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	06/28/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45455 Based on observation, interview, and record review, the facility failed to protect residents of one of three residents (Resident 143) to a dignified existence and self- determination by failing to properly dispose a soiled wash towel, cleaning and placing resident's toothbrush clean and secure environment after activities of daily living (ADL) care. This deficient practice had the potential to affect Resident 143's sense of self-worth and self-esteem. Findings: During a facility tour observation of Resident 143's bathroom on 6/25/2024 at 9:05 AM, a wash basin with a soiled washcloth and toothbrush was observed on top of the toilet lid of Resident 143's bathroom. During an interview with Licensed Vocational Nurse 9 (LVN 9) on 6/25/2024 at 9:10 AM, LVN 9 stated the wash basin with soiled wash cloth and toothbrush should not be placed on top of a toilet lid. LVN 9 stated placing the wash basin with soiled wash cloth and toothbrush on the to the toilet lid places increased the risk for contamination with disease causing baceria that could cause infection and demeans (lower) Resident 143's dignity and self-worth. During an interview with the Director of Nursing (DON) on 6/28/2024 at 4:44 PM, the DON stated, leaving a soiled towel and toothbrush inside a resident's wash basin and placing ithe wash basin on top of a toilet seat cover was demeaning to the resident's quality of life dignity, respect, and individuality. A review of facility's policy and procedures, titled, Quality of Life-Dignity dated 10/2023, indicated, Residents shall always be treated with dignity and respect. Treat with Dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Demeaning practices, and standards of care that compromise dignity is prohibited.

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
	056334	A. Building B. Wing	06/28/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843 Based on observation, and interview, the facility failed to ensure a safe, comfortable, sanitary, and clean homelike environment for three of seven residents (Residents 13, 71, and 328) by failing to: 1. Ensure Resident 328's room temperature was maintained between set at 74 or 75 Farenhiet (F- Unit of measurement). This failure resulted in Resident 328's room temperature was 68 degrees F, and the resident complained of feeling very cold and had the potential for the resident to develop hypothermia (a significant and dangerous drop in the body temperature). 2. Multiple dark spots on the floor in Resident 71 room were removed. 3. Soiled wash towel and toothbrush not left on top of a toilet lid in the bathroom for Residents 143 and 278. These dificient practices resulted in an unsanitary and unhomelike environemnt for Residents 71, 143 and 278. Findings: A. A review of Resident 328's Admission Record indicated Resident 328 was admitted to the facility on [DATE], with medical diagnoses that included anxiety (restlessness, intense worry), major depressive disorder (a common and serious medical illness that negatively affects how one feels, thinks and act), and muscle weakness. A review of Resident 328's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/18/2024, indicated Resident 328's cognition (the mental ability to make decisions of daily living) was moderately impaired, Resident 328 can make decisions regarding his daily care. The MDS indicated Resident 328 required some assistance from staff for toileting, hygiene, bathing, lower body dressing, and personal hygiene). During observation on 6/25/2024 at 9:55 AM, Resident 328 was lying in bed shivering and pulling the blankets up to the resident's chin. The air condition (AC) thermostat in Resident 328's room, was set at 68 degrees Farenheit (F- Unit of measurement). The AC was blowing cool air very hard and continuously. During an interview with Residennt 328 on 6/25/2024 at 10 AM, Resident 328 asked for help, because the resident was feeling very cold, and certified nursing assistant 1 (CNA 1) would not help the resident. Resident 328 stated he has been cold for a long time (unable to state for how long), and no one will help me. (continued on next page)

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	06/28/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 1 on 6/25/2024 at 9:57 AM, CNA 1 stated Resident 328, is always complaining that he is cold. CNA 1 stated when he complains, I just get him a blanket. CNA 1 entered and checked on Resident 328 and stated the room and stated that Resident 328 was covered with multiple blankets on the bed and that the resident was not cold. CNA 1 then left Resident 328's room without ensuring the resident was warm. During an observation and interview with LVN 6 on 6/25/2024 at 9:57 AM, LVN 6 stated that LVN 6 has been aware that Resident 328 has complaining of feeling cold. LVN 6 entered Resident 328's room and stated, it is freezing cold in this room. LVN 6 checked the AC thermostat in Resident 328's room and the thermostat temperature reading was at 68 degrees F. LVN 6 then turned the AC thermostat up to 74 degrees from 68 degrees. LVN 6 stated that the regular temperature in the residents' rooms is 74 degrees unless the residents agree to turn AC down or up. During an interview with the Maintenance Supervisor (MS) on 6/26/2024 at 4:27 PM., the MS stated the regular temperature is set at 74 degrees in the facility and also in the residents rooms unless the resident requests a lower or higher temperature. The MS stated, resident rooms and the facility temperature is normally set at 74 or 75 F degrees on a continual basis. During an interview with the Director of Nursing (DON) on 6/27/2024 at 2:22 PM, the DON stated If a resident has a roommate that does not agree with the temperature that is in the room. Or in other words if a roommate wants the room temperature to be low, and the other roommate wants the temperature to be high, then the roommates are incompatible, and one roommate must be relocated. The DON stated the DON stated was not aware that Resident 328 has complaining of being cold for the past several days. B. A review of Resident 71's Admission Record indicated Resident 71 was admitted to the facility on [DATE], with medical diagnoses that included anxiety, major depressive disorder, muscle weakness. A review of Resident 71's MDS dated [DATE], indicated Resident 71's cognition was severely impaired. The MDS indicated Resident 71 required maximum assistance from staff for toileting, bathing, lower body dressing, and personal hygiene. During observation on 6/25/2024 at 8:37 AM, Resident 71 was lying in bed, next to the resident's bed was multiple dark spots that covered a large area of the floor in what looked like black marks made from tires of a wheelchair or bicycle. During an interview on 6/25/2024 at 8:41 AM, Resident 71 stated that she has asked a staff if the multiple dark spots on the floor could be removed; however, the staff member told Resident 71 that the marks were permanent. During an interview on 6/27/2024 at 4:24 PM, the MS stated that the dark spots could be removed easily. During an interview on 06/28/24 at 2:24 PM, the Administrator (ADM) stated Resident 71's room will be deep cleaned at a time convenient for Resident 71 to completely remove the dark spots on the floor and disinfect the resident's living area. (continued on next page)

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	06/28/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled, Quality of Life - Homelike Environment dated 2001, indicated, Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . Policy Interpretation and Implementation 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order . g. Comfortable temperatures . 45455 C. During initial tour on 6/25/2024 at 9:05 AM. a wash basin with a soiled wash towel and toothbrush was observed on top of the toilet lid in of room [ROOM NUMBER] bathroom. During an interview with LVN 9 on 6/25/2024 at 9:10 AM, LVN 9 stated the wash basin with soiled wash cloth and toothbrush should not be placed on top of a toilet lid in room [ROOM NUMBER]. LVN 9 further stated placing the wash basin with soiled wash cloth and toothbrush on the to the toilet lid places Residents toothbrush at risk of contamination with disease causing pathogens micro-organisms that can cause infection and does not reflect good hygiene of a safe, clean, sanitary homelike environment. During an interview on 6/28/2024 at 4:44PM, DON stated, leaving a Residents soiled towel and toothbrush inside a wash basin and placing it on top of a toilet seat cover demeans the Resident's quality of life dignity, respect, and individuality. A review of the facility's policy and procedures title Quality of life-Homelike Environment dated 1/2024 indicated, Residents are provided with a safe, clean homelike environment. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order .

