

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Beachwood Post-Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15th Street Santa Monica, CA 90404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the facility staff did not refer to residents needing assistnace [NAME] feeding as Feeders for seven of seven sampled residents (37, 97, 94, 95, 165, 188, and 454).</p> <p>This deficient had the potential to result in lowered self esteem for the residents needing assistnace with feeding.</p> <p>Findings:</p> <p>During a record review, Resident 37's admission record, indicated Resident 37 was admitted to the facility (skilled nursing facility [SNF]) on 3/31/25, with diagnoses that included, muscle weakness (a lack of physical or muscle strength, throughout the body), diabetes Type 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel).</p> <p>During a record review, Resident 37's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/25, indicated Resident 37's cognition (the mental ability to make decisions of daily living) was moderately impaired. Resident 37 required substantial/maximal assistance with all activities of daily living (ADL- bed mobility, transfer, eating, toilet use and personal hygiene).</p> <p>During a record review, Resident 94's admission record, indicated Resident 94 was admitted to the facility on [DATE], with diagnoses that included, chronic obstructive pulmonary disease (COPD - a lung disease that damages the lungs and makes breathing difficult), and muscle weakness (a lack of physical or muscle strength, throughout the body).</p> <p>During a record review, Resident 94's MDS dated [DATE], indicated Resident 94's cognition was severely impaired. Resident 94 required substantial/maximal assistance with all ADL.</p> <p>During a record review of Resident 95's admission record, indicated Resident 95 was admitted to the facility on [DATE], with diagnoses that included, hypertension (Also known as high or raised blood pressure, a condition in which the blood vessels have persistently raised pressure causing a high blood pressure reading), and muscle weakness.</p> <p>During a record review, Resident 95's MDS dated [DATE], indicated Resident 95's cognition was severely impaired. Resident 95 required substantial/maximal assistance with all ADL.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056334
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review, Resident 97's admission record, indicated Resident 97 was admitted to the facility on [DATE], with diagnoses that included, muscle weakness, and anxiety disorder (restlessness, worried, tense, or afraid of what may happen in the future).</p> <p>During a record review, Resident 97's MDS dated [DATE], indicated Resident 97's cognition was severely impaired. Resident 97 required substantial/maximal assistance with all ADL.</p> <p>During a record review, Resident 165's admission record, indicated Resident 165 was admitted to the facility on [DATE], with diagnoses that included, pressure ulcer (also known as bedsore or pressure sore, is damage to the skin and underlying tissue caused by prolonged pressure, due to lying or sitting in one position for too long), of sacral region (the area between the lower back and the tailbone), and diabetes Type 2.</p> <p>During a record review, Resident 165's MDS dated [DATE], indicated Resident 165's cognition was moderately impaired. Resident 165 required substantial/maximal assistance with all ADL.</p> <p>During a record review, Resident 188's admission record, indicated Resident 188 was admitted to the facility on [DATE], with diagnoses that included, depression, (a constant feeling of sadness and loss of interest), and diabetes Type 2.</p> <p>During a record review, Resident 188's MDS dated [DATE], indicated Resident 188's cognition was moderately impaired. Resident 188 required substantial/maximal assistance with all ADL.</p> <p>During a record review, Resident 454's admission record, indicated Resident 454 was admitted to the facility on [DATE], with diagnoses that included, hypertension, muscle weakness, and diabetes Type 2.</p> <p>During a record review, Resident 454's MDS dated [DATE], indicated Resident 454's cognition was intact. Resident required substantial/maximal assistance with all ADLs.</p> <p>During an interview and concurrent record review on 6/24/25 at 1:10 PM with Certified Nursing Assistant (CNA) 6, the facility document titled Feeders was reviewed. CNA 6 stated staff have a list of feeders assigned to Restorative Nurse Assistants (RNAs - CNAs with specialized training in restorative care, focusing on helping patients regain or maintain their physical function and independence) and CNAs. CNA 6 stated while pointing on the document, that Resident 165, and all the people (Residents 37, 97, 94, 95, 165, 188, and 454) on the list are feeders.</p> <p>During an interview on 6/24/25 at 2:38 PM the Director of Staff Development (DSD) stated the residents who need assistance with feeding have a specific staff (RNAs and CNAs) assigned to feeds them (residents). The DSD stated that residents that are fed or need assistance with feeding are called the feeders.</p> <p>During an interview on 6/24/25 at 2:48 PM, the Interim Director of Nursing (IDON) stated, it is a matter of respect and dignity that the residents are addressed by their name, even if they do not understand what you are saying to them.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record record review, the facility policy and procedures (P&P) titled Assistance with Meals revised 1/2025, indicated Policy Statement Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.</p> <p>Policy Interpretation and Implementation.</p> <ol style="list-style-type: none"> 1. Facility Staff will serve resident trays and will help residents who require assistance with eating. 2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: <ol style="list-style-type: none"> A. Not standing over residents while assisting them with meals. B. Keeping interactions with other staff to a minimum while assisting residents with meals; C. Avoiding the use of labels when referring to residents (e.g., feeders).

