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	05/01/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to: 1. Ensure LVN 3 notified a physician and handed over to a licensed nurse that Resident 1 did not pass urine and urine was not collected for urinalysis (UA- is a medical test that analyzes a urine sample. It involves examining the appearance, chemical composition, and microscopic components of the urine to detect potential health issue) on [DATE] from 7 a.m. to 3 p.m. 2. Ensure Resident 1's vital signs (VS- Temperature [Temp], blood pressure [BP], pulse rate [PR-heart rate], respirations [RR], and oxygen saturation [O2sat- a measurement of how much oxygen the blood is carrying as a percentage] were monitored and recorded every four hours according to a physician's order dated [DATE] when Resident 1 experienced a change in condition (COC- a deterioration in health, mental, or psychosocial status in either life-threatening circumstances or clinical complications). 3. Ensure Registered Nurse (RN) and or the Assistant Director of Nursing (ADON) assessed Resident 1 when Resident 1 developed difficulty in breathing twice on [DATE] between 8 p.m. and 8.30 p.m. and again on [DATE] at 9 p.m. 4. LVN 2 immediately called 911 (a phone number used to contact the emergency services) and transfer Resident 1 to a GACH when Resident 1 developed difficulty in breathing on [DATE] between 8 p.m. and 8.30 p.m. and again on [DATE] at 9 p.m. These deficient practices resulted in Resident 1 was found 1 not breathing well On [DATE] at 10.08 p.m., the paramedics (persons trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) arrived at Resident 1's bedside and attempted to resuscitate (to revive a person from a state of apparent death or unconsciousness, often due to a cardiac or respiratory arrest) Resident 1. The paramedics pronounced Resident 1 dead in the facility on [DATE] at 10. 35 p.m. Cross Reference F760 Findings: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Actual harm Residents Affected - Few	During a record review, Resident 1's admission record indicated the facility originally admitted Resident 1 on [DATE] and most recently on [DATE] with diagnoses including, acute respiratory failure with hypoxia (condition where the lungs are unable to deliver enough oxygen to the blood), severe sepsis with septic shock (a life-threatening blood infection), pneumonia (an infection/inflammation in the lungs) due to methicillin resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics), urinary tract infection (UTI- an infection in the bladder/urinary tract), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysarthria and anarthria (difficulty and lost ability to speak), and pleural effusion (an abnormal buildup of fluid in the space between the thin layers of the lungs and the wall of the chest cavity). During a record review, Resident 1's Admission/Re-admission Summary Note dated [DATE] at 5:12 p.m., indicated Resident 1 was a Full Code (refers to a patient's status indicating they want all possible measures taken to resuscitate them if they stop breathing or their heart stops beating). During a record review, Resident 1's Care Plan (CP) on Respiratory . At Risk for Complications . initiated [DATE], indicated the CP goal included Resident 1 will have unlabored respirations . Will not exhibit respiratory distress such as wheezing . and report abnormal findings to physician promptly. The CP interventions indicated that Resident 1 will be assessed for hypoxia (a deficiency of oxygen reaching the tissues of the body), altered level of consciousness, irritability, restlessness, and cyanosis (a bluish or purplish discoloration of the skin and mucous membranes, primarily due to a decrease in oxygen saturation in the blood). The CP interventions also included to monitor Resident 1 for shortness of breath, irregular respirations, . decreased energy, rapid breathing, . and inform physician promptly. During a record review, the facility In-service Lesson Plan on Change of Condition dated [DATE], indicated the topic of In-service for nursing included: 1. Assessment of patient (resident). 2. Obtaining vital signs, reporting vital signs and change of condition (COC) to medical doctor (MD). 3. Worsening/deterioration of residents condition; following emergency procedures. 