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	06/28/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observations, interviews, and record reviews, the facility failed to provide oral (mouth) care for one of ten residents (Resident 4). This deficient practice resulted in Resident 4 developing a very dry tongue and lips with the potential for infection. Findings: A review of Resident 4's Face Sheet indicated Resident 4 was admitted to the facility on [DATE], with diagnoses that included chronic (ongoing) respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and candidiasis (infection caused by an overgrowth of a type of yeast). A review of Resident 4s History and Physical dated 10/20/23, indicated, Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 3/29/24, indicated Resident 4 did not have intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and was dependent on staff for eating, hygiene (oral and physical), and toileting. A review of Resident 4's untitled Care Plan (CP), dated 10/18/23, indicated Resident 4 was at risk for dehydration (excessive loss of water in the body). The CP interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) included to observe, document, and notify the medical doctor (MD) when Resident 4 developed symptoms (something that a person feels or experiences that may indicate a condition or disease) of dehydration including dry mucous membranes (the moist, inner lining of some organs and body cavities such as the nose, mouth, lungs, and stomach). The CP goals indicated the resident would not have any symptoms of dehydration. A review of Resident 4's Order Summary Report, dated 10/18/23, indicated, tracheostomy (a surgically created hole in your windpipe that provides an alternative airway for breathing) care every shift. A review of Resident 4's Order Summary Report, dated 11/23/23, indicated, the facility staff to assess and suction (any secretions) every 2 hours for retained or increased secretions as needed for Resident 4. During a review of Resident 4's Medication Administration Record (MAR) dated 6/27/24 indicated, to apply Biotene Dry Mouth Gel (a gel that moisturizes a resident's mouth) to Resident 4's mouth. (continued on next page)

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	06/28/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident 4's mouth on 6/25/24 at 11:36 AM, Resident 4's tongue was very dry and coated with a thick layer of white looking unidentifiable substance and chapped (dry and cracked) lips. During a concurrent observation and interview on 6/27/24 11:06 AM with Licensed Vocational Nurse 4 (LVN 4), Resident 4's mouth was observed. LVN 4 stated, [Resident 4's] tongue looks very dry. The respiratory therapist [RT; therapist that helps patients who are having trouble breathing] performs oral care for residents on this floor [the subacute floor]. The RT would put a moisturizer [unspecified] on the resident's mouth. During a concurrent observation and interview on 06/27/24 11:23 AM with Respiratory Therapist 1 (RT 1), a picture of Resident 4's mouth (taken on 6/25/24) was observed. RT 1 stated, [Resident 4's] tongue looks very dry. It looks like [Resident 4] has not received oral care for a while. During an interview on 6/28/24 at 2:18 PM with the Director of Nursing (DON), the DON stated, oral care is done twice a day with chlorhexidine (a mouth wash that kills bacteria) for tracheostomy residents. Infection is the consequence of a resident not getting oral care. A review of the facility's policy and procedures titled, Oral Care for a Resident with a Tracheostomy undated, indicated, Purpose: to prevent infections with residents with tracheostomy tubes. Proper oral care helps reduce the risk of pathogens [any organism that causes disease] entering the respiratory system which can cause infections.

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	06/28/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026 Based on observation, interview, and record review, the facility failed to turn and reposition five of five residents (Residents 30, 99, 103, and 105) every 2 hours as per physician's order and inaccordance with the facility's policy and procedures titled Prevention of Pressure Ulcers, Prevention of Pressure Ulcers/Injuries, and Repositioning. This failure placed Residents 30, 99, 103, and at increased risk to develop new pressure ulcers and or worsening of existing pressure ulcers. Findings: A. A review of Resident 30's admission record (background information; a document containing demographic and diagnostic information) indicated Resident 30 was admitted to the facility on [DATE] with the following diagnoses of cerebral infarction (stroke), dysphagia (difficulty swallowing), hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body), left hand contracture (curl or pull in towards the palm), and pressure ulcer (damaged to an area of the skin caused by constant pressure on the area for a long time) of sacral region (the part between the lower back and tailbone), Stage IV (pressure ulcer involving the muscle, bone, or joints). A review of Resident 30's untitled Care Plan (CP- a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) initiated on 1/2/2024, and revised on 5/06/2024, indicated, Resident 30 was at risk for skin breakdown related to existing multiple pressure ulcer, muscle weakness, and functional quadriplegia. The care plan indicated, Resident 30 had self-care performance deficit related to immobility, and pressure ulcer. A review of Resident 30's history and physical (H&P - a physician's complete patient examination) dated 6/16/2024, indicated, Resident 30 had no decision-making capacity. The H&P indicated Resident 30 had Stage IV decubitus ulcer (pressure ulcer) to the sacral region. A review of Resident 30's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 6/20/2024, indicated, Resident 30's cognitive skills for daily decision making was severely impaired. MDS indicated Resident 30 was at risk for developing pressure ulcers. The MDS indicated Resident 30 had one Stage IV pressure ulcer. A review of Resident 30's Physician Order Summary Report dated 6/25/2024, indicated, Resident 30 was not capable of understanding her rights, responsibilities, and give informed consent. The Physician Order Summary Report indicated, licensed nurse to verify Resident 30 was being turned and or repositioned every two hours for wound management. During an observation of Resident 30 on 6/26/2024 at 10:22 AM, 11:43 AM, and 2:14 PM., Resident 30 was found in bed supine (lying on the back) with head turned to the left side, pillow on the left side of her (continued on next page)

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	06/28/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant 6 (CNA 6) on 6/26/2024 at 2:56 PM, CNA 6 stated CNA 6 last turned Resident 30 on 6/26/2024 at 2 PM. The Surveyor and CNA 6 entered Resident 30's room, and observed Resident 30 in the same position since 10:22 AM. CNA 6 stated Resident 30 must be turned every two hours to prevent worsening pressure ulcers or develop new ulcers. During an interview with Licensed Vocational Nurse 8 (LVN 8) on 6/26/2024 at 4:46 PM, LVN 8 stated Resident 30 must be turned every two hours to prevent pressure ulcers or make the current ulcers worse. A review of the facility's policy and procedures (P&P) titled, Repositioning revised on 1/2024, indicated, repositioning is an effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Rrepositioning is critical for a resident who is immobile or dependent upon staff for repositioning. A review of the facility's P&P titled Prevention of Pressure Ulcers revised on 1/2024, indicated, residents who are in bed, their positioned must be changed at least every two hours or more frequently if needed. A review of the facility's P&P titled Prevention of Pressure Ulcers/Injuries revised on 1/2024, indicated, residents who are reclining and dependent on staff for repositioning should be repositioned at least every two hours. Residents who were impaired/decreased mobility and had decreased functional ability were at higher risks for pressure ulcers. B. A review of Resident 103's admission record indicated, Resident 103 was admitted to the facility on [DATE] with the following diagnoses: chronic respiratory failure with hypoxia (low oxygen in the body), osteomyelitis of the right ankle and foot (a disease that causes pain and damage in the right ankle and foot bones due to inflammation), paralytic syndrome (paralysis affecting both sides of the body) following other cerebrovascular disease (diseases of the blood vessels), bilateral (both) acquired absence of left leg below knee (below the knee amputation), unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and muscle weakness. A review of Resident 103's CP with an initiated date of 3/25/2024, revised on 4/16/2024, indicated, Resident 103 was at risk for skin breakdown related to impaired immobility. A review of Resident 103's Physician Order Summary Report dated 3/26/2024, indicated, licensed nurse to verify Resident 103 was being turned and or repositioned every two hours as tolerated. A review of Resident 103's H&P dated 3/27/2024, indicated, Resident 103 was at high risk for pressure sores. The H&P indicated Resident 103 was able to make her needs known but could not make medical decisions. A record review of Resident 103's MDS dated [DATE], indicated, Resident 103's cognitive skills for daily decision making was severely impaired. A review of Resident 103's physician progress notes dated 6/13/2024 indicated, Resident 103 must be frequently turned by staff. (continued on next page)

