

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  09/05/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, facility failed to: 1. Ensure one of four sampled residents (Resident 1)'s medications were not left at bedside after administering them according to facility's policy and procedures (P&amp;P) titled, Administering Medications. 2. Ensure that one of four sampled residents (Resident 1 and Resident 2)'s medications were administered in accordance with the physician's orders, including any required time frame according to facility's P&amp;P, titled, Administering Medications This deficient practice increased the risk for accidents, unintended complications from receiving more or less than the required medications dose and jeopardized resident's health and safety by failing to administer necessary medications in accordance with the physician order. Findings: 1. During a review of the admission Record, Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 8/1/2025 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 assistant 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). During a review of Resident 1's Medical Record, the facility did not do a Self-Administration of Medication Observation Assessment on Resident 1 upon readmission on [DATE]. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated the following medications: i. Sevelamer Carbonate (a medication that prevents increases in phosphates among people who are on dialysis due to chronic kidney disease) tablet 800 milligram (mg - unit of measurement) - give three tablets by mouth three times a day ii. Combigan ophthalmic solution (a prescription eye drop medication that helps lower pressure inside the eye) 0.2-0.5 percent (% - unit of measurement) - Instill one drop in both eyes two times a day for glaucoma (a group of eye diseases that damage the optic nerve, which carries visual information from the eye to the brain) During a review of Resident 1's Medication Administration Audit Record (MAAR) on 9/5/2025, the MAAR indicated that the sevelamer carbonate tablets were scheduled to be administered at 9 a.m., but the record indicated, the medications were administered on 10:33 a.m. The MAAR also indicated that on 9/4/2025, the combigan eyedrops were scheduled to be administered at 9 a.m., but the record indicated, the combigan were administered at 3:38 p.m. During a concurrent observation and interview with Resident 1 on 9/5/2025 at 11:29 a.m., observed Resident 1 with a medication cup filled with three white tablets at her bedside table. Resident 1 stated she did not take the medications after they were given to her because she wanted to take them before eating lunch. Resident 1 stated that the nurse gave her the medication, and they don't observe when she takes the medication. Resident 1 further stated, sometimes, her medications were being administered late and they don't follow the physician's order for the time frame the medications were due. During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 9/5/2025 at 11:39 a.m., LVN 1 stated, he administered Resident 1's medications this morning but he left Resident 1's room without observing her taking the medications. LVN 1 stated, he was called and was in a hurry and did not watch Resident 1 taking the medication after giving it to her. LVN 1 stated, he also documented the medications as administered in the electronic medical record. LVN 1 compared the three white tablets with the medications in the bubble pack and stated, the three white tablets on Resident 1's medication cup were sevelamer carbonate. During an interview with the Director of Nursing (DON) on 9/5/2025 at 3:02 p.m., DON stated, medications should not be left at bedside, and nurses must witness residents taking the medications. DON stated, if a resident refuses to take the medication at the time when it was scheduled, nurses need to explain the risk and benefits of not taking the medication timely and document the refusal and notify the physician. DON stated that not giving the medication on time was a delay of patient's care that may interfere with residents' recovery process and plan of care. 2. During a review of the admission Record, Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting left non-dominant side, acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and DM. During</p>		