

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  12/16/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342</b></p> <p>Based on interview and record review the facility failed to implement fall precautions to prevent falls for one of three sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> <li>1. Provide two-person assist when turning and repositioning for Resident 1 who was identified as high risk for fall.</li> <li>2. Implement the risk for fall care plan for Resident 1 to provide fall mats (a floor pad designed to help prevent injury should a person fall).</li> </ol> <p>As a result, on 11/4/2024 at 6:40 a.m., Resident 1 fell from the bed and hit head on the floor when Certified Nursing Assistant (CNA) 1 was providing care to the resident. Resident 1 was transferred to a general acute care hospital (GACH) and diagnosed with a 1 centimeter (cm-unit of measurement) thick right parietal subdural hematoma (SDH-a collection of blood outside of a blood vessel caused by a broken blood vessel between the brain and the skull). Resident 1 was subsequently admitted to the GACH intensive care unit (ICU - a department in a hospital where critically ill patients who are cared for constantly observed) for further care and management.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain), multiple fractures of left ribs, cerebral edema (swelling in the brain), respiratory failure, essential hypertension (high blood pressure), tracheostomy(surgical opening in the neck for breathing) and long term mechanical ventilator (a medical device to help support or replace breathing) dependence.</p> <p>A review of Resident 1's Nursing-Admission/Readmission Evaluation/assessment dated [DATE] at 6:40 p.m., indicated the following: Resident 1 had limited range of movement (ROM- a joint or body part cannot move through its normal range of motion); required assistance with transfer; and required assistance with eating, bathing, dressing, grooming, toileting, and bed mobility.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Fall Risk assessment dated [DATE] indicated the following: Resident 1 had 1-2 falls in the last 90 days; The fall risk score was 26 (a score of 16 to 42 is considered a high risk for fall); Resident 1's vision was moderately impaired (limited vision but can identify objects). Resident 1 was non-ambulatory (unable to walk).</p> <p>A review of Resident 1's care plan titled, Resident 1 is at risk for falls, dated 9/7/2024, indicated the goal included to minimize complications related to falls risks for falls and the resident will not have any major injuries related to falls. The care plan interventions included to keep bed in low position, side rails up (1/4 bed mobility bars) while in bed to aid in mobility and repositioning, and place safety devices as ordered fall mats (a floor pad designed to help prevent injury should a person fall).</p> <p>A review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 9/9/2024, indicated Resident 1's cognition (mental ability to make decisions for daily living) was not intact. The MDS indicated Resident 1 had impairment to both upper extremities (shoulder, elbow, wrists, hand) and both lower extremities (hip, knee, ankle, foot). The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with rolling left to right, toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair.</p> <p>A review of the Facility In-service lesson plan titled, Taking care of total dependent residents, dated 10/14/2024 and 10/15/2024 indicated use two-person assist when turning and repositioning.</p> <p>A review of Resident 1's Progress Notes date range of 11/1/2024 to 11/4/2024, indicated, CNA reported that while changing patient, patient rolled over to the opposite side of the bed and had a witness fall . Notified MD, awaiting further orders at this time.</p> <p>A review of Resident 1's Change in Condition Evaluation form dated 11/4/2024 timed at 7:09 a.m., Licensed Vocational Nurse (LVN) 1 documented that Resident 1 had a fall and that Certified Nursing Assistant (CNA) 1 reported that while CNA 1 was changing (providing care) Resident 1, Resident 1 rolled over to the opposite side of the bed and fell on the floor; No obvious injury was noted; Resident 1 was placed back into bed and the attending physician was notified, awaiting further orders.</p> <p>A review of Resident 1's Nurse's Note dated 11/4/2024 at 7:15 a.m., RN 2 documented that on 11/4/2024 at 6:40 a.m., CNA (CNA 1) reported to writer (RN 2) and Charge Nurse (LVN 1) regarding a witnessed fall involving the patient (Resident 1). Per CNA, the patient fell from the bed during patient care and that the bed was above the knee level. The writer and additional Nurses assisted in assessing the patient, finding no visible injuries at the time of assessment. The patient was safely placed back in bed .