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	06/28/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 103's Wound assessment dated [DATE] indicated, Resident 103's nursing care should include diligent offloading. During an observation and concurrent interview with CNA 2 on 6/26/2024, Resident 103 was found in bed supine on 6/26/2024 at 10:17 AM, 11:42 AM, 2:02 PM, and 3:12 PM. CNA 2 stated Resident 103 was placed on the supine position when Resident 103 arrived from dialysis, was turned at around 12 noon or 1 PM with placing a pillow under Resident 103's back. CNA 2 stated Resident 103 remained in the supine position from 10:17 AM to 3:12 PM. CNA 2 and another staff member then reposition Resident 103 by lifting and repositioning the pillows around Resident 103. CNA 2 left Resident 103 in supine position. CNA 2 stated Resident 103 should be turned every two hours to prevent getting new pressure ulcers. A review of the facility's P&P titled, Repositioning revised on 1/2024, indicated, repositioning is an effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Rrepositioning is critical for a resident who is immobile or dependent upon staff for repositioning. A review of the facility's P&P titled Prevention of Pressure Ulcers revised on 1/2024, indicated, residents who are in bed, their positioned must be changed at least every two hours or more frequently if needed. A review of the facility's P&P titled Prevention of Pressure Ulcers/Injuries revised on 1/2024, indicated, residents who are reclining and dependent on staff for repositioning should be repositioned at least every two hours. Residents who were impaired/decreased mobility and had decreased functional ability were at higher risks for pressure ulcers. C. A review of Resident 177's admission record indicated Resident 177 was admitted to the facility on [DATE] with the following diagnoses: hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction, type 2 DM, unspecified osteoarthritis (a progressive joint disease), lack of coordination, muscle weakness, and cognitive communication deficit (trouble participating in conversations). A review of Resident 177's Physician Order Summary Report dated 7/30/2023 indicated, licensed nurse to verify Resident 177 was being turned and or repositioned every two hours as tolerated. A review of Resident 177's MDS dated [DATE], indicated, Resident 177's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 177 had a pressure ulcer and was at risk for developing new pressure ulcers. A review of Resident 177's Physician Progress Notes dated 6/05/2024 indicated, Resident 177 had limited communication. A review of Resident 177's untitled CP initiated on 6/28/2023 and revised on 5/13/2024, indicated, Resident 177 had a self-care deficit as evidenced by Resident 177 requiring total assistance with her activities of daily living. (continued on next page)

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	06/28/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 177's CP initiated on 6/28/2023, and revised on 5/13/2024, indicated, Resident 177 was at risk for skin breakdown related to decreased mobility, and existing pressure ulcer. A review of Resident 177's Weekly Summary Notes dated 6/22/2024 at 3:24 PM indicated, Resident 177 was dependent on bed mobility. During an interview on 6/26/2024 at 3:54 PM with LVN 8, LVN 8 stated Resident 177 must be turned every two hours to prevent additional or new pressure ulcers or make the current ulcers worse. During an observation of Resident 177 and concurrent interview with CNA 4 on 6/26/2024, Resident 177 was found in supine position on 6/26/2024 at 9:57 AM, 11:41 AM, 2:01 PM and 2:46 PM. CNA 4 stated Resident 177 was turned several times (unable to state how many times the resident was turned). CNA 4 stated if Resident 177 was not turned the resident could develop new wounds or make the current wounds worse. A review of the facility's P&P titled, Repositioning revised on 1/2024, indicated, repositioning is an effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Rrepositioning is critical for a resident who is immobile or dependent upon staff for repositioning. A review of the facility's P&P titled Prevention of Pressure Ulcers revised on 1/2024, indicated, residents who are in bed, their positioned must be changed at least every two hours or more frequently if needed. A review of the facility's P&P titled Prevention of Pressure Ulcers/Injuries revised on 1/2024, indicated, residents who are reclining and dependent on staff for repositioning should be repositioned at least every two hours. Residents who were impaired/decreased mobility and had decreased functional ability were at higher risks for pressure ulcers. c. A review of Resident 105's admission record indicated Resident 105 was admitted on [DATE] with the following diagnoses: metabolic encephalopathy (a general term that describes a brain disease), type 2 DM, unspecified joint contracture (a permanent tightening of the muscles), muscle weakness, and lack of coordination. A review of Resident 105's Physician Order Summary Report dated 12/29/2023 indicated, licensed nurse to verify Resident 105 was being turned and or repositioned every two hours as tolerated. A review of Resident 105's CP initiated date of 12/07/2023, and revised on 5/13/2024, indicated, Resident 105 wa at risk for skin breakdown related to generalized weakness. A review of Resident 105's CP initiated on 1/13/2024, and revision on 5/13/2024, indicated, Resident 105 was at risk for further skin breakdown and/or slow, delayed healing related to advanced aging process with decreased mobility and impaired circulation. A review of Resident 105's CP initiated on 2/2/2024, and revised on 5/13/2024, indicated, Resident 105 was at risk for skin breakdown related to red spot on her right ear. (continued on next page)

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	06/28/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 105's MDS dated [DATE] indicated, Resident 105 was at risk for developing pressure ulcers. The MDS indicated Resident 105 had one Stage I (observable, pressure-related alteration of intact skin with redness of a specific area over a bony prominence) pressure ulcer, and one Stage IV pressure ulcer. A review of Resident 105's physician progress notes dated 5/16/2024 indicated, Resident 105 did not have the capacity for medical decision making due to dementia. The physician progress notes indicated Resident 105 had lower extremity contractures and had a pressure ulcer to the sacrum (a triangular bone in the lower back between the two hipbones of the pelvis). A review of IDT (Interdisciplinary Team - a group of different healthcare professionals working together towards a common goal for a resident) Notes dated 6/20/2024 at 8:56 AM indicated, Resident 105 had Stage IV pressure ulcer to the sacral region. IDT Notes indicated, Resident 105's nursing care must include off-loading of the Stage IV pressure ulcer site with the use of pillows. A review of Resident 105's Weekly Summary Notes dated 6/25/2024 at 11:23 PM indicated, Resident 105 was dependent on bed mobility. During an observation on 6/26/2024 at 9:51 AM, 1:59 PM, and at 2:33 PM, Resident 105 was found in bed on her left side with the head turned to the left side with pillows near the right shoulder. During an observation on 6/26/2024 at 11:40 AM, Resident 105 in supine position. CNA 5 stated Resident 105 should be turned every two hours because her body can easily develop wounds or pressure ulcers and if she was not turned, Resident 105 may develop new pressure ulcers. During a concurrent interview with CNA 5, CNA 5 stated Resident 105 was initially turned at around 9:30 AM' and that the last time Resident 105 was turned was at 2:30 PM on 6/26/2024. The Surveyor and CNA observed Resident 105 in supine position. CNA 5 stated Resident 105 should be turned every two hours because her body can easily develop wounds or pressure ulcers and if she was not turned, Resident 105 may develop new pressure ulcers. During an interview on 6/27/2024 at 4:24 PM with LVN 7, LVN 7 stated residents must be turned every two hours to prevent new pressure ulcers and from getting their pressure ulcers worse. A review of the facility's P&P titled, Repositioning revised on 1/2024, indicated, repositioning is an effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Rrepositioning is critical for a resident who is immobile or dependent upon staff for repositioning. A review of the facility's P&P titled Prevention of Pressure Ulcers revised on 1/2024, indicated, residents who are in bed, their positioned must be changed at least every two hours or more frequently if needed. A review of the facility's P&P titled Prevention of Pressure Ulcers/Injuries revised on 1/2024, indicated, residents who are reclining and dependent on staff for repositioning should be repositioned at least every two hours. Residents who were impaired/decreased mobility and had decreased functional ability were at higher risks for pressure ulcers.