4. Transferring of residents via paramedics. During a record review, the facility In-service Staff Attendance on Change of Condition dated [DATE], indicated Topic . Charge nurse will continue to monitor resident. If condition deteriorates and resident has no restrictions to transfer out, charge nurse/nurse sup (supervisor) will transfer patient (pt-resident) via paramedics, after transfer, charge nurse will notify MD and family/responsible party.' (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	During a record review, Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated [DATE] indicated Resident1's cognition (mental ability to make decisions for daily living) was not intact. The MDS indicated Resident 1 was dependent (helper does all the effort) for dressing, bathing, and toileting) The MDS indicated Resident 1 transfers (moving between surfaces) from bed to chair were not attempted due to medical condition or safety concerns. The MDS indicated Resident 1 was not on oxygen. During a record review, Resident 1's Nurse's Note dated [DATE] at 11:15 a.m., indicated that on [DATE] at around 9:30 a.m., the charge nurse (unidentified) noted Resident 1's BP ,d+[DATE] millimeters of mercury (mmHg- unit of measurement), PR (pulse rate-71 per minute), RR 20, O2 sat 95% on room air (RA- Normal O2 sat range is between 90%-100%), and elevated temp of 100.2 degrees F with yellow emesis (vomit). Resident 1 was provided with cold packs and administered PRN (as necessary) Acetaminophen to reduce the fever. The Nurse's Note indicated MD was notified of Resident 1's condition who ordered to transfer Resident 1 to non-emergent to GACH 1 related to (r/t) elevated temp and emesis, notified Resident 1's responsible party (RP) and family (unspecified). The Nurse's Note indicated that family (unspecified) requested to transfer Resident 1 to GACH 2 and that family was notified of MD's order to transfer Resident 1 to GACH 1. The Nurse's Note indicated family (unspecified) requested not to transfer Resident 1 to GACH and keep the resident in the facility. The Nurse's Note indicated MD ordered the following for Resident 1: -VS every (Q) 4 hours (Hrs) for 72 Hrs -Stat (now) CBC and CMP -Start Augmentin 875 mg PO BID x 10 days - UA with culture. During a record review, Resident 1's History and Physical (H&P- the attending physician assessment and plan of care) dated [DATE], indicated nursing concerns about Resident 1 having increased shortness of breath today and a mild fever of 100.2 F. The H&P plan indicated to continue Augmentin every 12 hours (started today), monitor vital signs closely, obtain CBC (complete blood count-measures the numbers and types of cells in the blood), CMP (comprehensive metabolic panel-14 blood tests that provide information about the functions of the liver, kidneys, blood sugar levels, electrolyte [mineral] and fluid balance), UA with culture (a laboratory procedure used to identify microorganisms/bacteria etc) and assess the need for respiratory support. During a record review, Resident 1's Physician Order dated [DATE] at 11.14 a.m., indicated Resident 1 to receive Amoxicillin-Pot Clavulanate (Augmentin) tablet ,d+[DATE] mg, give 1 tablet by mouth every 12 hours for possible UTI for 10 days. During a record review, Resident 1's Physician Order dated [DATE] at 11.14 a.m., indicated to check vital signs every 4 hours x 72 hours for 3 days. During a record review, Resident 1's Weight and Vital Summary record effective [DATE] - [DATE], indicated the following: O2 sats Summary. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 9.34 a.m. - 95% (Room Air) [DATE] at 1.32 p.m. - 97% (Room Air) Pulse Summary. [DATE] at 9.34 a.m. - 71 beats per minute (bpm) (Regular) [DATE] at 1.32 p.m. - 100 beats bpm (Regular). Respiration Summary. [DATE] at 9.34 a.m. - 20 breaths per minute (/min) [DATE] at 1.32 p.m. - 19 bpm Temperature Summary. [DATE] at 9.34 a.m. - 97.8 degrees F (Forehead non-contact). [DATE] at 9.49 a.m. - 100.2 degrees F (Forehead noon-contact). [DATE] at 1.32 p.m. - 98.6 degrees f (Forehead non-contact). The same Weight and Vital Summary record indicated no vital signs were entered/recorded after 1.32 p.m. on [DATE]. During a record review, Resident 1's Change in Condition Evaluation form dated [DATE] timed 11:21 a.m. indicated Resident 1 was noted with a fever of 100.2 F (checked on the forehead) and had color yellow emesis. The COC indicated a medical doctor (MD) was notified who ordered to monitor vital signs every 4 hours, stat (now) CBC and CMP, UA with culture and to start Augmentin twice a day. The COC Evaluation form indicated the order was carried out and the family/RP notified. The COC Evaluation form indicated that on [DATE] at 9:34 a.m., Resident 1's BP was ,d+[DATE] mm/Hg, PR 71 beats per minute, RR 20 per minute, and O2 sat was 95% on RA. During a record review, the facility undated document titled Inventory Item (E-KIT), indicated Amoxicillin 500 mg-potassium clavulanate 125 mg tablet (Amox TR-K ,d+[DATE] mg TA) is amongst medications included in the E-Kit. During a record review, the facility pharmacy document E-Rx New Prescription for Resident 1, indicated Amoxicillin-Pot Clavulanate tablet ,d+[DATE] mg was received by the pharmacy on [DATE] at 1:47 p.