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	08/18/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate and review a resident specific discharge planning during admissions and quarterly reviews for one of three sample residents (Resident 3). This deficient practice resulted in a lack of individualized discharge planning to ensure Resident 3 receive appropriate and timely planning during a transition of care. Findings: A review of Resident 3's admission record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of acute pulmonary edema (a condition where fluid builds up in the lungs, making it hard to breathe), muscle weakness (a lack of strength in the muscles), anxiety disorder (a person is often worried or anxious about many things and finds it hard to control), type 2 diabetes mellitus without complications (A long-term condition in which the body has trouble controlling blood sugar and using it for energy), bilateral primary osteoarthritis of knee (a degenerative joint disease where cartilages cushioning the bones wears down, leading to pain, stiffness, and limited mobility in both knees). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 3/26/2025 indicated partial/moderate assistance (helper does less than half the effort, lifts, holds, or supports trunk or limb) for toilet transfer, chair/bed-to-chair transfer. No active discharge planning already occurring for the resident to return to the community. During a review of Resident 3's MDS dated [DATE] indicated, set up or clean-up assistance for eating. Supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard to complete activity) to sit and stand, toilet transfer (the ability to get in and out of a toilet or commode). No active discharge planning already occurring for the resident to return to the community.During a review of Resident 3's admissions care plan initiated on 3/20/2025, discharge care plans were not documented. During a review of Resident 3's quarterly care plan revised on 6/23/2025, discharge care plans were not documented. During an interview on 8/16/2025 at 9:25 AM with Resident 3, Resident 3 stated, the facility staff has been discussing discharge planning but did not provide a specific discharge date . Resident 3 stated, Two weeks ago, if no longer they told me I am ready to discharge because I was asking for it.During an interview on 8/16/2025 at 10:07 AM, Licensed Vocational Nurse (LVN) 1 stated, Resident 3 has been wanting to go home, I don't believe she can maintain her activities of daily living (ADL) fully by herself. Resident 3 will need assistance to ambulate to the toilet, bathroom, and for cleaning. During a concurrent interview and record review on 8/18/2025 at 10:40 AM, with LVN 1, Resident 3's care plans during admissions and quarterly review were reviewed. The care plan for discharge planning was not documented. LVN stated, care plan is implemented by MDS coordinator and Social Services (SS) worker. Care plan for discharges can benefit Resident 3 with proper planning and accommodation after discharge. During an interview on 8/18/2025 at 11:01 AM with Social [NAME] assistant (SS), SS stated, discharge planning is initiated by admitting licensed person and social services during resident admissions. Resident 3's discharge care plan was not documented during admissions and quarterly review. SS stated, discharge planning has been discussed with Resident 3 at different occasions, but care plan is not documented. During a concurrent interview and record review on 8/18/2025 at 11:34 AM with MDS coordinator, Resident 3's MDS and care plans during admissions on 3/20/2025 and quarterly review on 6/23/2025 were reviewed. MDS stated, care plans are implemented based on MDS assessments and resident's individual care needs. Discharge care planning should be initiated during admissions regardless of a resident's status. MDS stated, It is a deficiency not to document required care plans because it potentially affects the resident's care delivery. During an interview with the Director of Nursing (DON), on 8/18/2025 at 12:34 PM, the DON stated, I am not sure if Resident 3 was supposed to have a discharge care plan during admission. Discharges are determined by residents' desire, physician's decision and care team evaluations. A review of the facility's Policy and Procedures (P&P) titled, Care Plans -Comprehensive revised January 2025, the P&P indicated, The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. The care planning/Interdisciplinary Team is responsible for the review and updating of care plans: when the resident has been readmitted to the facility from a hospital stay; and at least quarterly.