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	06/28/2024

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 0689 Level of Harm - 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** 45455 Based on observation, interview, and record review, the facility failed to: A. 1. Ensure the staff did not leave a hot cup of coffee at Resident 108's bedside table. 2. Ensure Certified Nursing Assistant 7 (CNA7) did not prepare hot liquid in an electric water kettle on the resident's bedside table, serve, and leave a cup of hot coffee unattended and within the resident's reach. 3. Ensure a licensed nurse assessed and measured Resident 108's skin immediately after the resident was burnt with the hot coffee. As a result, on 4/2/2024, Resident 108 reached, grabbed, and spilled the hot cup of coffee onto the resident's right upper lateral (side) hip resulting in a 2nd degree burn (involving the two layers of the skin) injury and pain, and treatment with Lidocaine (medication for pain) and Silvadene 1% (medication used to treat and prevent wound infections in people with severe burns) on the resident's right upper lateral hip. B. Implement accident prevention protocols and interventions for one of 13 sampled residents (Resident 428). As a result, Resident 428 suffered a skin tear to the forehead and a deviated (a departure from the normal) nose. C.1 Ensure an oscillating pedestal electric fan was not placed and left standing in the middle of a high-traffic walkway in one of 13 residents room (Resident 137). C.2 Ensure CNA 2 locked the wheels of a wheelchair when one of 13 residents (Resident 103) was sitting in the wheelchair. These failures had the potential for physical harm related to fall for Resident 137 and Resident 103. Findings A. A review of Resident 108's admission record indicated Resident 108 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus type II (DM- high blood sugar), chronic (on-going) obstructive pulmonary disease (COPD- a lung disease causing restricted airflow and breathing problems), congestive heart failure (CHF- a weak heart), peripheral vascular disease (the narrowing of blood vessels) cervical spinal stenosis (narrowing of the spinal canal), abnormalities of the gait and mobility and generalized muscle weakness. (continued on next page)

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	06/28/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 108's medical record titled, Change in Condition (CIC- a deterioration in health, mental, or psychosocial status in either life-threatening circumstances or clinical complication), dated 4/2/2024, indicated, Resident's care provider (Medical Doctor -MD) was notified of coffee burn on 4/2/2024 at 7:30am. The MD ordered to apply Lidocaine (dose not indicated) for pain not on the blister and Silvadene 1% to Resident 108's right hip 2nd degree burn. A review of Resident 108's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 5/29/2024, indicated Resident 108's cognition (the mental ability to understand and make decisions of daily living) was intact, required partial/moderate assistance with eating and upper body dressing. The MDS indicated Resident 108 was dependent on staff for dressing. The MDS indicated Resident 108 was non-ambulatory. A review of Resident 108's medical record on 6/27/2024 with MDS coordinator medical record titled, Progress Note dated 4/27/2024-6/27/2024 were reviewed. The progress notes dated 4/2/2024, indicated the facility did not take the initial/progress pictures of the burn injury, did not conduct/complete burn injury evaluation assessment, did not perform/complete burn injury measurement and/or did not document the degree level of the burn injury. During initial tour observation and concurrent interview with Resident 108 on 6/25/24 at 9:50 AM, Resident 108 was observed in bed with both hands covered with a towel. Resident 108 did not move either hands. Resident 108 stated that on 4/2/2024 during early hours of the morning on the 11PM-7 AM shift, Resident 108 requested CNA7 to heat up some hot water using Resident 108's electric hot water kettle on the resident's bedside table and make a cup of coffee for the resident. Resident 108 stated CNA7 heated water in an electric hot water kettle owned by the resident and made a cup of coffee for the resident. Resident 108 stated CNA7 placed the cup with hot coffee on the resident's bedside table and told Resident 108 to wait a few minutes because the coffee was still hot. Resident 108 stated Resident 108 waited for few minutes (unable to recall the wait time) then grabbed the coffee cup from the resident's bedside table, tried to bring the cup of hot coffee close to the resident's mouth, and the resident spilled the coffee on herself. The resident states she has hand tremors (shaking or trembling movements). Resident 108 stated she sustained burns to the right hip as a result. During an interview with the Director of nursing (DON) on 6/25/2024 at 3:19 PM, the DON stated the DON could not recall the exact date Resident 108 sustained the 2nd degree burn. The DON stated the DON did not investigate how Resident 108 sustained the 2nd degree burn to the right upper lateral hip. A review of Resident 108's Summary Report with active orders from 6/27/2024, indicated the change the treatment orders for Resident 108 as follows: 1. Right Hip fragile (delicate) scar: Cleanse (wash) with Normal Saline (NS- Solution for wound care), pat dry, apply triple antibiotic (medication to prevent/treat infection) and cover with dry dressing (DD) daily (QD) and as necessary (PRN) x 14 days . 2. Right hip reddened area/peeled area: Cleanse with NS, pat dry, apply xeroform (non-stick wound care material) and cover with foam dressing (a bandage that cushions a wound) QD and PRN x 14 days . (continued on next page)

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	06/28/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation of treatment and measurement of Resident 108's right hip burn injury by Treatment Nurse 1 (TX1) on 6/27/2024 from 11:13 AM, Resident 108's right hip burn injury was measured by the TX1. The burn injury measured 13 centimeters (cm- unit of measurement) x 12cm, pink in color with some bleeding observed. TX1 cleansed the burn injury with NS, patted the wound dry, applied triple antibiotic then applied xeroform dressing and covered the wound with foam dressing. During a concurrent interview and record review, TX1 stated that on 4/2/2024 at 7:00AM change of condition evaluation regarding Resident 108's burn was documented, Resident 108's care provider (MD) was notified at 7:30AM, a treatment order for Lidocaine for pain, not on the blisters and Silvadene 1 % was given and carried out. Resident TX1 stated she did not assess, measure and document Resident 108's 2nd degree burn injury because the burn injury was red and blistered (a fluid filled sac). TX1 stated Resident 108 sustained the burn injury from hot coffee prepared and provided by CNA7. TX1 stated CNA7 boiled water and made the coffee for Resident 108 using Resident 108's personal hot water kettle. During an interview with CNA7 on 6/27/2024 at 4:11 PM, CNA7 stated that on 4/2/2024 at about 7 AM, CNA7 used Resident 108's personal electric hot water kettle to boil water and made coffee for the resident. CNA7 stated the electric hot water kettle was on top of Resident 108's bedside table. CNA7 stated CNA7 left the cup of hot coffee at Resident 108's bedside and instructed the resident not to touch the coffee, and to let the coffee cool down because the coffee was hot. CNA7 stated that on 4/2/2024 during 11 PM - 7 AM shift, CNA7 found out that Resident 108 had accidentally spilled the very hot coffee on herself [Resident 108], sustained a burn on the right hip, and a bandage/dressing was applied. A review of the facility's policy and procedures (P&P) titled Safety and Supervision of Resident, revised 1/2024 indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The risk factors and environmental hazards include Electrical safety and water temperatures. A review of facility's P&P titled, Assistance with Meals, dated 1/2024, indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each Resident. Facility will serve .and will help residents who require assistance with eating. 48903 B. A review of Resident 428's face sheet indicated Resident 428 was admitted to the facility, on 6/11/24, with diagnoses including tracheostomy (a surgically created hole in your windpipe that provides an alternative airway for breathing), transient cerebral ischemic attack (a temporary blockage of blood flow to the brain) and cardiomyopathy (a condition that makes it hard for the heart to deliver blood to the body). A review of Resident 428's History and Physical (H&P) dated 6/13/24, indicated Resident 428 did not have the capacity to understand and make decisions. A review of Resident 428's MDS dated [DATE], indicated Resident 428 did not have intact cognition and was dependent on staff for oral hygiene, toileting, showering, dressing and personal hygiene. (continued on next page)