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a record review, Resident 1's Medication Administration Record (MAR) for the month of ,d+[DATE], indicated effective [DATE] at 6:50 p.m., Acetaminophen (Tylenol- medication for pain and raised temperature) tablet 325 mg, give 2 tablets . every 6 hours as needed for elevated temperature (degree of temperature not indicated) and pain, and do not exceed 4 grams (G-unit of measurement) in 24 hours (hrs). The same MAR did not indicate Resident 1 was administered Acetaminophen on [DATE]. During a record review, Resident 1's Change in Condition Evaluation form dated [DATE] timed 10:50 p.m. LVN 2 documented that while making rounds, certified nursing assistant (CNA) asked LVN 2 to check on Resident 1. LVN 2 documented that Resident 1's O2 sat was low at 78% at room air (RA-without extra oxygen) and Resident 1 was placed on oxygen and saturation improved (the amount of oxygen administered, and saturation not indicated). LVN 2 documented that while monitoring Resident 1, the resident desaturated gain (level not indicated) and that the paramedics were called. LVN 2 documented that the paramedics were unsuccessful at resuscitation attempts and that Resident 1 expired (date and time not indicated). During a record review, the Paramedic Run Sheet (a printable EMS (Emergency Medical Service) run report is a document that contains important information about a medical response or transport provided by EMS personnel) dated [DATE], indicated the paramedics arrived on [DATE] at 10:08 p.m. and found Resident 1 in supine (on the back) position . with a chief complaint of cardiac arrest for unknown amount of time. Staff called for a low O2 sat. Upon assessment, [Resident 1] was found to be in cardiac arrest (no heartbeat). Resuscitation was immediately started. Initial rhythm (heart rate pattern) was asystole (no heartbeat). The Paramedic -resident remained in asystole throughout resuscitation efforts. The paramedic run sheet indicated Resident 1 received epinephrine (a stimulant medication administered during cardiac arrest to stimulate the heart and help restore the heartbeat) on [DATE] at I mg at 10:10 p.m., 10:15 p.m., and 10:20 p. m. The paramedic run sheet indicated the time on scene to pronouncement (dead) was 27 minutes. During a record review, Resident 1's Late Entry Communication note dated [DATE] at 1:30 p.m., indicated the facility conducted a conference call Resident 1's family member (FM), MD, and the ADON. The communication note indicated that on [DATE] at around 11 p.m., the nurses were completing their rounds and noted that Resident 1 with a decrease in oxygen saturation. After the RT interventions proved ineffective (duration not specified), 911 was called. 911 arrived and implemented their (911) interventions which eventually led them to call the time of death. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review on [DATE] at 12:26 p.m. with Licensed Vocational Nurse (LVN) 1. Resident 1's COC form dated [DATE] and physician's order for Augmentin dated [DATE] were reviewed. LVN 1 stated that while LVN1 was rounding on [DATE] at 7 a.m., LVN 1 touched Resident 1 and the resident felt warm to touch, checked Resident 1's temperature, and the resident's temperature was elevated at 100.2 Degrees F. LVN 1 stated Resident 1 vomited yellow fluid and informed MD (time not specified nor stated) who gave an order to transfer Resident 1 to GACH 1. LVN 1 stated LVN 1 then notified Resident 1's FM and the FM requested to transfer Resident 1 to GACH 2. LVN 1 stated LVN 1 then informed the MD of the FM request. LVN 1 stated the MD cancelled the transfer to GACH altogether and decided to treat/manage the resident in the facility. LVN 1 stated I remember her (MD) saying something like he (Resident 1) wasn't stable enough but I am not sure for what but I don't remember exactly LVN 1 stated LVN 1 was not sure why the MD cancelled the transfer to