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's staff failed to ensure for One of one sampled resident (Resident 10):</p> <ol style="list-style-type: none"> 1. Had a physician's order to self-administer a medical nutritional supplement/tube feeding formula via bolus feeding (a method of enteral tube feeding where a large dose of formula is administered into the stomach or small intestine over a short period of time, typically 15-20 minutes, several times a day) 2. Was assessed, educated and determined to have cognitive and physically demonstrated capability to safely self-administer a bolus feeding. <p>These deficient practice had the potential to result in negative outcomes from food inhalation which could lead to adverse reactions, unnecessary hospitalization and possible poor outcomes for Resident 10.</p> <p>Cross reference F693</p> <p>Findings:</p> <p>During a review of Resident 10's admission record indicated Resident 10 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that include malignant neoplasm of larynx (a cancerous tumor that develops in the larynx (voice box)), Malignant neoplasm of the esophagus (a cancerous tumor that develops in the esophagus, the tube connecting the throat to the stomach), gastrostomy status (presence of a gastrostomy tube surgically placed into the stomach for feeding or medication administration), pneumonitis (inflammation of the lung tissue, often triggered by inhaled irritants) due to inhalation of food and vomit, lack of coordination (lack of voluntary muscle coordination) and, chronic respiratory failure (when the lungs are unable to adequately exchange gases)</p> <p>During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 05/27/2025 indicated the resident 10's cognition (The mental ability to make decisions of daily living) was intact, Resident 10's could not ingest food orally, and required supervision, or touching assistance with oral hygiene.</p> <p>During a facility tour on 6/25/2025 at 8:34 AM, Resident 10's bedside drawer was observed to have an open water pitcher (a container designed for serving water to patients) that had brown/tan liquid inside and a piston syringe (a medical device used for injecting fluids into or withdrawing fluids from the body) inside the water pitcher.</p> <p>During an interview on 6/25/2025, at 8:43 AM, Licensed Vocational Nurse (LVN) 14 was unable to state the name of the liquid inside the open water pitcher at Resident's 10's bedside. LVN 14 stated I don't know what that is.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2025, at 8:57 AM, Resident 10 stated the tan/brown liquid in the water open water pitcher was Jevity (a medical product, specifically a tube feeding formula used for nutritional support in individuals who cannot eat or have difficulty eating),</p> <p>During an interview on 6/25/2025, at 9:00 AM Registered Nurse (RN) 6 stated Resident 10 self-boluses the feeding and has a physician's orders and has been care-planned to self-administer the Jevity independently.</p> <p>During a review of Resident 10's physician order summary dated 6/27/2025 indicated Resident 10 had an order for Jevity 1.5 viat gravity (Bolus) 237 ml, 5 times per day (1185ml/1778kcal) give water 50ml before and after each bolus feeding.</p> <p>During a review of Resident 10's physician order summary dated 6/27/2025 indicated there was not order for Resident 10 to self-administer/bolus his g-tube feeding.</p> <p>During an interview on 6/27/2025 at 5:02 PM Acting Director of Nursing (DON) stated Residents are only allowed to self-administer g-tube feeding at bedside if they have been assessed to have cognitive and physically demonstrated they can safely able to do so and have a physician approval, DON stated self-administering without a physicians order and/or assessment and education can lead to negative outcomes from food inhalation which could lead to an adverse reactions, unnecessary hospitalization and possible poor outcomes,</p> <p>During a review of the facility policy and procedures (P&P) titled, Self-Administering of Drugs dated 01/2025, the P&P indicated:</p> <ol style="list-style-type: none"> 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. 2. In addition to the general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: <ol style="list-style-type: none"> a. Ability to read and understand medication labels. b. Comprehension of the purpose and proper dosage and administration time for his or her medications. c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them; and d. Ability to recognize risks and major adverse consequences of his or her medications. 		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure to provide a Notice of Medicare Non-Coverage (NOMNC, is a document used in Medicare [a Federal health insurance program] to inform beneficiaries when their Medicare-covered services are ending, and to explain their appeal rights) to one of three sampled resident ' s (Resident 254), representative (responsible party).</p> <p>This failure had the potential to result in Resident 254's representative not being able to exercise their right to file an appeal.</p> <p>Findings:</p> <p>During a review of Resident 254's admission Record, the admission Record indicated the facility admitted Resident 254 on 6/9/2025, with diagnoses including unspecified heart failure heart does not pump as well as it should), unspecified dementia(a progressive state of decline in mental abilities), unspecified edema (swelling caused by an abnormal accumulation of fluids in the body ' s tissues), hypertension(high blood pressure), dysphagia(difficulty swallowing), generalized muscle weakness, unsteadiness on feet, malaise(overall weakness or discomfort), and unspecified disorientation(a state of being confused).</p> <p>During a review of Resident 254's History and Physical (H&P) dated 6/9/2025, the H&P indicated the resident had limited decision-making capacity.</p> <p>During a review of Resident 254's Minimum Data Set (MDS- a resident assessment tool) dated 6/19/2025, the MDS indicated Resident 254 was dependent (helper does all of the effort) from the staff for toileting, and tub/shower transfer, required substantial/maximal assistance (helper does more than half the effort) from the staff with bathing/shower self, had frequent urinary incontinence(involuntary leakage of urine) and always incontinent of bowel(losing control of bowel movements).</p> <p>During a concurrent interview and record review on 6/25/2025 at 3:12p.m., with the Infection Preventionist/Case Management (IPC, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment), Resident 254's Case Management Notes, dated 6/17/2025 were reviewed. The IPC stated Resident 254 was discharged home with family. The Case Management Notes indicated, informed Resident 254's Family Member (FM)1 of the discharge for 6/19/2025, and the financial responsibility beginning on 6/20/2025, should the resident remain in facility. The Case Management Notes indicated FM1 stated Resident 254 was unable to return home in Resident 254's current condition.</p> <p>During a concurrent interview and record review on 6/26/2025 at 2:25p.m., with Registered Nurse (RN)2, Resident 254's NOMNC form dated 6/16/2025 was reviewed. The NOMNC indicated a voicemail was left on 6/16/2025 at 11:24a.m. The NOMNC indicated information on how the responsible party could file an appeal and notification by certified mailed to representative and return receipt requested if direct phone contact could not be made. RN 2 stated she (RN2) did not speak with FAM1. RN2 stated she (RN2) only left a message once and did not attempt another phone call. RN2 stated she (RN2) did not send the NOMNC notice by certified mail according to the form's instructions.