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	06/28/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 428's Care Plan (CP) dated 6/23/24, indicated Resident 428 had impaired skin integrity as evidenced by a skin tear to his forehead. The CP interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) indicated that facility staff to identify potential causative factors of the skin tear and eliminate when possible, educate resident on avoiding skin injuries, and administer treatments as ordered. A review of Resident 428's CP dated 6/23/24, indicated Resident 428 was at risk for falls related to cognitive impairment and impaired mobility (refers to conditions that limit a person's coordination or ability to move). The CP interventions indicated that staff anticipate and meet the needs for Resident 428, educate the resident to call for assistance, keep the call light within reach, monitor for changes in condition and notify doctor, and safety devices as ordered. A review of Resident 428's Progress Notes dated 6/23/24 at 7:50 AM, indicated, a clip board accidentally fell on Resident 428's head resulting in a small cut to the resident's forehead with minimal bleeding. The MD was notified who recommended to continue monitoring Resident 428's skin breakdown and mental status. A review of Resident 428's Progress Notes dated 6/23/24 at 8:15 AM, indicated, open blister on forehead was cleaned and antibiotic (unspecified) applied. A review of Resident 428's Treatment Administration Record (TAR) dated 6/1/24 to 6/30/24, indicated, cleanse skin tear on the forehead with normal saline, pat dry and cover with dry dressing daily for 14 days every shift. Start date: 6/25/24. There is no order for antibiotic. A review of Resident 428's Progress Notes dated 6/23/24 at 1:05 PM, indicated, Resident 428's family member 1 (FM 1) noticed that Resident 428's nose looked deviated towards the left. A review of the facility's Inservice Lesson Plan dated 6/24/24, indicated, Program Outline: 2) Make rounds, remove possible hazardous items which may fall on patients 3) Report accidents to MD/family accurately, describe facts to MD/family. During an interview on 6/28/24 at 11:18 AM with Resident 428's FM 2, FM 2 stated, the nurse that took care of [Resident 428] overnight told me the cut on Resident 428's head was a water blister that it had had burst. [Resident 428's] nose looked bent. It looked like someone punched [Resident 428] in the face. The charge nurse told me that the cut was from a clipboard that fell on [Resident 428's] head. During an interview on 6/26/24 at 5:38 PM with the Director of Nursing (DON), the DON stated, the overnight nurse told [Resident 428's] family that the cut on [Resident 428's] head was a burst water blister. I don't know why she [nurse] didn't tell the family the truth but she [nurse] was suspended. A review of the facility's P&P titled, Accidents and Incidents: Investigating and Reporting dated 1/24, indicated, All accidents or incidents involving residents occurring on our premises shall be investigated and reported to the Administrator. (continued on next page)

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	06/28/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's P&P titled, Safety and Supervision of Residents dated 1/24, indicated, Our facility strives to make the environment as free from accident hazards as possible. When accident hazards are identified, the Safety Committee shall evaluate and analyze the cause of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. 48026 C.1. A review of Resident 137's admission record indicated, Resident 137 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis [complete or partial loss of muscle strength] that affects all four limbs and body from the neck down), type 2 diabetes mellitus (a long-lasting condition when the pancreas does not produce enough insulin or when body cannot effectively use the insulin it produces causing blood glucose [sugar] to go high), abnormal posture (rigid body movements and chronic abnormal positions of the body), and muscle weakness (when muscles are weak causing difficulty performing normal activities that require strength). A review of Resident 137's MDS dated [DATE], indicated, Resident 137 was cognitively intact. A review of Resident 137's CP did not include Resident 137 brought her own electric fan to the facility for personal use. The CP did not include Resident 137's risk and environmental hazards to minimize the likelihood of accidents. During an interview on 6/25/2024 at 9:59 AM with Resident 137, Resident 137 stated she owns the oscillating pedestal electric fan found in her room. Resident 137 stated she liked where the electric fan was placed exactly where it is because the fan provided her with the cooling relief she needed. During an interview on 6/27/2024 at 3:56 PM with LVN 7, LVN 7 stated it was not safe to have the fan in the middle of the walkway because someone may trip on the cord causing an accident. During an interview on 6/27/2024 at 5:57 PM with DON, DON stated, the staff can accidentally trip on the cord when the pedestal electric fan was left standing in the middle of high-traffic walkway. A review of the facility's P&P titled Falls - Clinical Protocol revised on 1/2024, indicated, facility staff will document risk factors for falling which included musculoskeletal abnormalities, gait and balance disorders, cognitive impairment, weakness, environmental hazards, and illnesses affecting the central nervous system. C.2. A review of Resident 103's admission record indicated, Resident 103 was admitted to the facility on [DATE] with the following diagnoses: chronic respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body leading to insufficient amount of oxygen at the tissue level), chronic multifocal osteomyelitis of the right ankle and foot (a disease that causes pain and damage in the right ankle and foot bones due to inflammation [a normal part of the body's response to injuries and invaders like germs]), paralytic syndrome following other cerebrovascular disease, bilateral (paralysis affecting both sides of the body), acquired absence of left leg below knee (below the knee amputation), unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and muscle weakness (when muscles are weak causing difficulty performing normal activities that require strength). (continued on next page)

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	06/28/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 103's care plan with an initiated date of 3/25/2024, revised on 4/16/2024, and a target date of 7/25/2024 indicated, Resident 103 was at risk for falls with or without injury related to impaired mobility and left below the knee amputation (BKA). A review of Resident 103's H&P dated 3/27/2024, indicated, Resident 103 was able to make needs known but cannot make medical decisions. The H&P indicated Resident 103 was a high risk for fall. A record review of Resident 103's MDS dated [DATE] indicated, Resident 103's cognitive skills for daily decision making was severely impaired. During an observation and interview with CNA 2 on 6/26/2024 at 9:05 AM, CNA 2 was observed walking away from Resident 103 who was sitting in an unlocked wheelchair unattended. CNA 2 later returned to Resident 103 accompanied by CNA 3. CNA 2 stated, Yes when asked if CNA 2 had locked the wheelchair before walking away from Resident 103. The surveyor and CNA 2 inspected the wheelchair and observed that the wheelchair wheels were unlocked. CNA 2 stated it is important to always lock the wheelchair heelsfor Resident 103's safety. During an interview on 6/27/2024 at 4:15 PM with LVN 7, LVN 7 stated wheelchairs must be in a locked position when resident is in sitting in one because the resident may fall and get hurt. A review of the facility's policy and procedures (P&P) titled Falls - Clinical Protocol with a revision date of 1/2024, indicated, facility staff will document risk factors for falling which included musculoskeletal abnormalities, gait and balance disorders, cognitive impairment, weakness, environmental hazards, and illnesses affecting the central nervous system (made up of the brain and spinal cord that controls how we think, learn, move, and feel).

