STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056334	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachwood Post-Acute & Rehab	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)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record reviews, facility failed to ensure one of four sampled residents, (Resident 2) was notified and informed by failing to: 1. Provide monthly statements for costs and charges of the services that facility provided for Resident 2. 2. Provide information how to dispute and/or appeal Resident 2 ' s share of cost as indicated in the facility ' s policy and procedure (P&P) titled, Medi-Cal Share of Cost. These deficient practices violated resident ' s right to be informed of the services that the facility charged and resident ' s wish to appeal. Findings. During a record review of the Admission Record indicated Resident 2, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), paraplegia (an injury that occurs lower down the spinal cord may only affect a person's lower body and legs) and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a record review of the Minimum Data Set (MDS - resident assessment tool) dated 1/15/2025, indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 2 required 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). During a record review of Resident 2 ' s Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN - notice used by skilled nursing facilities [SNFs] to inform Medicare beneficiaries of potential financial liability for services that Medicare may not cover, allowing the patient to make an informed decision about receiving care), dated 6/22/2024, indicated, Resident 2 ' s skilled nursing services has been exhausted, beginning 6/23/2024 which Resident 2 ' s opted to choose, Option 3: I don ' t want the care listed above. I understand that I ' m not responsible for paying. (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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 2 ' s Statement, dated 1/7/2025 indicated, Resident 2 ' s total balance was $62,139.00 with a monthly share of cost of $2.959.00, starting 5/1/2023. During a record review of Resident 2 ' s General Notes Report from Business Office Department (BOD), indicated on: i. On 5/24/2023, Resident (2) does not have a secondary insurance . called Resident 2 ' s family member 1 (FM 1) for any discharge plan, no answer, left message. ii. On 5/25/2023, FM 1 is applying for medical and medical application was submitted on 5/25/2023. iii. On 7/17/2023, FM 1 wants facility to bill another insurance. Resident 1 ' s medical was approved with $2959.00 share of cost. During an interview with Resident 2 on 2/25/2025 at 11:49 a.m., Resident 2 stated, she was given a statement that she owed the facility about $20,000, she was confused so she called her insurance to verify. Resident 2 stated, her insurance notified her that they are not being billed so she let the facility know and asked for statement with a detailed billing receipt. Resident 2 stated, then she was given another statement, and it increased to about $40,000, she then notified facility to call her insurance because she was told that they were billing the insurance incorrectly. Resident 2 then stated, until just recently, she was given another statement that indicated her balance increased to $68,000 and she was very confused. Resident 2 then asked the facility to give her some time to investigate because it doesn ' t seem right. Resident 2 stated, she was not being billed and given statement every month and the last time the staff talked to her, they gave her a notice from a lawyer that if she does not pay the balance, she must leave the facility. During an interview with Business Office Assistant (BOA) 1 on 2/25/2025 at 12:28 p.m., BOA 1 stated, Resident 2 has a remaining balance of $21,000 as th resident gave a check of $42,000 on 2/3/2025. BOA 1 stated, they (facility) stopped giving monthly statement to Resident 2 because of non-payment. BOA1 stated, there is no information that Resident 2 was given information on how to appeal the denial of payment from secondary insurance or information how to pay her share of cost. During an interview with Social Services Assistant (SSA) 1 on 2/25/2025 at 1:49 p.m., SSA 1 stated, Resident 2 ' s share of cost with Medi-Cal started in May 2023. SSA 1 was asked for any documentation if Resident 2 was provided a notice in advance when Medicare will no longer pay for SNF ' s services, and the cost of the share of cost, SSA 1 was unable to provide supporting documentations. During a record review of facility ' s P&P titled, Medi-Cal Share of Cost, undated, the P&P indicated, Individuals may be able to dispute the share of cost (SOC) applied b y Medi-Cal to lower or possibly eliminate the SOC. Individuals who appeal the SOC to Medi-Cal do not have to pay the SOC until a decision on the appeal has been determined. During a record review of facility ' s P&P titled, Resident Rights, revised on 1/2024, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: Be informed about what rights and responsibilities he or she has . Residents are entitled to exercise their rights and privileges to the fullest extent possible.