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/27/2025 at 9:49a.m. with the Interim Director of Nursing (IDON), Resident 254's NOMNC form was reviewed. The IDON stated the NOMNOC form was incomplete, it was not completed according to the instructions. The IDON stated the importance of the beneficiary notification was to be completed so the resident or the resident's family or representative had enough time to make an informed decision about their care and have enough time to plan their care and aware of their resources or even appeal if they choose to.</p> <p>During a review of the document provided by the facility titled Notice of Medicare Non-Coverage (NOMNC), the document indicated, How to contact your Beneficiary and Family Centered Care Quality Improvement Organization to ask for a fast appeal . How to appeal if the resident or representative believes the services are ending too soon.</p> <p>During a review of the facility's job description titled Case Manager, undated, the job description indicated, Coordinate care with resident, care providers, facilities financial services .</p> <p>During a review of the facility's policy and procedure(P&P) titled, Resident ' s Rights, dated January 2025, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents in this facility. These rights include the resident ' s right to be informed what rights . he or she has .</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one out of one sampled resident (Resident 404) was free from physical restraint by failing to ensure that the physicians order for hand mittens indicated a reason for the use of the mittens in accordance with the facility's policy and policy (P&P) titled Physician Orders with a revised date of 1/2025.</p> <p>This deficient practice had the potential to result in unnecessary restraints and placed the residents at risk of physical harm from impeding the circulation of resident 404's arms.</p> <p>Findings:</p> <p>During a review of Resident 404's admission Record, the admission record indicated the facility admitted Resident 404 on 4/8/2025 with diagnoses including encephalopathy (a disease or damage that affects the brain, leading to a change in how it functions), hypertension (HTN-high blood pressure), and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 404's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2025, the MDS indicated Resident 404 was cognitively impaired (ability to think, read, learn, remember, reason, express thoughts, and make decisions). The MDS indicated Resident 404 was dependent on staff for assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 404's physician's order dated 5/29/2025, the physician's order indicated Ok for patient to have bilateral hand mittens. Check</p> <p>every 2 hours while in place for skin integrity and circulation every shift.</p> <p>During a concurrent interview and record review, on 6/26/2025, at 3:16 P.M., with the Registered Nurse Supervisor (RNS 1), RNS 1 reviewed Resident 404's physician's order dated 5/29/2025 and stated the physicians order for bilateral hand mittens was missing the indication (reason for use) for the mittens. RNS 1 stated the indication for the order was required to ensure facility staff knew what the order was for and so that facility staff would be able to monitor the resident's behavior. RNS 1 stated the missing indication for the order could lead to inadequate communication between the facility, the provider (doctor) and the resident's family. RNS 1 stated the missing indication for the order could also lead to facility staff not being able to monitor the resident for the restricted movement caused by the hand mittens.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/27/2025, at 5:35 P.M., with the Interim (temporary) Director of Nursing (IDON) reviewed physician's order dated 5/29/2025 and stated the physician's order was incomplete. The IDON stated Resident 404's hand mitten order was missing an indication for the order. The IDON stated the indication for the physician's order allowed the facility staff and the resident/family to know why the resident had the order for hand mittens. The IDON stated the indication for the use of hand mittens needed to be consistent with the resident's plan of care. The IDON stated not having the indication for the use of hand mittens could prevent staff from knowing what behavior the resident was being monitored for and would help to determine if there was a need for the order.</p> <p>During a review of the facility policy and procedures (P&P), titled, Physician Orders revised 1/2025, indicated,</p> <p>6. Orders for medications must include:</p> <p>e. Reason or problem for which given.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>Based on observation, interview, and record review, the facility failed to follow through with the Preadmission Screening and Resident Review (PASARR- a federally required screening to help identify individuals with possible serious mental illnesses requiring a specialized follow up evaluation) recommendation to obtain a PASRR level II (assessment that determines if resident's mental condition could be met in the nursing facility or if the individual requires specialized services) evaluation for one of two sampled residents (Resident 150).</p> <p>This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 150.</p> <p>Findings:</p> <p>During a review of Resident 150's admission Record, the admission record indicated the facility admitted Resident 150 on 12/5/2023 and readmitted the resident to the facility on 1/25/2025 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 150's Minimum Data Set (MDS - a standard assessment and care screening tool) dated 5/23/2025, the MDS indicated Resident 150 was cognitively intact (ability to think, read, learn, remember, reason, express thoughts, and make decisions). The MDS indicated Resident 150 required supervision to set up and/or clean up assistance from staff for activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of resident 150's PASARR level I dated 7/24/2024, the PASARR level 1 indicated the assessment was positive for a serious mental illness (SMI - a mental health condition that significantly disrupts a person's ability to function in daily life, impacting their thoughts, feelings, and behaviors) and that level II mental health evaluation was required.</p> <p>During a review of resident 150's notice of attempted evaluation dated 7/24/2024, the evaluation notice indicated the PASARR level II evaluation for serious mental illness (SMI) was not able to be completed.</p> <p>During a concurrent interview and record review, on 6/27/2025, at 5:24 P.M., the Director of Nursing (DON) reviewed Resident 150's PASARR level I, and the notice of attempted evaluation. The DON stated the DON was responsible for ensuring that PASARR level II's were completed. The DON confirmed by stating Resident 150's PASARR level II was not completed because facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the PASARR I screening (7/24/25). The DON stated the facility did not follow up to complete PASARR level II and the facility should have. The DON stated PASARR level II needed to be completed to gather information to help with the care of the residents, to ensure that the resident was right for the facility and to ensure there was no lapse in care.</p> <p>(continued on next page)</p>		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, PASRR, dated 1/2025, indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admissions Screening and Resident Review (PASARR) process. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential residents that are outlines in the evaluation.		