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	06/28/2024

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 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** 48903 Based on observation, interview, and record review, for one of ten residents (Resident 202) the facility failed to: 1. Monitor Resident 202's urine for signs and symptoms (S/S- something an individual experiences.) of urinary tract infection (UTI- an infection involving any part of the urinary system). Resident 202 had an indwelling catheter (a flexible tube to drain urine). 2. Notify a medical doctor (MD) that Resident 202's urine had sediments in the indwelling catheter. These deficient practices had the potential for Resident 202 to develop UTI. Findings: A review of Resident 202's Face Sheet indicated Resident 202 was admitted to the facility on [DATE], with diagnoses that included traumatic brain injury (a brain injury that is caused by an outside force), altered mental status (a disruption in how the brain works that causes a change in behavior) and multiple fractures (broken bones) of pelvis (area below the abdomen that includes the hip bones). A review of Resident 202's History and Physical dated 4/21/24, indicated, Resident 202 did not have the capacity to understand and make decisions. A review of Resident 202's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 4/11/24, indicated Resident 202 did not have intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and was dependent on staff for eating, hygiene (oral (related to mouth) and physical), and toileting. A review of Resident 202's untitled Care Plan (CP) dated 4/8/24, indicated Resident 202 has an indwelling catheter). The CP interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) indicated staff to monitor and report signs of UTI such as cloudiness to a MD. The CP goals indicated Resident 202 would show no S/S of urinary infection. A review of Resident 202s Order Summary Report, dated 6/11/24 indicated, order for indwelling catheter care every shift. During an observation on 6/25/24 at 9:31 AM, Resident 202's indwelling catheter tubing was observed with sediments (solid material that settles to the bottom of liquid). (continued on next page)

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	06/28/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/25/24 at 9:50 AM with Licensed Vocational Nurse 5 (LVN 5), Resident 202's indwelling catheter was observed. LVN 5 stated, there is sediment in the foley catheter. The doctor is notified if there is sediment and a urinalysis [UA- a urine test to check for UTIs] would be ordered. The consequences of sediment in urine are UTI. LVN 5 stated MD was not notified about the sediments in the indwelling catheter. A record review of Resident 202's Progress Notes on 6/26/24 at 11:03 AM, indicated no documented evidence that a doctor was notified of sediments in Resident 202's indwelling catheter. During a concurrent interview and record review on 6/28/24 at 12:23 PM with the Director of Nursing (DON), Resident 202's Progress Notes were reviewed. The DON stated, there is no doctor notification or change in condition (CIC -a significant change in a resident's health or functional status) found on 6/25/24 [the day sediment was noted in Resident 202's foley catheter]. During an interview with the DON on 6/28/24 at 2:17 PM, The DON stated, if a resident's urine looks unusual such as strange color, smell, and or has sediments, it indicates infection. The DON stated, The doctor needs to be notified, UA ordered. That is the protocol. The DON stated, Infection is the consequence of not reporting it to the MD. A review of the facility's policy and procedures titled, Catheter Care, Urinary dated 1/24, indicated, The purpose of this procedure is to prevent infection of the resident's urinary tract. Check the urine for unusual appearance. Observe the resident for signs and symptoms of UTI. Report the findings to the supervisor immediately.

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	06/28/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026 Based on observation, interview, and record review, the facility failed to ensure the hourly water flush volume was administrated as ordered through a percutaneous endoscopic gastrostomy (PEG - surgically placed that allows a person to receive nutrition through the stomach) tube while on enteral feeding (delivery of nutrients through a feeding tube directly into the stomach) for one of two sampled residents (Resident 30). This deficient practice had the potential for Resident 30 to experience dehydration and tube blockage when the hourly water flush through the PEG tube ran less than the calculated amount as prescribed. Findings: A review of Resident 30's Admission Record (background information; a document containing demographic and diagnostic information) indicated Resident 30 was admitted to the facility on [DATE] with the following diagnoses: unspecified sequelae of cerebral infarction (a loss of blood flow to part of the brain, which damages brain tissues), dysphagia (difficulty swallowing) following cerebral infarction (damage to the tissues in the brain due to loss of oxygen to the area), hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), gastrostomy (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and meds), and left hand contracture (curl or pull in towards the palm). A review of Resident 30's care plan (CP- a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) with an initiated date of 10/19/2022, revision date of 4/29/2023, and target date of 9/18/2024 indicated, Resident 30 was at risk for dehydration related to enteral feeding. A review of Resident 30's CP initiated on 10/19/2022, and revised on 6/20/2024, with a target date of 9/18/2024 indicated, Resident 30 was at risk for clogged tubing. A review of Resident 30's CP initiated on 3/28/2024, and revised on 3/28/2024, with a target date of 9/18/2024 indicated, Resident 30 was at nutritional risk due to the potential for altered nutrition and/or hydration status related to enteral nutrition (aka enteral feeding). A review of Resident 30's history and physical (H&P - a physician's complete patient examination) dated 6/16/2024, indicated, Resident 30 was receiving nutritional feeding through a PEG tube. A review of Resident 30's Minimum Data Set (MDS - a standardized care screening and assessment tool) dated 6/20/2024 indicated, Resident 30's cognitive (relating to thought process such as such as thinking, reasoning, or remembering) skills for daily decision making were severely impaired. (continued on next page)

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	06/28/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 30's Physician Order Summary Report (a list of all types of physician orders) dated 6/25/2024 indicated, Resident 30 was incapable of understanding rights, responsibilities, and informed consent. The Physician Order Summary Report also indicated Resident 30's water flush through her PEG tube to run at 45 milliliters (mL - a unit of measure in fluid volume; 1 mL = 0.001 liter) per hour (45mL/hr.). During a concurrent observation and interview on 6/27/2024 at 3:54 PM with licensed vocational nurse 7 (LVN 7), Resident 30's water flush was running at 40mL/hr, which was confirmed by LVN 7. When asked what would happen to Resident 30 when the water flush ran at less than what the physician prescribed, LVN 7 stated the resident's tubing may become clogged. During an interview on 6/27/2024 at 4:28 PM with director of nursing (DON), the DON stated if the rate of water flush is running less than what the physician prescribed, Resident 30 may become dehydrated, and her PEG tubing may get clogged causing delay in providing her nutrition and adequate water flush. A review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Enteral Nutrition with a revision date of 01/2024 indicated, enteral feeding orders are written to ensure consistent volume infusion.

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	06/28/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility staff failed to ensure one of ten sampled residents (Resident 64) received tracheostomy (trach- a surgically created hole in your windpipe that provides an alternative airway for breathing) care by leaving his trach unsecured and not applying a dressing around the trach. This deficient practice placed Resident 64 at risk increased for the trach to become dislodged (move out of place) and the potential for respiratory distress and death. Findings: A review of Resident 64's Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses including chronic (long term) respiratory failure (when the lungs cannot get enough oxygen into the blood), trach, dependence on ventilator (machine that assists in breathing) and schizophrenia (a serious mental health disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). A review of Resident 64's History and Physical dated 2/5/24, indicated, Resident 64 did not have the capacity to understand and make decisions. A review of Resident 64's Minimum Data Set (MDS; a standardized assessment and care screening tool) dated 5/6/24, indicated Resident 64 did not have intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and was dependent on staff for eating, hygiene (oral and physical), and toileting. A review of Resident 64's Order Summary Report, dated 1/16/23, indicated, change and date trach ties as needed one time a day. A review of Resident 64's untitled Care Plan (CP) dated 1/15/23, indicated Resident 64 has potential for complications related to trach. The CP interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) indicated to provide trach care every shift and monitor and report signs of hypoxia (low oxygen). During an observation at Resident 64's bedside on 6/25/24 at 11:09 AM, Resident 64's trach was not secured in place with trach ties and had no dressing. During an interview with Respiratory Therapist 1 (RT 1; therapist that helps patients who are having trouble breathing) on 6/25/24 at 11:29 AM RT stated, I check the trach every 2 hours. I check cleanliness, if the trach is secured with trach ties, any attention that is needed. We do dressing changes every shift. If the resident does not have the trach secured there could be: decannulation [removal of trach], trach getting out of place, trach being dislodged [coming out]. The RT 1 stated Resident 64, is confused and pulls on things. [Resident 64] could easily pull it [trach] out. It would be harmful to the resident if he [Resident 64] pulls out his trach. (continued on next page)

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	06/28/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 6/28/24 at 2:19 PM, the DON stated, If a trach is not secured the resident can pull out the trach, get respiratory distress and can die. A review of the facility's policy and procedures titled, Tracheostomy Care dated 10/23, indicated, Tracheostomy care should be provided as often as needed. Replacing neck ties: If the resident's condition is unstable apply new ties before removing old ones.

