

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 04/01/2025
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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</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 complete a notice of bed-hold policy and return form when the resident was transferred to General Acute Care Hospital 1 (GACH 1) for one of two sampled residents (Resident 1).</p> <p>This deficient practice had a potential to result in the resident's responsible party being unaware of the bed hold policy and can lead to a transfer of the resident to another skilled nursing facility not of the resident's or responsible party's preference.</p> <p>Findings:</p> <p>During a review of the Resident 1 ' s Admission Record, it indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), ESRD (End Stage Renal Disease-irreversible kidney failure) and heart failure (a condition in which the heart does not pump blood as well as it should). The Admission Record indicated, Resident 1 was discharged on [DATE].</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 2/20/2025, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximal assistance to 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).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 2/21/2025, the H&P indicated, Resident 1 has the capacity to understand and make decisions.</p> <p>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), dated 2/27/2025, the SBAR indicated the physician ' s recommendation to send Resident 1 to GACH 1 due to nausea and vomiting of coffee ground emesis (the forceful ejection of some or all of the contents of the stomach through the mouth).</p> <p>During a review of Resident 1 ' s Physician Order Summary and electronic and paper medical chart as of 4/1/2025, it indicated that there was no order for Bed-hold and no Bed-hold notice completed after Resident 1 was hospitalized on [DATE].</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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Assistant Director of Nursing (ADON) on 4/1/2025 at 2:11 p.m., ADON stated, there was no physician order for Resident 1 ' s bed hold and there was no Bed hold notice completed after Resident 1 ' s hospitalization . ADON stated, he was unsure of the facility ' s policy and procedure (P&P) on bed hold but there should be a notification of Bed-hold and documentation if bed-hold was offered to Resident 1 and/or Resident 1 ' s responsible party.</p> <p>During an interview with Administrator (ADM) on 4/1/2025 at 3:29 p.m., Resident 1 did not have a Medi-cal (California's Medicaid program) insurance, and they don ' t put residents on bed hold if they don ' t have Medi-cal insurance. ADM stated, bed-hold notice, and bed hold information was not offered to Resident 1.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Bed Hold (Medi-Cal), revised on 1/2025, the P&P indicated, If the patient must be transferred to an acute hospital for seven days or less, our team will notify the patient or their representative that we are willing to hold the patient's bed. The patient or their representative have 24 hours after receiving this notice to let us know whether they want us to hold the bed for the patient . The benefit of the bed hold is that during the bed hold period, it provides the patient with an opportunity to return to their bed in the same facility after their hospital stay . Individuals who do not have Medi-Cal have the option to pay to hold the bed until the patient can return.</p> <p>Based on interview and record review, the facility failed to complete a notice of bed-hold policy and return form when the resident was transferred to General Acute Care Hospital 1 (GACH 1) for one of two sampled residents (Resident 1).</p> <p>This deficient practice had a potential to result in the resident's responsible party being unaware of the bed hold policy and can lead to a transfer of the resident to another skilled nursing facility not of the resident's or responsible party's preference.</p> <p>Findings:</p> <p>During a review of the Resident 1's Admission Record, it indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), ESRD (End Stage Renal Disease-irreversible kidney failure) and heart failure (a condition in which the heart does not pump blood as well as it should). The Admission Record indicated, Resident 1 was discharged on [DATE].</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 2/20/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximal assistance to 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).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 2/21/2025, the H&P indicated, Resident 1 has the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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), dated 2/27/2025, the SBAR indicated the physician's recommendation to send Resident 1 to GACH 1 due to nausea and vomiting of coffee ground emesis (the forceful ejection of some or all of the contents of the stomach through the mouth).</p> <p>During a review of Resident 1's Physician Order Summary and electronic and paper medical chart as of 4/1/2025, it indicated that there was no order for Bed-hold and no Bed-hold notice completed after Resident 1 was hospitalized on [DATE].</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 4/1/2025 at 2:11 p.m., ADON stated, there was no physician order for Resident 1's bed hold and there was no Bed hold notice completed after Resident 1's hospitalization . ADON stated, he was unsure of the facility's policy and procedure (P&P) on bed hold but there should be a notification of Bed-hold and documentation if bed-hold was offered to Resident 1 and/or Resident 1's responsible party.</p> <p>During an interview with Administrator (ADM) on 4/1/2025 at 3:29 p.m., Resident 1 did not have a Medi-cal (California's Medicaid program) insurance, and they don't put residents on bed hold if they don't have Medi-cal insurance. ADM stated, bed-hold notice, and bed hold information was not offered to Resident 1.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Bed Hold (Medi-Cal) , revised on 1/2025, the P&P indicated, If the patient must be transferred to an acute hospital for seven days or less, our team will notify the patient or their representative that we are willing to hold the patient's bed. The patient or their representative have 24 hours after receiving this notice to let us know whether they want us to hold the bed for the patient . The benefit of the bed hold is that during the bed hold period, it provides the patient with an opportunity to return to their bed in the same facility after their hospital stay . Individuals who do not have Medi-Cal have the option to pay to hold the bed until the patient can return.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 ensure Resident 1 received quality of care and treatment in accordance with facility ' s policy and procedure titled, Acute Changes, to monitor Resident 1 after she had a change of condition (COC) on 2/23/2025.</p> <p>This deficiency had the potential to result in poor quality of care and delayed response to resident needs after a COC.</p> <p>Findings:</p> <p>During a review of the Resident 1 ' s Admission Record, it indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), ESRD (End Stage Renal Disease-irreversible kidney failure) and heart failure (a condition in which the heart does not pump blood as well as it should).</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 2/20/2025, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximal assistance to 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).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 2/21/2025, the H&P indicated, Resident 1 has the capacity to understand and make decisions.</p> <p>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), dated 2/23/2025 at 8:50 p.m., the SBAR indicated, Resident 1 complained of nausea and vomiting, Resident 1 vomited times (x) 3 during this shift . Resident 1 stated, she ' s still feeling nauseous.</p> <p>During a review of Resident 1 ' s Progress Notes on 2/24/2025 during morning (a.m.: 7:00 a.m. - 3:30 p.m.) shift and 2/25/2025, a.m. shift, there was no monitoring documented on Resident 1 ' s status after a COC.</p> <p>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), dated 2/27/2025, the SBAR indicated the physician ' s recommendation to send Resident 1 to GACH 1 due to nausea and vomiting of coffee ground emesis (the forceful ejection of some or all of the contents of the stomach through the mouth).</p> <p>During an interview with Licensed Vocational Nurse (LVN 1) on 4/1/2025 at 11:00 a.m., LVN 1 stated, Resident 1 had a COC for nausea and vomiting. LVN 1 stated, she was assigned to Resident 1 during a.m. shift after Resident 1 had a COC but she does not remember Resident 1 ' s status and if she documented the monitoring assessment after Resident 1 had a COC.</p> <p>(continued on next page)</p>		

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