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NAME OF PROVIDER OR SUPPLIER Beachwood Post-Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15th Street Santa Monica, CA 90404	
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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to refer and provide podiatry service to one of two sampled residents (Resident 62). Resident 62 has not seen a podiatrist since the resident's admission on [DATE] (1 year and 4 months ago).</p> <p>This deficient practice placed Resident 62 at risk for pain or discomfort.</p> <p>Findings:</p> <p>During a review of Resident 62's admission Record indicated the facility was originally admitted Resident 62 on 2/26/2024 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 62's risk for skin breakdown care plan, initiated 2/26/2024, indicated the resident was at risk for skin breakdown due to prolonged periods of time sitting on electric wheelchair, COPD and DM. A review of the care plan also indicated the interventions included to check skin during daily care provisions, notify the physician of abnormal findings, minimize exposure of skin to moisture from incontinence, wound drainage, or perspiration and to refer the resident to podiatry.</p> <p>During a review of the Social Services Note, dated 7/9/2024, indicated Resident 62 was referred to podiatry services. The Social Services Note further indicated the resident was to see the podiatrist on the next visit, however the visit was not scheduled at that time.</p> <p>During a review of the Resident 62's History and Physical, dated 8/24/2024, indicated the resident had the capacity for medical decision making.</p> <p>During areview of Resident 62's Minimum Data Set (MDS-a resident assessment tool), dated 5/13/2025, indicated Resident 62's cognition was moderately impaired. The MDS also indicated Resident 62 was dependent on staff for toileting hygiene, showering/bathing, and personal hygiene.</p> <p>During a review of Resident 62's At Risk for Skin Breakdown care plan, initiated 2/26/2024, indicated was at risk for skin breakdown due to prolonged periods of time sitting on electric wheelchair, COPD and DM. A review of the care plan also indicated the interventions included to check skin during daily care provisions. Notify physician of abnormal findings, minimize exposure of skin to moisture from incontinence, wound drainage, or perspiration and to refer to podiatry.</p> <p>During an interview on 6/25/2025 at 9 AM, Resident 62 stated he has resided at the facility for one and a half years and has not seen a podiatrist. Resident 62 stated social services never scheduled a podiatrist to visit the resident. Resident 62 stated the growth of the toenails causes him pain.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/26/2025 at 11:50 AM, the Social Service Director (SSD) reviewed Resident 62's electronic health record. SSD stated the podiatrist visits the facility every two months. The SSD Resident 62 was referred to podiatry in July 2024, however the resident was never seen by the podiatrist. SSD stated there are no documentation that a podiatry visit was requested or attempted.</p> <p>During an interview on 6/27/2025 at 5:01 PM, the Interim Director of Nursing (IDON) stated social services schedules podiatry visits. The IDON also stated it was the expectation a resident would be seen within two weeks to a month once a referral was made. The IDON further stated a possible outcome could of not having a podiatry visit would be discomfort from toenails or overgrown toenails.</p> <p>During a review of the facility undated policy and procedure (P&P) titled, Ancillary Services (Dental, Podiatry, Hearing, Vision, Psychiatry Psychology), revised 1/2025, indicated each resident shall undergo a review of ancillary services needs prior to or within 90 days of admission. The P&P also indicated:</p> <ol style="list-style-type: none"> 1. Residents shall be offered ancillary services as needed. 2. Examinations will be made by the resident's personal doctor or by the facility's Consultant providers. 3. Records of ancillary services and care providers shall be made a part of the residence medical record. 4. Upon conducting an ancillary examination, a resident needing ancillary services shall be referred to a personal doctor or facility's consulting provider. 		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled resident's (Resident 162) urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) was securely anchored (secured to the resident) per the resident's per the resident's physician order.</p> <p>This deficient practice had the potential for the resident to endure pain from potential pulling tractions and dislodgement of the catheter that may result in urethral (a muscular structure that helps keep urine in the bladder until voiding can occur) trauma.</p> <p>Findings:</p> <p>During a review of Resident 162's admission record indicated the facility admitted Resident 162 on 5/20/2024 with diagnoses that included neuromuscular bladder dysfunction (condition in which the nerves and muscles controlling the bladder do not work together properly), heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and dementia (a progressive state of decline in mental abilities)</p> <p>During a review of Resident 162's Minimum Data Set (MDS - a resident assessment tool), dated 5/12/2025, indicated the resident had severe cognitive (ability to acquire and understand knowledge) impairment. The MDS also indicated the resident had an indwelling urinary catheter and was not part of a toileting program. The MDS further indicated and required partial/moderate assistance with toileting hygiene, bathing and dressing.</p> <p>During a review of the physician orders, dated 6/10/2025, indicated Resident 162 was to receive the following care:</p> <ol style="list-style-type: none"> 1. Staff were to secure indwelling urinary catheter with stabilization device (goal reduce pulling and friction) change every Wednesday and as needed if soiled/peeling. 2. Foley Catheter size 16 French (fr - measurement of the catheter's outer diameter) with 10 milliliter (ml) bulb. Monitor for placement and function as needed. 3. Irrigate indwelling urinary catheter with 60 milliliters of normal saline as needed for clogging <p>During a review of Resident 162's Has Indwelling Catheter care plan, initiated 5/20/2024, indicated Resident 162 had a urinary catheter related to neuromuscular bladder dysfunction. The care plan indicated a goal was for the resident will not have catheter related trauma (injury that can occur during the insertion, use, or removal of a urinary catheter. These injuries can range from minor discomfort to severe damage to the urethra [tube that connects urinary bladder to the body exit], bladder or surrounding tissues). The interventions included to monitor for signs/symptoms of discomfort on urination and to use Foley catheter strap to secure the catheter.