GACH and was not comfortable with the decision to not transfer Resident 1 to GACH and treat the resident in the facility. LVN 1 stated LVN 1 checked the facility Ekit for the Augmentin but there was no Augmentin in the Ekit and so LVN 1 ordered the Augmentin from pharmacy. LVN 1 stated that on [DATE] before 3 p.m., LVN 1 rechecked Resident 1's Temp and the Temp came down (LVN 1 unable recall the exact temperature recording). LVN 1 stated, I gave him (Resident 1) Tylenol thru the g tube and placed ice packs. The Augmentin did not arrive during my shift, so I endorsed it to the next shift at 3 p.m. LVN 1 stated LVN 3 tried to get the UA via straight catheter multiple times with no success. During a telephone interview on [DATE] at 12:58 p.m., LVN 3 stated that on [DATE], Resident 1 had an order for UA. LVN 3 stated Resident 1 had a urinary indwelling catheter and there was no urine output it was dry so initially I thought it was plugged so I irrigated it and it was not plugged, then after that I changed the indwelling catheter bag and checked for leaking and there was no leaking. It was dry and still no output. LVN 3 stated that after about 1 (one) and half hours later LVN 3 came back and still had no output in the dwelling catheter bag and informed LVN 1. LVN 3 stated, we need endorse to the next shift. LVN 3 stated, I did not inform the doctor there was no urine output because I thought someone else would report that. There was no urine when I left at 3pm so it was endorsed to the next shift. During a concurrent interview and record review on [DATE] at 2 p.m. with LVN 2, Resident 1's MAR for , d+[DATE] was reviewed. The MAR indicated that on [DATE], Resident 1's MAR indicated number 10 (patient [Resident 1] unavailable) next to the Augmentin dose. LVN 2 stated LVN 2 did not recall what happened to the Augmentin and could not explain why the number 10 was documented on the MAR. LVN 2 stated LVN 2 did not recall administering any medication including Augmentin to Resident 1. LVN 2 stated LVN 2 worked on [DATE] from 3 p.m. to 11 p.m. LVN 2 stated that on [DATE] (time not specified), LVN 2 called RT to come and assist and the RT put Resident 1 on 15 liters of oxygen to increase the resident's 02 sat. LVN 2 stated LVN 2 then called 911 because the resident's O2 sat was not increasing. LVN 2 stated 911 came, stayed with [Resident 1] for about 30 minutes and started CPR. LVN 2 stated, I was not in the room when that happened. LVN 2 stated LVN 2 called 911 because Resident 1 desaturated below 90% and checked the vital sign machine and Resident 1 had a pulse. LVN 2 stated LVN 2 did not recall getting any endorsement for Resident 1 during report about monitoring the resident's vital signs every four hours. LVN 2 stated LVN 2 could not remember what happened with the order to administer Augmentin to Resident 1 and LVN 2 was very quiet on the phone. LVN 2 stated LVN 2 could not remember administering Augmentin to Resident 1 on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:30 p.m., CNA stated that CNA worked on [DATE] on the 3 p.m. to 11p.m. shift and was assigned Resident 1. CNA stated that on [DATE] during CNA's rounds at 3 pm Resident 1 was okay. CNA stated that on [DATE] at around 8 p.m. and 8.30 p.m., Resident 1 was not breathing well so I let the charge nurse (LVN 2) know to come and check on him. CNA stated LVN 2 went to Resident 1's, and I went to take care of my other patients (residents). CNA stated Resident 1 was wearing an oxygen cannula at the time LVN 2 called respiratory therapist (RT - a healthcare professional who specializes in diagnosing, treating, and managing breathing problems and disorders of the cardiopulmonary system) and the supervisor and the resident seemed to get better a few minutes later. CNA stated that on [DATE] at about 9 p.m. something, I passed back by the room to see [Resident 1] and [Resident 1] was not breathing well again, CNA called LVN 2 who then called 911. CNA stated that LVN 2 checked Resident 1's VS but could not remember the VS numbers. CNA stated CNA did not take Resident 1's VS on [DATE]. During an interview on [DATE] at 2 p.m. LVN 2 stated, I did not know [Resident 1] had a change in condition earlier that day ([DATE]) and was on vital sign monitoring every four hours. During an interview on [DATE] at 2:30 p.m. with the certified nursing assistant (CNA). The CNA stated, I worked from 3 p.m. to 11 p.m. on [DATE] and was assigned to [Resident 1]. Sometimes we do the vital signs and sometimes the nurses