abuse Investigation and Reporting, revised 1/24.</p> <p>This deficient practice had the potential to result in a delay of an onsite inspection by the California Department of Public Health (CDPH) to ensure Resident 1's allegation was investigated timely. This deficient practice also had the potential to place Resident 1 at further risk for abuse.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 11/20/20 and readmitted the resident on 6/2/21 with diagnoses of spinal stenosis (a condition in which the spaces in the spine narrow, placing pressure on the spinal cord and nerves which can lead to pain, numbness, tingling or cramping), post laminectomy syndrome (condition in which a person experiences pain after a surgery that removes part of a vertebra to relieve pressure on the spinal cord) and chronic pain (pain that lasts longer than three months).</p> <p>A review of Resident 1's activities of daily living (ADL - eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) care plan, initiated 6/7/22, indicated Resident 1 required total assistance with dressing, toilet use and personal hygiene. The ADL interventions included to explain procedures to the resident prior to providing care or treatment, assist or provide shower or bed bath as scheduled.</p> <p>A review of Resident 1's Quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/5/24, indicated Resident 1's cognition (ability to think, understand, and reason) was intact. The MDS also indicated Resident 1 was always incontinent and was dependent upon staff for toileting hygiene.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Change in Condition (COC- significant worsening of an employee's physical health or a change in circumstances), dated 10/21/24 timed at 10:11 AM, indicated Resident 1 verbalized that other assigned certified nursing assistant (CNA) allegedly rough handled Resident 1 when getting the resident up from bed. Charge nurse, intervene and separated the resident and CNA. The COC indicated, the charge nurse continued to help the resident up in bed and get the resident ready for morning routine. The COC indicated, abuse protocol was implemented by separating Resident 1 and CNA 1, and that the administrator, CDPH, . were notified as mandated for suspected elderly abuse.</p> <p>During an interview on 10/28/24 at 9:10 AM, Resident 1 stated two CNAs (Resident 1 did not know the names of their names) were providing incontinence (inability to voluntarily control passage of urine and or stool) care to Resident 1. Resident 1 stated one of the two CNAs, placed a knee on Resident 1's back and also hurt Resident 1's leg. Resident 1 stated one of the CNAs, was scrubbing me like she was burning a car. Resident 1 also stated Licensed Vocational Nurse 1 (LVN 1) was also in the room and Resident 1 asked LVN 1 how could LVN 1 allow CNA 1 to continue to abuse the resident.</p> <p>During an interview on 10/28/24 at 12:55 PM, LVN 1 stated on 10/21/24 at around 8 AM or 9 AM, LVN 1 went into Resident 1's room while CNA 1 and CNA 2 were providing morning care to Resident 1. LVN 1 stated Resident 1 was crying, and Resident 1 reported that CNA 1 was rough with Resident 1's care and that the resident was not being treated like a human. LVN 1 stated CNA 1 was removed from Resident 1. LVN 1 stated LVN 1 and CNA 2 finished giving care to Resident 1 and used a Hoyer lift (mechanical device used to assist in transfer/move a person), to transfer Resident 1 from the bed o a wheelchair. LVN 1 further stated Resident 1 repeatedly stated CNA 1 treated Resident 1 roughly. LVN 1 stated the facility's abuse protocol was initiated in which staff are to report the abuse allegation to the Director of Nursing and Administrator within 2 hours.</p> <p>During an interview on 10/28/24 at 1:23 PM, the Social Services Director (SSD) stated the SSD reported Resident 1's abuse allegation to Licensing & Certification, law enforcement and the ombudsman on 10/21/24. The SSD stated Resident 1 made the abuse allegation on 10/21/24 at 10:21 AM. SSD stated the abuse allegation was first reported by fax on 10/21/24 at 12:59 PM more than 2 hours after the abuse allegation was made. The SSD stated abuse allegation is reported within 2 hours. The SSD further stated, the facility staff always report within 2 hours because if there is some kind of abuse we want to report it right away.</p> <p>During an interview on 10/28/24 at 1:50 PM, the Director of Staff Development (DSD) stated the facility suspended CNA 1 and CNA 2 after Resident 1's abuse allegation until the facility's investigation was completed. The DSD further stated the reporting time for abuse is 2 hours. The DSD further stated abuse must be reported within 2 hours to the ombudsman, licensing and Certification and law enforcement. The DSD further stated there is a 2-hour time frame to report abuse because the facility needs to ensure the resident is not injured and for the facility to begin the investigation and verify if abuse occurred.</p> <p>During an interview on 10/28/24 at 2:57 PM, the Director of Nursing (DON) stated Resident 1 made an allegation of abuse on 10/21/24 at 10:11 AM. The DON stated the abuse allegation was not reported within 2 hours because there was a lot going on as Resident 1 had several changes of conditions that morning.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedures (P&P) titled, Abuse Investigation and Reporting, revised 1/24, indicated all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:</p> <ol style="list-style-type: none"> a. The State licensing/certification agency responsible for surveying/licensing the facility. b. The local/State Ombudsman. c. The Resident's Representative (Sponsor) of Record. d. Adult Protective Services (where state law provides jurisdiction in long-term care). e. Law enforcement officials. f. The resident's Attending Physician; and g. The facility Medical Director. <p>2. Suspected abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours.</p>		