</p> <p>During an observation on 06/25/25 at 9:04 AM, Resident 162's was observed lying in bed with an indwelling catheter draining yellow urine.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview and record review on 06/26/25 at 8:55 AM with Licensed Vocational Nurse (LVN) 4 inside Resident 162's room, Resident 162's urinary catheter care was observed. LVN 4 stated Resident 162's catheter was not anchored to the resident's leg or to the bed. LVN 4 then reviewed the physician orders and stated there was a physician order for a stabilization device and LVN 4 would apply one.</p> <p>During an interview on 6/27/25 at 5:00 PM, the Interim Director of Nursing (IDON) stated staff are to secure resident's catheter to maintain the catheter's placement and prevent moving. The IDON also stated the catheter tubing is secured so that the foley catheter will not be dislodged.</p> <p>During a review of the facility policy and procedures P&P titled, Catheter Care, Urinary, revised 1/2025, the P&P indicated, staff were to ensure that the [urinary] catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh). The P&P further indicated staff were to report unsecured catheters to the supervisor. Be observant of skin irritation.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Complete annual performances evaluations and annual skills competencies for eight of eight employees. <p>This deficeint practice had the potential to cause harm to the residents.</p> <ol style="list-style-type: none"> 2. Licensed nurses did not identify discrepancy (difference) between the medication on hand and what the medical doctor (MD) ordered for Resident 9. 3. Three of Three sampled Licensed Vocational Nurses (LVNs- 9, 11, and 13) were not able to correctly identify basic nursing dosage calculation conversions including the conversions from one ounce (oz - standard unit of weight) to milliliters (ml - a unit of volume) and from a tablespoon (tbsp - a common prescription used to dose liquid medications) to milliliters. 4. One of nine licensed nurses did not use proper dosing measurement tools to accurately measure the medication for Resident 157 as ordered by the MD. <p>These deficient practices of failing to identify the discrepancy between the medication on hand and what the MD ordered, basic nursing dosage calculation conversions, and accurately measuring medications using proper dosing tools had the potential to cause physical and psychological harm to Residents 9 and 157.</p> <p>Cross Reference F759 and F760</p> <p>Findings:</p> <p>During an interview and concurrent record review on 6/24/2025 from 2:45 PM, eight of eight employee files were reviewed with Director of Staff Development (DSD) and the following were noted:</p> <ol style="list-style-type: none"> 1. House Keeping Supervisor-no annual tuberculosis (TB, is caused by bacteria that are spread through the air from person to person) skin test, last background check was 2017, last sexual harassment prevention completion was 3/7/2017, there was no annual physical and competencies. 2. LVN 9-TB Skin Test Report 1st step dated 4/2 (no year indicated), no date of skin test reading. The employee health examination was incomplete, Personal protective equipment (PPE, is equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) competency was incomplete, the room cleaning check list incomplete, and the terminal room cleaning check list incomplete. 3.LVN 10 with hire date of 9/3/2020 there was no current TB skin test, no current elder abuse screening, last annual employee health questionnaire/physical 9/3/2020, there were no annual skills competencies. <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. RN 3 with date of hire of 5/7/2023, the last elder abuse training was completed on 5/7/2023, and the last background check 6/12/2023.</p> <p>5. LVN 16 with hire date of 4/29/2016, the last annual physical was dated 12/28/2018, last TB skin test was dated 2/2/2018, BLS/CPR (BLS [Basic Life Support] and CPR [Cardiopulmonary Resuscitation] are medical procedures used to save lives in emergency situations) card with expiration date of 5/2025, and a background check dated 12/22/2015.</p> <p>6. Respiratory Therapist (RT -) is a healthcare professional specializing in the diagnosis, treatment, and the last competency 10/13/2021,</p> <p>7. RT 2 with hire date of hire 5/31/2018, there was no current abuse training, annual skills, current physical, and no TB skin test,</p> <p>8. RT Lead with hire date of 9/20/2022, the last background check was completed on 5/15/2025, there was no annual skills competency, no TB skin test, no background check, no abuse training, and no annual physical.</p> <p>During the same interview and concurrent record review with the DSD, the DSD stated sexual harassment training is renewed every two years. The DSD stated that the staff physicals and TB skin test are supposed to be completed yearly, the fire safety and CPR cards are supposed to be renewed every two years. The DSD further stated that the abuse training was supposed to be completed quarterly and as needed. The DSD stated performance evaluations annual skills competencies are to be completed by the DSD. The DSD stated if annual skills competencies are not completed annually, the staff can forget how to care for the residents competently in which it could cause harm to the residents. The DSD further stated all employee documents should be kept in the employee files and readily accessible.</p> <p>During a review of the facility's policy and procedures (P&P) titled Competency of nursing Staff with a revised date of 1/2025, the P&P indicated,</p> <p>Policy Interpretation and implementation:</p> <p>3. The facility assessment includes an evaluation of the staff competencies annually that are necessary to provide the level and types of care specific to the resident population.</p> <p>2. During a review of Resident 9's admission Record (face sheet - a document containing demographic and diagnostic information) indicated Resident 9 was admitted on [DATE] and was readmitted on [DATE] with the following diagnoses: neuromuscular dysfunction of the bladder (neuromuscular dysfunction of the bladder), peptic ulcer (a condition that causes ulcers (open sores) to develop in the lining of your digestive tract), gastroesophageal reflux (GERD - digestive disorder where stomach acid flows back into the esophagus), tracheostomy (a surgical procedure that creates an opening in the neck, directly into the windpipe, to assist breathing), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), dependence on supplemental (extra) oxygen, gastrointestinal hemorrhage (a type of bleeding in the gut), and persistent vegetative state (a severe neurological condition characterized by a lack of awareness of oneself and the environment, despite the presence of sleep-wake cycles and basic reflexes).