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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 interview and record review, the facility failed to: 1. Ensure one of three sampled residents, (Resident 1) was thoroughly assessed and monitored after Resident 1 was found lying on the floor beside the bed and had an alleged fall which resulted in increased pain and bump on the occipital area (refers to the back of the head, specifically the area covered by the occipital bone). 2. Ensure Resident 1 was monitored and staff immediately documented the interventions to prevent falls after Resident 1 was found lying on the floor such as necessary laboratory test and/or radiology test to ensure resident was stable without any delayed complications. These deficient practices had a potential for Resident 1 ' s fall not properly assessed and investigated and placing resident at risk for further falls or accidents. Findings: During a review of the Admission Record indicated Resident 1, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis following non-traumatic intracranial hemorrhage (bleeding within the skull, or brain, cavity) affecting left non-dominant side, respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 2/10/2025, indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required 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). During a review of Resident 1 ' s Order Summary Report (OSR), dated 1/14/2025 indicated, Eliquis (an anticoagulant [blood thinner] medication used to treat and prevent blood clots and to prevent stroke) oral tablet 5 milligram (mg - unit of measurement) - give 1 tablet by mouth two times a day for afib. During a review of Resident 1 ' s fall risk assessment, dated 1/14/2025, indicated resident was at moderate risk for fall. No other re-assessment was done during the fall incident dated 2/3/2022. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), effective date 2/8/2025 and signed on 2/9/2025, the SBAR indicated, Patient (Resident 1) was found lying on the floor. The skin status evaluation, pain status evaluation and neurological status evaluation on the SBAR form indicated, not clinically applicable to the change in condition being reported. The pain assessment questionnaire on the SBAR form was blank with no assessment completed if Resident 1 was assessed if she had any pain after she was found lying on the floor. For anticoagulant assessment on the SBAR form indicated, No (Resident 1 is not on any anticoagulant medication). During an interview with Registered Nurse (RN) 1 on 2/25/2025 at 1:31 p.m., RN 1 stated, she worked the night shift (11 p.m. - 7 a.m.) on 2/8/2025 and they received a call from Resident 1 ' s Family Member 1 (FM) 1 at about 11:30 p.m., where FM 1 asked about Resident 1 ' s status after she was found on the floor. RN 1 was confused because she was not made aware that Resident 1 fell during the evening shift. RN 1 then asked Registered Nurse 2 (RN 2) who worked during the evening shift (3 pm - 11:30 p.m.) and RN 2 verified, Resident 1 was found on the floor. RN 1 stated, she did not receive any report from RN 2, so she went ahead and assessed Resident 1. During assessment of Resident 1, Resident 1 reported she had pain on her left leg. Resident 1 was also observed with a redness and a bump on her occipital area and redness on her left leg. RN 1 stated, she then called the physician (MD) to notify of the bump on the head and MD ordered Resident 1 to be transferred to General Acute Care Hospital (GACH) 1 for a computed tomography scan (CT scan, also known as a CAT scan - uses X-rays and computer technology to create detailed images of the inside of the body, showing bones, muscles, organs, and blood vessels, and is more detailed than standard X-rays). RN 1 stated, it is also very important to do further test on residents when they have an injury after a fall if they are on anticoagulant medication because they are more prone to internal bleeding. During an interview with RN 2 on 2/25/2025 at 1:45 p.m., RN 2 stated, Resident 1 was found lying on the floor on 2/8/2025 at around 7 p.m., RN 2 stated, she assessed Resident 1 after she was found on the floor, and she did not complain of any pain, RN 2 stated, she did not complete the SBAR form and she was not aware that Resident 2 was on any anticoagulant medication. RN 2 stated, she was very busy that day. RN 2 stated, if a resident is on any anticoagulant medication and was found on the floor, they need to call MD and need to do further test to rule out any injury and internal bleeding. During an interview with Quality Assurance Nurse (QAN) on 2/25/2025 at 3:15 p.m., QAN stated, if resident is found on the floor, they need to do x-ray test or any test to rule out any fracture and injury. QAN stated, they should have document any interventions completed after resident was found on the floor. During a review of facility ' s policy and procedures (P&P) titled Falls - Clinical Protocol, revised on 1/2024, the P&P indicated, The staff, with the physician ' s guidance, will follow up on any fall with associated injury until the resident is stable and delated complications such as late fracture (a break in a bone that can be partial or complete) or subdural hematoma (a pool of blood between the brain and its outermost covering) have been rules our or resolved. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding (bleeding within the skull, affecting the brain) could occur up to several weeks after a fall.

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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 infection (UTI- an infection in the bladder/urinary tract) for one of three sampled residents (Resident 2) by failing to change and monitor Resident 2 ' s incontinent brief promptly when soiled. This deficient practice had the potential to result or resulted in urinary tract infections for the resident. Findings: During a review of the Admission Record indicated Resident 2, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), paraplegia (an injury that occurs lower down the spinal cord may only affect a person's lower body and legs) and UTI. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 1/15/2025, indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 2 required 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). The MDS also indicated, Resident 2 was always incontinent with bowel and bladder. During a review of Resident 2 ' s Care Plan initiated on 8/4/2023 and revised on 1/15/2025 indicated, (Resident 2) is incontinent of bowel and bladder with a goal of, (Resident 2) will be clean, dry and odor free and interventions including to monitor for signs and symptoms (s/sx) of infection. During an interview with Resident 2 on 2/25/2025 at 11:49 a.m., Resident 2 stated, often, her incontinent brief was not being changed frequently, and today, the last time she was changed was at 5:30 a.m. Resident 2 stated, she is unable to feel and tell if she had a bowel movement. During an observation of Resident 2 on 2/25/2025 at 11:57 a.m., Resident 2 ' s incontinent brief was being changed by Certified Nursing Assistant (CNA 1). Resident 2 was observed with a soiled incontinent brief and Resident 2 had a bowel movement that was sticking to the resident's rectum. During an interview with Certified Nursing Assistant (CNA) 1 on 2/25/2025 at 12:22 p.m., CNA 1 stated, she had not changed Resident 2 ' s incontinent briefs today but she should have checked and asked her to be changed after breakfast. CNA 1 stated, she has many residents assigned to her and she was unable to change Resident 2 ' s incontinent brief on time. CNA 1 further stated, this may cause Resident 2 to have 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 Quality Assurance Nurse (QAN) on 2/25/2025 at 3:29 p.m., QAN stated, residents who are incontinent must be changed at least twice per shift, once after breakfast and again after lunch and as needed. QAN stated, if residents ' incontinent briefs are not changed and checked frequently, this puts residents at risk of acquiring infection like UTI. During a review of the facility ' s policy and procedures (P&P) titled, Urinary Incontinence - Clinical Protocol, revised January 2024, the P&P indicated, As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual ' s continence status.