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	06/28/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45037 Based on observation, interview, and record review, the facility failed to ensure missing narcotics (the controlled medications used to treat moderate to severe pain) were documented and reported per the facility's policy. This deficient practice had the potential for medication loss and diversion, placing the resident at risk not receiving pain medication when needed. Findings: During a concurrent observation and interview with licensed vocational nurse 2 (LVN 2) for a narcotic counting on 6/27/24 at 2:37 PM, there were two (2) tablets of hydrocodone (type of pain medication) 5-325 milligrams were missing and not signed out by any of the nurses on the medication cart on the station. LVN 2 confirmed and stated she received the medication cart with two tablets of Hydrocodone 5-325 milligrams missing from the 11pm-7am shift nurse but had not reported to the director of nursing (DON) or registered nurse (RN) supervisor of two tablets of hydrocodone 5-325 milligrams being missing. When asked what could happen if missing narcotics were not reported, LVN 2 stated the residents could be in pain if they did not have the medication on hand. During an interview with the DON on 06/27/24 3:50 PM, the DON stated she was not aware of two narcotic tablets were missing from the medication cart. The DON stated she is going to complete an investigation of the inaccuracy of the narcotic count of 2 tablets of Hydrocodone 5-325 mgs. The DON also stated the nurses are supposed to report to the RN supervisors or DON right away if narcotics are missing. When asked what could happen if a resident's pain medication was missing, the DON stated the resident could be left in pain. During an interview with RN 1 on 06/28/24 9:38 AM, RN 1 stated if the nurses have a discrepancy in any medication during the narcotic count, they are supposed to report it right away to the RN Supervisors if the DON is not in the building. A review of the facility's policy titled Controlled Substances with a revised date of 1/24, indicated, nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON.

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	06/28/2024

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	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on interview and record review, the facility failed to ensure one of 13 sample residents (Resident 9) was free from significant medication errors. By failing to: 1. Obtain and document a physician's order to keep pain relieving medications (1). Salonpas Lidocaine 4% patch (patch used to reduce itching and relieve pain from certain skin conditions), and (2) Diclofenac Sodium topical gel 1% (medication used to relieve pain and reduce inflammation) at bedside. 2. Allow Resident 9's responisble party (RP) to administer Diclofenac Sodium topical gel 1% and a box with 7 Salonpas Lidocaine 4% patches to Resident 9 without supervision or assessment of competency to administer medications. This deficient practice had the potential to cause complications of redness, swelling, blisters, or changes in the skin color at the site of application and serious allergic reactions including itching/swelling of the face/tongue/throat) severe dizziness and trouble breathing. Cross-reference F658 and F759 Findings: A review of Resident 9's admission record indicated Resident 9 was admitted originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hypotension (lower than normal blood pressure) bradycardia (lower than normal heart rate), shortness of breath, rheumatoid arthritis (a chronic autoimmune disease that affects the joints), and muscle weakness. A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 5/27/2024, indicated Resident 9's cognition ((the mental ability to understand and make decisions of daily living) was severely impaired and the resident required supervision or touching assistance with eating, partial to moderate assistance with oral hygiene and upper body dressing, was dependent for toileting hygiene, lower body dressing and putting on/taking off footwear. During an initial tour on 6/25/2024 at 10:20 AM Resident 9's bedside table was observed to have 2 tubes of Diclofenac Sodium topical gel 1% and a box with 7 Salonpas Lidocaine 4% patches on Resident 9's bedside drawer in a visible open unsecured area as she (Resident 9) lay asleep in bed. During a concurrent interview and record review on 6/25/2024 at 10:34 AM licensed vocational nurse 9 (LVN9) stated Resident 9's family brought the medications and they (family) applied the Diclofenac Sodium topical gel 1% and a box with 7 Salonpas Lidocaine 4% patches on the resident. A review of Resident 9's electronic medical administration (emar) record indicated Resident 9 did not have a physician's order for the Diclofenac Sodium topical gel 1% and a box with 7 Salonpas Lidocaine 4% patches. LVN9 stated the risks of having medication without a physician's order in a visible unsecured open area at bedside included: poisoning if ingested by a wandering confused resident, overdose, drug interactions, and allergic reactions that could lead to unnecessary hospitalization and even death. (continued on next page)

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	06/28/2024

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	A review of Resident 9's emar on 6/27/2024 at 12:46 PM indicated Resident 9 had a physician's order for and was receiving: 1. Orencia solution 125mg/ml, 1ml subcutaneously every Monday for rheumatoid arthritis pain. 2. Tramadol 50mg x2 tablets every 8 hours for severe pain. 3. Tylenol extended release 650mg every 12 hours for mild pain as needed. During an interview on 6/27/2024 at 2:51 PM Resident 9's daughter/responsible party (RP), stated she applied the Diclofenac Sodium topical gel 1% on Resident 9 on Resident 9 foot and joint during RP's visit every other day. The RP stated she placed the Salonpas Lidocaine 4% patch on Resident 9's back when Resident 9 did not have the patch on the back. During an interview on 6/28/2024 at 9:55 AM, Resident 9's doctor indicated he received a text message from the facility 7-10 days prior from staff regarding the use of Diclofenac Sodium topical gel 1% and Salonpas Lidocaine 4% patch and he approved it. The doctor stated the facility staff licensed staff was supposed to apply the medication on the Resident and not the Family. During an interview on 6/28/2024 at 4:30PM, the director of nursing (DON) stated Resident 9 and/or the pesponsible party did not have an order for self-administration and/or to administer medication to the Resident. The DON was unable to provide text from staff to and from doctor indicating an order for approval of the use of both medications on Resident 9. The DON stated leaving Diclofenac Sodium topical gel 1% and a box with 7 Salonpas Lidocaine 4% patches at bedside and using the Diclofenac Sodium topical gel 1% and a box with 7 Salonpas Lidocaine 4% patches on Resident 9 without a physician's order placed the Resident at risk for overdosing, dependency, and possible poisoning if ingested by a wandering confused patient. A review of facility policy titled Identifying and Managing Medication Errors and Adverse Consequences dated 1/2024 indicated, the staff and practitioner shall strive to minimize adverse consequences by: a) Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration and monitoring of the medication b) Defining appropriate indications for use; and c) Determining that the resident: 1. Has no known allergies to a medication. 2. Is not taking other medications, nutritional supplements including herbal products or good that would be incompatible with the medication and 3. Has no condition, history, or sensitivities that would preclude use of that medication.

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	06/28/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843 Based on observation, interview, and record review the facility failed ensure medications were discarded as per facility policy and procedure titled, Discarding and Destroying Medications dated 2001. By failing to: 1. Check the expiration date, remove, and discard from use, one box of BD Vacutainer Safety-Lok Blood Collection Set (tubing and needle used to collect blood specimens). 2. Remove one box of expired Bisacodyl (laxative- medication that prevents/treats constipation) 10 milligrams. These deficient practices had the potential to cause a mechanical failure of the expired blood collection set during an attempt to collect blood from a resident and affect medication efficacy (the power to produce the desired effect) and reduce the therapeutic (intended to treat diseases or disorders) effects of medications administered. Finding: During observation of the 4th floor medication storage area at the nursing station on 06/27/24 at 3:42 p.m., a half-used box of Safety-Lok Vacutainers were observed on the counter in the medication room open and ready for use and available for staff to use by staff to draw blood from residents. The half-used box of Safety-Lok Vacutainers was observed to have an expiration date of 4-30-2023. During an interview on 6/27/24 at 3:45 p.m., Registered Nurse Supervisor 1 (RNS 1) worked at the facility for [AGE] years and stated she was not aware the expired Safety-Lok Vacutainers were in the medication room. RNS 1 was not aware if anyone that had recently used the expired vacutainer; RNS1stated that she would dispose of the expired Safety-Lok Vacutainers immediately. RNS 1 stated expired equipment should not be used due to the possibility of potential contamination, or mechanical failure due to the expiration date being 4-30-23. During an interview on 06/27/24 at 4:05 p.m., Director of Nursing (DON) stated no expired medications or equipment were to be kept in the medication storage area. The DON stated expired medication or equipment kept in the medication storage area could have been by mistake. The DON stated medication areas were inspected and checked for expired medication and equipment every month by staff. During medication storage and labeling observation on 06/27/24 at 2:37 p.m., licensed vocational nurse 2 (LVN 2) observed and noted 1 box of house supply Bisacodyl 10 milligrams with an expiration date of 4-24. LVN 2 stated if residents received expired medication the residents could get sick. LVN 2 stated she did not administer any Bisacodyl to any resident on the date of observation (6/27/2024). (continued on next page)