</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 9's History and Physical (H&P - a physician's complete patient examination) dated 1/04/2025 indicated, Resident 9 did not have capacity to understand and make medical decisions.</p> <p>During a review of Resident 9's MDS dated [DATE], indicated, Resident 9 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 157 was completely dependent on staff for all self-care (the act of attending to one's physical or mental health) needs.</p> <p>During a review of Resident 9's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for June 2025 indicated, an MD ordered to give Resident 9 Polyethylene Glycol 1450 powder 17 milligram (mg - unit of measure) with 8 oz of water and stir with disposable spoon via gastrostomy tube (G-Tube - a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and meds) two times a day for constipation.</p> <p>During a review of Resident 157's admission Record indicated Resident 157 was admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses: atherosclerotic heart disease (damage or disease in the heart's major blood vessels), idiopathic hypotension (low blood pressure that develops without a known, identifiable cause), benign prostatic hyperplasia with lower urinary tract symptoms (frequent urination, a sudden urge to urinate, waking up at night to urinate), resistance (the act or power of resisting, opposing, or withstanding to multiple antibiotics), and history of other infectious and parasitic diseases (previously experienced infections or parasitic infestations that are not specified elsewhere in their medical history).</p> <p>During a review of Resident 157's H&P dated 5/27/2025 indicated, Resident 157 did not have capacity to make medical decisions.</p> <p>During review of Resident 157's Minimum Data Set (MDS - a resident assessment tool) dated 5/27/2025, indicated that Resident 157 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 157 was completely dependent on staff for all self-care (the act of attending to one's physical or mental health) needs.</p> <p>During review of Resident 157's MAR for June 2025 indicated, an MD ordered to give Resident 157 Psyllium Husk Powder (psyllium husk bulk - a dietary fiber supplement in a powder form helps with constipation) to give 1 tablespoon (tbsp) via gastrostomy tube (G-Tube - a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and meds) one time a day for bowel management, hold if loose stool, add 8 oz of fluid, stir well .</p> <p>During a review of Resident 157's MD Progress Notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 6/24/2025, indicated Resident 157 did not have capacity to make medical decisions.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a concurrent medication pass observation and interview on 6/25/2025 at 8:27 AM with Licensed Vocational Nurse (LVN) 11, LVN 11 was observed using a white plastic spoon to scoop out fiber powder (psyllium husk) medication from the medication container then placed the fiber powder in a 30 mL measuring cup. LVN 11 was then observed transferring the fiber powder into a 9 oz clear cup then added water without measuring 1 tbsp of fiber powder and 8 oz water as ordered by the MD. Just before LVN 11 was about to enter resident's room to gown up then pass the medications to Resident 157, the writer asked LVN 11 to demonstrate how LVN 11 measured 1 tbsp of fiber powder. LVN 11 observed take a white plastic spoon from the medication cart, placed the spoon about 6 inches in front of LVN 11's face while frowning. When asked if the spoon is what LVN 11 uses to measure 1 tbsp of fiber powder, LVN 11 stated, Ahhh .yeah, this is a tablespoon while rolling her eyes. When LVN 11 was asked why LVN 11 did not use any measuring tools to measure 1 tbsp of fiber powder and 8 oz of water as ordered by the MD, LVN 11 was very quiet and did not answer. the writer. When asked how many mL was in a tbsp (correct answer 15 mL), LVN 11 she was very quiet .then shook her head, stated I don't know. When asked how many mL was in an ounce (correct answer 30 mL), LVN 11 stated, I don't know. LVN 11 it is important to follow MD's order by measuring 1 tbsp of fiber powder and 8 oz of water prior to administering the medication to Resident 157 for accuracy because too much fiber can cause Resident 157 to have diarrhea (loose stools), dehydration, tiredness, and stomach pain.</p> <p>During a concurrent observation, interview, and record review on 6/25/2025 at 8:27 AM with LVN 11 and LVN 13, Resident 9's MAR for 6/2025 was reviewed and a bottle of Polyethylene Glycol 3350 was inspected. LVN 11 did not read the bottle of Polyethylene Glycol 3350 on hand to compare with the MD's orders. LVN 11 stated the MAR indicated Polyethylene Glycol 1450 while the bottle indicated Polyethylene Glycol 3350. When asked LVN 11 if LVN 11 prepared the correct dose of Polyethylene Glycol for Resident 9, LVN 11 did not answer and remained quiet. LVN 11 then asked LVN 13 to check the medication room for Polyethylene Glycol 1450. LVN 13 returned and stated, we don't have that on stock, our house stock is always the 3350 (Polyethylene Glycol) . We never had (Polyethylene Glycol) 1450.</p> <p>During an interview on 6/25/2025 at 11:35 AM with LVN 13, LVN 13 was asked for a basic nursing dosage calculation of how much mL was in a tbsp, LVN 13 answered 16 mL (correct answer 15 mL). LVN 13 was asked for a basic nursing dosage calculation of how much mL was in an oz, LVN 13 was not able to provide any answers (correct answer 30 mL).</p> <p>During an interview with LVN 9, on 6/25/2025 at 12 PM, LVN 9 was asked for a basic nursing dosage calculation of how much mL was in a tbsp, LVN 9 answered 2.5 mL (correct answer 15 mL).</p> <p>During an interview with the Interim Director of Nursing (IDON), on 6/25/2025 at 2:58 PM, the IDON stated licensed nurses who administer medications to residents were expected to follow MD orders as written and to use their resources they have to measure properly.</p> <p>During an interview with the IDON, on 6/25/2025 at 3:42 PM, the IDON stated, if the nurse staff notices the MAR is different from what they have on hand, then they need to reach out to the MD for clarification. IDON also stated IDON expected the licensed nurses should reach out to MD to clarify and state what we have on hand and what we have as an order and to clarify with the MD how [MD] would like us to proceed.</p> <p>During a review of the facility's P&P titled Administering Medications with a revision date of January 2025, indicated, medications shall be administered .as prescribed and medications must be administered in accordance with the orders.