will do the vital signs. That day ([DATE]), I did not take any vital signs for [Resident 1] and I did not know about him having a fever earlier in the day. During a concurrent interview and record review on [DATE] at 11 a.m. with the Assistant Director of Nursing (ADON), Resident 1's vital sign summary document dated [DATE] was reviewed. Resident 1's vital sign summary indicated vital sign entries at 9:34 a.m. and at 1:32 p.m. and no other vital sign entries were made. The ADON stated Resident 1 was noted with a temperature of 102 degrees F and emesis, MD was notified who ordered to monitor Resident 1's vital sign every 4 hours and to start Resident 1 on Augmentin BID (twice a day). The ADON stated, I would start the Augmentin as soon as it is available. Normally we would have it in the Ekit. Resident 1's COC dated [DATE] at 10:50 p.m. was also reviewed. The ADON stated to assess a resident every four hours means to see if there is any change from the initial COC and continue to monitor and comment on what is observed and measured for four hours. The ADON stated a CNA was rounding and noticed that it looked like Resident 1 was having trouble breathing. The CNA called the charge nurse to assess Resident 1 and the charge nurse called RT to assist. Resident 1's O2 sat was 78%, was placed oxygen (O2) and the O2 sats went up, and then resident started to desaturate (desat- occurs when the amount of oxygen in the blood falls below the normal level) again and called 911 who came and were unsuccessful in resuscitating Resident 1. The ADON stated, It's hard to say if [Resident 1's] vital signs were monitored every four hours because there are no vital signs [documented]. We should see the vital signs documented every four hours after they are ordered. The Augmentin should have been given as [to Resident 1] soon as it was available. ADON stated, I don't see any notes from RT. On [DATE] a 12 p.m., the writer contacted MD and no answer. A voicemail was left for MD to call back the writer. During a record review, the facility Policy and Procedures (P&P) titled, Vital Signs revised ,d+[DATE], indicated, Vital signs shall be monitored according to the following guidelines: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon Admission - All residents shall have baseline vital signs recorded upon admission to the facility. Routine Monitoring- Vital signs shall be taken as ordered by the physician or per the resident's care plan. Change in Condition - Vital signs shall be taken immediately when a resident exhibits signs of distress, deterioration, or any significant change in condition. Post-Procedure/Medication Administration- Vital signs shall be monitored as required after certain medical procedures or medication administration, especially for high-risk drugs (e.g., antihypertensives [medications to treat/control] high blood pressure), opioids [controlled prescription medications used to treat pain]). As Needed (PRN) - Vital signs shall be taken when requested by a physician, resident, or per nursing judgment. During a record review, the facility P&P titled Acute Condition Changes -Clinical Protocols revised , d+[DATE], indicated: Assessment and Recognition: 1. As part of the initial assessment, the licensed nurses will help identify individuals with significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling urinary catheter who has recurrent urinary tract infections . 2. The nurse shall assess and document/report the following . a. Vital signs g. Onset, duration severity . 5. The nursing staff will contact the physician based on the urgency of the situation. Monitoring and Follow-Up: 1. The staff will monitor and document the resident's progress and responses to treatment, and the Physician will adjust treatment accordingly. During a record review, the facility Policy and Procedures (P&P) titled Administering Medications revised , d+[DATE], indicated, Policy Statement: Medication shall be administered in a safe and timely manner and as prescribed. 3. Medication must be administered in accordance with the orders, including any required time frame. During a record review, the facility P&P titled Identifying and Managing Medication Errors and Adverse Consequences revised ,d+[DATE], indicated, Policy Statement: The Staff and practitioner shall try to prevent medication errors . and shall strive to identify and manage them appropriately when they occur.