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	06/28/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/24 at 3:50 pm, the DON Stated the licensed nurses were supposed to check medication carts daily to ensure there were no expired medications in the medication carts. The DON stated the residents could get sick if expired medications were consumed. A review of the facility policy and procedures titled, Discarding and Destroying Medications dated 2001 indicated, Policy Statement Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, and hazardous waste.

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	06/28/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45037 REVIEWED Based on oservation, interview, and record review, the facility failed to ensure safe and sanitary food storage, food labeling practices in accordance with professional standards and facility policy to ensure food service safety and ensure routine maintenance of kitchen pipes was performed. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses and other toxins) and corrosion to the pipes, safety hazards in 211 of 211 medically compromised residents who received food and have food prepared from the kitchen, staff getting injured due to large puddles of water on the floor, and large industrial fan blowing in kitchen while food is being prepared. Findings: During an initial tour and observation of the facility kitchen with the Dietary Supervisor (DS) on 6/25/2024 at 7:50 AM. Two blocks of yellow sliced cheese were observed labeled with an expiration date of 2/23/24, one large plastic container with food in it was observed without a label indicating the contents, open date, or expiration date, one loaf of whited bread was observed with an expiration date of 3/18/24, one large container of ranch dressing was observed with an expiration date of 2/7/24, one large plastic container was observed labeled jelly with an expiration date of 6/20/24 . A large amount of water was observed on the floor underneath the sink and near the sink where the dishes were washed. A pipe under the sink where dishes were washed was observed to have a greenish color on the pipes and a large amount of dust was observed under the sink where the dishes were washed. During an observation of resident food storage refrigerator on the facility's 5th floor with licensed vocational nurse 1 (LVN 1) on 6/25/2024 at 8:40 AM, 15 food items in plastic containers (unable to identify food items) were not labeled with expiration dates. During an observation of food storage refrigerator on 4th floor with LVN 1 on 06/25/24 08:43 AM, 11 food items in plastic containers (unable to identify food items) were observed without expiration dates on them. During an observation of food storage refrigerator on 3rd floor with LVN 1 on 06/25/24 09:03 AM, 2 food items in plastic containers (unable to identify food items) and 4 drinks (labeled Beautiful) were not labeled with expiration dates. During an observation of food storage refrigerator on 2nd floor with LVN 1 on 06/25/24 09:08 AM, 2 food items in plastic containers (unable to identify food items) were not labeled with expiration dates. (continued on next page)

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	06/28/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up observation of the facility kitchen on 06/27/24 07:18 AM, three puddles of water we observed on the floor. A large orange industrial fan was blowing in the kitchen and a pipe under the sink was observed leaking water into the green bucket. During an interview on 06/25/24 at 8:18 AM, the DS stated the staff did not clean underneath the sink where the dishes were washed. The DS stated the residents could get sick if the kitchen was not cleaned regularly. The DS stated she reported the leaking pipe underneath the kitchen sink a week prior to the date of observation to the maintenance supervisor (MS). During an interview on 06/25/24 10:40 AM, the MS stated the plumbing/pipes were last serviced approximately one year prior. During a follow up interview on 6/25/24 11:20 AM, the MS stated he did not have any invoices on hand for the last time the leaking pipe in the kitchen was repaired or serviced. The MS stated the leaking pipe could lead to corrosion of the pipes and someone could slip and fall and get injured. During an interview on 06/27/24 07:18 AM, SA asked the MS/HS how long the pipe has been leaking and he said he did not know. SA asked MS/HS what could happen to the staff with puddles of water on the floor, MS/HS stated the staff could slip and fall and hurt themselves. A review of the facility policy and procedures (P&P) titled Maintenance Service with a revised date of January 2024, indicated 1. Maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. F. establish priorities in providing repair services. I. providing routinely scheduled maintenance services to all areas. 8. The maintenance Director is responsible for maintaining the following records/reports. L. Work order request. M. Maintenance schedules records shall be maintained in the Maintenance Director's office. A review of the facility P&P titled Food Receiving and Storage with a revised dated of January 2024, indicated 8. All food stored in the refrigerator or freezer will be covered, labeled, and dated. 14. Food items and snacks kept on the nursing units must be maintained as indicated: b. All foods belonging to residents must be labeled with the resident's name, the item, and the use by date. d. beverages must be dated when opened and discarded after twenty-four hours. f. Partially eaten food may not be kept in the refrigerator. A review of the facility P&P titled Food for Residents from Outside Sources (undated), indicated 2. The dietary department is not responsible for keeping food for residents. a. Such food must be eaten within one (1) hour of receiving. b. Any food not eaten must be taken home or disposed of that day. A review of the facility P&P titled Food brought by Family/Visitors with a revised date of January 2024, indicated 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, and the use by date. 7. The nursing staff is responsible for discarding perishable foods on or before the use by date.

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	06/28/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843 Based on observation, interview, and record review, the facility failed to ensure call lights (device with a button or touch pad a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) were within reach for one of seven sampled residents (Resident 165). This deficient practice had the potential to result in a delay in meeting Resident 165's needs for hydration, toileting, and activities of daily living. Findings: A review of Resident 165's Admission Record indicated Resident 165 was admitted to the facility on [DATE], with medical diagnoses that included: Paraplegia (a chronic condition that causes the loss of muscle function and feeling in the lower half of the body, including both legs), major depressive disorder (a common and serious medical illness that negatively affects how you feel, the way you think and how you act), and muscle weakness (a lack of physical or muscle strength, throughout the body). A review of Resident 165's Minimum Data Set (MDS - a standardized assessment and care screening tool) indicated Resident 165's cognition (the mental ability to make decisions of daily living) was intact.The MDS indicated the resident required maximum assistance from staff for toileting, hygiene, bathing, lower body dressing, and personal hygiene. During observation in Resident 165's room on 6/25/2024 at 8:54 a.m., Resident 165 was observed lying in bed with the call light hanging off the bed and out of reach of Resident 165. During an interview on 6/25/2024 at 9:04 a.m., Resident 165 asked if someone could get the call light from under the bed because Resident 165 could not reach the call light. During an interview on 6/25/2024 at 9:09 a.m., Certified Nurse Assistant (CNA1) stated Resident 165 did not have the call light within reach; however, it was okay because CNA1 was always checking on CNA1's assigned residents. CNA1 stated not having the call light within reach could result in the resident needing help and not being able to call for help because the call light was not within reach. During an interview on 6/27/2024 at 2:22 p.m., the Director of Nursing (DON) stated call lights were to remain within reach of the residents. The DON stated staff were to perform room checks periodically to ensure resident safety was maintained and call lights were within reach of each resident. A review of the facility's policy and procedures titled, Answering the Call Light dated 2001, indicated, The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines 4. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.