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's note titled Communication with Family dated 11/4/2024 at 9:25 a.m., Registered Nurse (RN) documented that on 11/4/2024 at 6:40 a.m., CNA (unidentified) reported to Registered Nurse Supervisor (RNS) and Charge Nurse (LVN) of a witnessed fall involving the patient (Resident 1). Per the CNA, the patient fell from the bed during patient care. A full head to toe assessment completed, finding no visible injuries and the patient was safely placed in bed. Vital signs were as follows: Blood Pressure (BP) 152/73 milliliters of mercury (mmHg-Unit of measurement), Heart Rate (HR-Pulse) 87 (beats per minute, Temperature (T) 98.9, RR (Respirations) 18, SpO2 (amount of oxygen in the blood) 99 percent (%-normal range is 96% to 99%). The Communication with Family note indicated Medical Doctor (MD) 1 and MD 1's Nurse Practitioner (NP) were informed that Resident 1 fell . RN supervisor recommended to transfer the resident to general acute care hospital (GACH) for further evaluation. The NP approved and ordered a transfer Resident 1 to GACH for further evaluation via ambulance. LVN 1 and CNA 1 were not assigned to care for the resident in the future.</p> <p>A review of CNA 1's statement dated 11/4/2024 indicated while changing Resident 1, CNA 1 turned Resident 1 on the side and before turning back Resident 1, Resident 1 rolled over the other side and fell . The bed was above knee level and slightly below the waist. Licensed Vocational Nurse (LVN) 1 was immediately made aware of the resident's fall.</p> <p>A review of Resident 1's Nursing Progress Note dated 11/4/2024 timed 11:12 a.m. indicated Resident 1 was transferred to the GACH for evaluation post (after) the fall.</p> <p>A review of Resident 1's GACH Neurocritical Care Note dated 11/4/2024 indicated Resident 1 had a computed tomography (cat- is a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) scan of the head that indicated a 1cm thick acute right parieto-occipital SDH. Resident 1 was admitted to neuro ICU for blood pressure monitor and repeat cat scan to monitor the size of the SDH.</p> <p>A review of Resident 1's Interdisciplinary Team (IDT - a group of professional and direct care staff that have primary responsibility for the development of a Service Plan for an individual receiving services) dated 11/5/2024 indicated that CNA reported to RN supervisor and charge nurse of a witnessed fall involving Resident 1 from bed during care. Per CNA the resident fell to the floor from bed as she (CNA) was adjusting the pad and the sheets under the resident .</p> <p>A review of Resident 1's Nursing-Admission/Readmission Evaluation/assessment dated [DATE] at 7:43 p.m., indicated the following: Resident 1 was in coma/vegetative state; confused; had short-term and long-term memory loss; was on oxygen; had a tracheostomy; and was on a ventilator/respirator. Resident 1 had left side craniotomy stitches/scar.</p> <p>During an interview on 12/16/2024 at 1:58 p.m. LVN 1 stated that on 11/4/2024 CNA 1 informed LVN 1 that Resident 1 fell on the floor during morning care. LVN 1 stated upon entering the room Resident 1 was observed lying on the floor, next to the bed in supine position (on the back) looking up at the ceiling. LVN 1 stated, I am not sure what fall precautions were in place prior to the fall but I did not see any fall mats on the floor underneath Resident 1. LVN 1 stated that it took four staff members to pick up and place Resident 1 back into the bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/16/2024 at 2:24 p.m. the Director of Nursing (DON) stated Resident 1 was identified as high risk for fall upon admission. DON stated, On 11/4/2024, I was here that morning but when I went to the room Resident 1 was already back in the bed. I don't recall seeing the fall mats on the floor. On that floor (where Resident 1 was located) we train everyone to provide two-person assist because all the residents are totally dependent and CNA 1 did not ask for help and that is why Resident 1 fell , it is our fault. We fired CNA 1 after the incident.</p> <p>A review of the facility policy and procedures titled, Falls and Fall Risk Managing revised 1/2024 indicated:</p> <ol style="list-style-type: none"> <li>1. The licensed staff will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once).</li> <li>2. Examples of initial approaches might include exercise and balance training or a rearrangement of room furniture. If a medication is suspected as a possible cause of a resident's falling, the initial intervention might be to ta per or stop that medication.</li> <li>3. In conjunction with the Consultant Pharmacist and nursing staff, the Attending Physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period.</li> <li>4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.</li> <li>5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.</li> <li>6. In conjunction with the Attending Physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.</li> </ol>