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42342 Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to: 1. Ensure Augmentin (Amoxicillin-Pot Clavulanate - antibiotic - medication to treat infection) tablet 875-125 mg-unit of measurement) was readily available in the Emergency Kit (Ekit - a kit consisting of drugs, including controlled substances, needed to effectively manage a critical care incident or need of a patient). 2. Ensure Resident 1 received Amoxicillin-Pot Clavulanate tablet 875-125 mg 1 tablet by mouth BID (twice a day) for possible urinary tract infection (UTI- an infection in the bladder/urinary tract) for 10 days according to the physician's order dated 4/2/2025 at 11.14 a.m. 3. Ensure a physician was notified that Resident 1 was not administered Amoxicillin-Pot Clavulanate 875-125 mg according to physician's order dated 4/2/2025 at 11.14 a.m. As a result, Resident 1 never received Amoxicillin-Pot Clavulanate tablet 875-125 mg on 4/2/2025 (a total of 11 hours 16 minutes). Cross Reference F684 Findings: During a record review, Resident 1's admission record indicated the facility originally admitted Resident 1 on 8/29/2024 and most recently on 3/21/2025 with diagnoses including, acute respiratory failure with hypoxia (condition where the lungs are unable to deliver enough oxygen to the blood), severe sepsis with septic shock (a life-threatening blood infection), pneumonia (an infection/inflammation in the lungs) due to methicillin resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics), urinary tract infection (UTI), and pleural effusion (an abnormal buildup of fluid in the space between the thin layers of the lungs and the wall of the chest cavity). During a record review, Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/27/2025 indicated Resident1's cognition (mental ability to make decisions for daily living) was not intact. The MDS indicated Resident 1 was dependent (helper does all the effort) for dressing, bathing, and toileting) The MDS indicated Resident 1 transfers (moving between surfaces) from bed to chair were not attempted due to medical condition or safety concerns. The MDS indicated Resident 1 was not on oxygen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 1's Nurse's Note dated 4/2/205 at 11:15 a.m., indicated that on 4/2/2025 at around 9:30 a.m., the charge nurse (unidentified) noted Resident 1's BP 119/54 millimeters of mercury (mmHg- unit of measurement), PR (pulse rate-71 per minute), RR 20, O2 sat 95% on room air (RA- Normal O2 sat range is between 90%-100%), and elevated temp of 100.2 F (Normal range is 97.7F and 99.5F) with yellow emesis (vomit). Resident 1 was provided with cold packs and administered PRN (as necessary) Acetaminophen to reduce the fever. The Nurse's Note indicated MD was notified of Resident 1's condition who ordered to transfer Resident 1 to non-emergent to GACH 1 related to (r/t) elevated temp and emesis, notified Resident 1's responsible party (RP) and family (unspecified).The Nurse's Note indicated MD gave an order to start resident 1 on Augmentin 875 mg PO BID x 10 days. During a record review, Resident 1's History and Physical (H&P- the attending physician assessment and plan of care) dated 4/2/2025, indicated nursing concerns about Resident 1 having an increased shortness of breath today and a mild fever of 100.2 degrees Fahrenheit (F). The H&P plan indicated to continue Augmentin every 12 hours (started today), monitor vital signs closely, obtain CBC (complete blood count-measures the numbers and types of cells in the blood), CMP (comprehensive metabolic panel-14 blood tests that provide information about the functions of the liver, kidneys, blood sugar levels, electrolyte [mineral] and fluid balance), urinalysis (UA-urine test for presence of infection) with culture (a laboratory procedure used to identify microorganisms/bacteria etc) and assess the need for respiratory support. During a record review, Resident 1's Physician Order dated 4/2/2025 at 11.14 a.m., indicated Resident 1 to receive Amoxicillin-Pot Clavulanate (Augmentin) tablet 875-125 mg, give 1 tablet by mouth every 12 hours for possible UTI for 10 days. During a record review, Resident 1's Physician Order dated 4/2/2025 at 1.47 p.m., indicated order clarification, Resident 1 to receive Amoxicillin-Pot Clavulanate (Augmentin) tablet 875-125 mg, give 1 tablet by mouth every 12 hours for possible UTI for 7 days. During a record review, Resident 1's Change in Condition Evaluation form dated 4/2/2025 timed 11:21 a.m. indicated Resident 1 was noted with a fever of 100.2 F (checked on