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of 5 percent (%-unit of measurement) or less with 25 opportunities, for two of two sampled residents (Residents 9 and 157) during the medication administration, when:</p> <ol style="list-style-type: none"> 1. Licensed nurses did not identify discrepancy (difference) between the medication on hand and what the medical doctor (MD) ordered for Resident 9. 2. Three of three sampled Licensed Vocational Nurses (LVNs- 9, 11, and 13) were not able to correctly identify basic nursing dosage calculation conversions including the conversions from one ounce (oz - standard unit of weight) to milliliters (ml - a unit of volume) and from a tablespoon (tbsp - a common prescription used to dose liquid medications) to milliliters. 3. One of nine licensed nurses did not use proper dosing measurement tools to accurately measure the medication for Resident 157 as ordered by the MD. <p>This deficient practice resulted in 8% medication error rate and had the potential to cause physical and psychological harm to Residents 9 and 157.</p> <p>Cross Reference F726 & F760</p> <p>Findings:</p> <p>During a review of Resident 9's admission Record (face sheet - a document containing demographic and diagnostic information), the admission Record indicated Resident 9 was admitted on [DATE] and was readmitted on [DATE] with the diagnoses that included neuromuscular dysfunction of the bladder (neuromuscular dysfunction of the bladder), peptic ulcer (a condition that causes ulcers [open sores] to develop in the lining of your digestive tract), gastroesophageal reflux (GERD - digestive disorder where stomach acid flows back into the esophagus), tracheostomy (a surgical procedure that creates an opening in the neck, directly into the windpipe, to assist breathing), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), dependence on supplemental (extra) oxygen, gastrointestinal hemorrhage (a type of bleeding in the gut), and persistent vegetative state (a severe neurological condition characterized by a lack of awareness of oneself and the environment, despite the presence of sleep-wake cycles and basic reflexes).</p> <p>During a review of Resident 9's History and Physical (H&P - a physician's complete patient examination) dated 1/04/2025, the H&P indicated Resident 9 did not have the capacity to understand and make medical decisions.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 157's admission Record, the admission Record indicated Resident 157 was admitted to the facility on [DATE] and was readmitted on [DATE] with the diagnoses that included atherosclerotic heart disease (damage or disease in the heart's major blood vessels), idiopathic hypotension (low blood pressure that develops without a known, identifiable cause), benign prostatic hyperplasia with lower urinary tract symptoms (frequent urination, a sudden urge to urinate, waking up at night to urinate), resistance (the act or power of resisting, opposing, or withstanding to multiple antibiotics), and history of other infectious and parasitic diseases (previously experienced infections or parasitic infestations that are not specified elsewhere in their medical history).</p> <p>During a review of Resident 157's H&P, dated 5/27/2025, the H&P indicated Resident 157 did not have the capacity to make medical decisions.</p> <p>During a review of Resident 157's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/27/2025, the MDS indicated Resident 157 had severely impaired cognition (the mental ability to make decisions of daily living). The MDS indicated Resident 157 was completely dependent on staff for all self-care (the act of attending to one's physical or mental health) needs.</p> <p>During a review of Resident 9's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for June 2025, the MAR indicated that an MD ordered to give Resident 9 Polyethylene Glycol (a medication that is used in the management and treatment of constipation) 1450 powder 17 milligrams (mg - unit of measure) with 8 oz of water and stir with disposable spoon via gastrostomy tube (G-Tube - a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and meds) two times a day for constipation.</p> <p>During a review of Resident 157's MAR for June 2025, the MAR indicated that an MD ordered to give Resident 157 Psyllium Husk Powder (psyllium husk bulk - a dietary fiber supplement in a powder form helps with constipation) to give 1 tablespoon (tbsp) via gastrostomy tube (G-Tube - a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and meds) one time a day for bowel management, hold if loose stool, add 8 oz of fluid, stir well .</p> <p>During a review of Resident 157's MD Progress Notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 6/24/2025, the Progress Notes indicated Resident 157 did not have capacity to make medical decisions.</p> <p>During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had severely impaired cognition. The MDS indicated Resident 9 was completely dependent on staff for all self-care (the act of attending to one's physical or mental health) needs.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Beachwood Post-Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15th Street Santa Monica, CA 90404	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/25/2025 at 8:27 AM with LVN 11, LVN 11 was observed using a white plastic spoon to scoop out fiber powder (psyllium husk) medication from the medication container then placed the fiber powder in a 30 milliliter (ml - a unit of volume) measuring cup. LVN 11 was then observed transferring the fiber powder into a 9 ounce (oz - standard unit of weight) clear cup then added water without using any measuring tools to accurately measure 1 tbsp of fiber powder and 8 oz of water as ordered by the MD. Just before LVN 11 was about to enter resident's room to gown up then pass the medications to Resident 157, the writer asked LVN 11 to demonstrate how LVN 11 measured 1 tbsp of fiber powder. LVN 11 was observed taking a white plastic spoon from the medication cart, placing the spoon about 6 inches in front of LVN 11's face. When asked if the spoon is what LVN 11 uses to measure 1 tbsp of fiber powder, LVN 11 stated, Ahhh .yeah, this is a tablespoon. When asked that LVN 11 did not use any measuring tools to measure 1 tbsp of fiber powder and 8 oz of water as ordered by the MD, LVN 11 did not provide any answers. When asked for a basic nursing dosage calculation of how much mL is in a tbsp measurement (correct answer 15 mL), LVN stated I don't know. When asked how much mL equals an ounce (correct answer 30 mL), LVN 11 did not provide an answer. When asked about the importance to follow MD's order by measuring 1 tbsp of fiber powder and 8 oz of water prior to administering the medication to Resident 157, LVN 11 stated for accuracy.