

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 01/30/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on interview and record review, the facility failed to assure that residents receive care and services for the provision of hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) consisted with professional standard of practice by failing to ensure ongoing assessment of the resident's condition and monitoring for complications after hemodialysis treatment was received for two of four sampled residents (Resident 1, Resident 2).</p> <p>This deficient practice had the potential to negatively impact the delivery of care and services provided to Resident 1 and Resident 2.</p> <p>Findings:</p> <p>i. During record review, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including ESRD (End Stage Renal Disease-irreversible kidney failure), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During record review, the Minimum Data Set (MDS - resident assessment tool) dated 1/3/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was totally 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).</p> <p>During record review, Resident 1's order summary report (OSR), dated 10/29/2024, indicated dialysis scheduled time every Tuesday, Thursday and Saturday for Resident 1.</p> <p>During record review, Resident 1's Care Plan (CP) for hemodialysis initiated on 4/6/2024 and revised on 11/1/2024, indicated a goal that (Resident 1) will have immediate intervention should any signs and symptoms (s/sx) of complications from dialysis occur. The CP indicated interventions included to monitor/document/report as needed (PRN) for s/sx of renal insufficiency (a condition where the kidneys are not functioning properly).</p> <p>During record review, Resident 1's Post (after) Dialysis Evaluation Form (PODE), dated 1/25/2025 and 1/28/2025, indicated the PODE form was blank and no information and no documentation if Resident 1 was assessed and monitored post dialysis.</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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NAME OF PROVIDER OR SUPPLIER Beachwood Post-Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15th Street 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)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ii. During record review, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including ESRD, respiratory failure and DM.</p> <p>During record review, the MDS dated [DATE], indicated Resident 2's cognitive skills for daily decisions was severely impaired. The MDS indicated Resident 2 required total dependent from staff for ADLs.</p> <p>During record review, Resident 2's OSR, dated 1/29/2025, indicated dialysis scheduled time every Tuesday, Thursday and Saturday for Resident 2.</p> <p>During record review, Resident 2s' CP for risk for complications with renal/urinary system related to dependence on renal dialysis, revised on 10/12/2024 indicated a goal that (Resident 2) will be free of from further complications of renal/urinary system disease. The CP interventions included to observe for signs and symptoms of urinary retention and notify physician as needed.</p> <p>During record review, Resident 2's Dialysis Assessment (DA - communication form that staff from dialysis noted while on dialysis) form, dated 1/7/2025, indicated, cloudy urine on 1/14/2025. The DA form indicated, please clean patient (Resident 2) before sending (to dialysis).</p> <p>During record review, Resident 2's Progress Notes on 1/7/2025 and 1/14/2025, there was no documentation noted regarding follow-up interventions from dialysis nurse's notification and communication to the facility regarding Resident 2's cloudy urine and to clean resident before sending to the dialysis.</p> <p>During an interview with Registered Nurse (RN) 1 on 1/30/2025 at 12:27 p.m., RN 1 stated, after dialysis, residents must be assessed and monitor for any signs of complication after dialysis such as bleeding. RN 1 reviewed Resident 1 and Resident 2's PDE form and confirmed, there were no PDE completed for Resident 1 and no information if any follow-up was done when the staff from the dialysis facility communicated that Resident 2 had a cloudy urine.</p> <p>During an interview with Director of Nursing (DON) on 1/30/2025 at 1:59 p.m., DON stated, post dialysis form should be completed as that is their documentation that the assessment and monitoring was done after dialysis. DON further stated any communication from the dialysis clinic must be followed-up and documented if there was any intervention done</p> <p>regarding resident's dialysis.</p> <p>During record review, the facility's policy and procedures (P&P) titled, Dialysis Services, revised 1/2024, the P&P indicated, It is the policy of the facility that each resident receives care and services for the provision or hemodialysis consistent with professional standards of practice including the: ongoing assessment or the resident s condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility . ongoing communication and collaboration with the physician and dialysis facility regarding dialysis care and services.</p>		