the forehead) and had yellow emesis. The CIC indicated a medical doctor (MD) was notified who ordered to monitor vital signs every 4 hours, stat (now) CBC and CMP, UA with culture and to start Augmentin twice a day. The CIC Evaluation form indicated the order was carried out and family/RP notified. During a record review, the facility undated document titled Inventory Item (E-KIT), indicated Amoxicillin 500 mg-potassium clavulanate 125 mg tablet (Amox TR-K 500-125 mg TA) is amongst medications included in the E-Kit. During a record review, the facility pharmacy document E-Rx New Prescription for Resident 1, indicated Amoxicillin-Pot Clavulanate tablet 875-125 mg was received by the pharmacy on 4/2/2025 at 1:47 p.m. During a record review, the facility packing slip proof of delivery dated 4/2/2025 at 6:43 p.m. indicated LVN 2 received and signed for Augmentin 14 tablets for Resident 1. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 1's MAR for the month of 4/2025, indicated Resident 1 to received Amoxicillin-Pot Clavulanate Tablet 875-125 mg give b1 tablet by mouth every 12 hours for possible UTI for 7 days. However, the same MAR was marked with letter X on 4/2/2025 at 9 a.m. and had 10- 00TK typed in on 4/2/2025 at 9 p.m. The MAR legend indicates that 00-TK are the initials for LVN 2 and that 10 indicates Resident Unavailable. During an interview on 5/1/2025 at 12:26 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that while LVN1 was rounding on 4/2/2025 at 7 a.m., LVN 1 touched Resident 1 and the resident felt warm to touch, checked Resident 1's temperature, and the resident's temperature was elevated at 100.2 F. LVN 1 stated Resident 1 vomited yellow fluid. LVN 1 stated LVN 1 checked the facility Ekit for Augmentin but there was no Augmentin in the Ekit and therefore LVN 1 ordered the Augmentin from a pharmacy on 4/2/2025 at 11.14 am. LVN 1 stated, the Augmentin did not arrive during my shift, so I endorsed it to the next shift at 3 p. m. During a concurrent interview and record review on 5/1/2025 at 2 p.m. with LVN 2, Resident 1's MAR for 4/2025 was reviewed regarding Augmentin. LVN 2 stated that on 4/2/2025 at 9 p.m., LVN 2 documented 10 which means Resident is unavailable. LVN 2 stated LVN 2 did not recall what happened to the Augmentin for Resident 1 and could not explain why LVN 2 documented 10 on the MAR. LVN 2 stated LVN 2 did not recall administering any medication to Resident 1. During an interview on 5/1/2025 at 2 p.m. LVN 2 stated, I did not know [Resident 1] had a change in condition earlier that day (4/2/2025) and was on vital sign monitoring every four hours. During an interview on 5/1/2025 at 2:30 p.m. with the certified nursing assistant (CNA). The CNA stated, I worked from 3 p.m. to 11 p.m. on 4/2/2025 and was assigned to [Resident 1]. Sometimes we do the vital signs and sometimes the nurses will do the vital signs. That day (4/2/2025), I did not take any vital signs for [Resident 1] and I did not know about him having a fever earlier in the day. During an interview on 5/5/2025 at 11 a.m., the Assistant Director of Nursing (ADON) stated Resident 1 was noted with a temperature of 102F and emesis, the MD was notified who ordered to start Resident 1 on Augmentin BID. The ADON stated, I would start the Augmentin as soon as it is available. Normally we would have it in the Ekit. The ADON stated Augmentin should have been given as [to Resident 1] soon as it was available. During a record review, the facility Policy and Procedures (P&P) titled Administering Medications revised 1/2025, indicated, Policy Statement: Medication shall be administered in a safe and timely manner and as prescribed. 3. Medication must be administered in accordance with the orders, including any required time frame. During a record review, the facility P&P titled Identifying and Managing Medication Errors and Adverse Consequences revised 1/2025, indicated, Policy Statement: The Staff and practitioner shall try to prevent medication errors . and shall strive to identify and manage them appropriately when they occur. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, the facility document titled Core Elements of a SNF (Skilled Nursing Facility) Stewardship Program revised 1/2025, indicated, Antibiotics have transformed the practice off medicine, making once lethal infections readily treatable and making other medical advances . The prompt initiation of antibiotics to treat infections that has been proven to reduce morbidity and save lives .