</p> <p>During a concurrent observation and interview on 6/25/2025 at 8:27 AM, with LVN 11 and LVN 13, Resident 9's MAR for 6/2025 was reviewed and a bottle of Polyethylene Glycol 3350 was inspected. LVN 11 did not read and compare the bottle of Polyethylene Glycol 3350 on hand with the MD's orders. When asked what the medication on hand indicated, LVN 11 stated Polyethylene Glycol 1450, and when asked what MD order indicated on the MAR, LVN 11 stated Polyethylene Glycol 3350. When asked if the medication LVN 11 prepared for Resident 9 was the correct medication ordered by the MD, LVN 11 did not provide any answers but asked LVN 13 to check the medication room for Polyethylene Glycol 1450. LVN 13 returned and stated, we don't have that in stock, our house stock is always 3350 .we never had [1450].</p> <p>During an interview on 6/25/2025 at 11:35 AM with LVN 13, when asked for a basic nursing dosage calculation of how much mL was in a tbsp, LVN 13 answered 16 mL (correct answer 15 mL). When asked for a basic nursing dosage calculation of how much mL was in an oz, LVN 13 was not able to provide any answers (correct answer 30 mL).</p> <p>During an interview on 6/25/2025 at 12 PM with LVN 9, when asked for a basic nursing dosage calculation of how much mL was in a tbsp, LVN 9 answered 2.5 mL (correct answer 15 mL).</p> <p>During an interview on 6/25/2025 at 2:58 PM with Interim Director of Nursing (IDON), the IDON stated licensed nurses who administer medications to residents were expected to follow MD orders as written and to use their resources they have to measure properly.</p> <p>During an interview on 6/25/2025 at 3:42 PM with IDON, the IDON stated if the nurse staff notices the MAR is different from what they have on hand, then they need to reach out to the MD for clarification. The IDON also stated IDON expected the licensed nurses should reach out to MD to clarify and state what we have on hand and what we have as an order and to clarify with the MD how [MD] would like us to proceed.</p> <p>During a review of the facility's policy and procedures (P&P) titled Administering Medications with a revision date of January 2025, the P&P indicated, medications shall be administered .as prescribed and medications must be administered in accordance with the orders.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of nine sampled residents (Residents 9, 37, and 157) were free from significant medication errors (an error in medication preparation or administration that can cause the resident discomfort or jeopardizes his or her health and safety) according to professional standards of practice by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 37's Insulin Lispro (man-made version of human insulin used to manage blood sugar levels in people with diabetes [DM: a chronic condition where the body does not produce or use insulin properly, leading to high blood sugar levels]) Injection Solution 100 Unit/mL (milliliters) Inject 18 units subcutaneously (beneath the skin) before meals for DM 2 Rotate site. Hold for blood sugar (BS) less than (&lt;) 100 and notify medical doctor (MD) if BS&lt;80 or greater than (&gt;) 400 was administered before dinner on 6/23/2025. 2. Ensure Licensed Vocational Nurse (LVN) 11 identified the discrepancy (differences) between the medication on hand and what the medical doctor (MD) ordered for Resident 9. 3. Ensure LVN 11 used the correct dosing tools to accurately measure Psyllium Husk Powder (psyllium husk bulk - a dietary fiber supplement in a powder form that helps with constipation) for Resident 157. 4. Three of three sampled Licensed Vocational Nurses (LVNs- 9, 11, and 13) were not able to correctly identify basic nursing dosage calculation conversions including the conversions from one ounce (oz - standard unit of weight) to milliliters (ml - a unit of volume) and from a tablespoon (tbsp - a common prescription used to dose liquid medications) to milliliters. 5. One of nine licensed nurses did not use proper dosing measurement tools to accurately measure the medication for Resident 157 as ordered by the MD. <p>These deficient practices had the potential to result in:</p> <ol style="list-style-type: none"> 1. Resident 37 suffering from complications caused by uncontrolled blood sugar, organ failure, and death. 2. The facility residents being underdosed or overdosed with medications, which could result in serious injury, harm, or death. 3. Resident 157 experiencing stomach issues, electrolyte loss, dehydration, organ failure, and death. <p>Cross Reference: F726, F759</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. During a review of Resident 37's admission record, the admission record indicated the facility admitted the resident on 3/31/2025, with diagnoses that included DM, muscle weakness (a lack of physical or muscle strength, throughout the body), and Alzheimer's disease (progressive mental decline due to generalized breakdown of the brain).</p> <p>During a review of Resident 37's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/24/2025, the MDS indicated Resident 37's cognition (the mental ability to make decisions of daily living) was moderately impaired. The MDS indicated Resident 37 required substantial/maximal assistance with all activities of daily living (ADL's: activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>During a review of Resident 37's physician's order dated from 3/31/2025 to 4/1/2025, the orders indicated an active order of Insulin Lispro Injection Solution 100 Unit/ML Inject 18 unit subcutaneously before meals for DM 2 Rotate site. Hold for BS<lt;100 and notify MD if BS<lt; (less than) 80 or >gt; (greater than) 400.</p> <p>During an interview on 06/24/2025 at 11:27 AM, Resident 37 stated she did not get her insulin before dinner time on 6/23/2025 when the Resident's blood sugar was 140. Resident 37 stated the nurse just left after checking the blood sugar and did not come back to administer the insulin shot before dinner that evening.</p> <p>During a concurrent interview and record review on 6/24/2025 at 11:31 AM, LVN 1 reviewed Resident 37's record for diabetic medication administration record dated 6/23/2025 at 5:45 PM and stated LVN 2 did not administer Resident 37's Insulin Lispro Injection before dinner on 6/23/2025 when the resident's blood sugar was 141 grams per deciliter (g/dl).</p> <p>During a concurrent interview and record review on 06/26/25 at 02:40 PM, the Interim Director of Nursing (IDON) reviewed Resident 37's diabetic medication administration record and stated that nursing staff were required to follow doctor's orders regarding Resident care. The IDON stated LVN 2 did not administer Resident 37's Insulin Lispro Injection before dinner time on 6/23/2025.</p> <p>During a review of the facility's policies and procedures (P&P) titled Insulin Administration revised 1/2025, the P&P indicated the purpose of the policy was to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 2. Check blood glucose per physician order or facility protocol. 7. Check and re-check that the type of insulin on the vial matches the type of insulin ordered. 8. Check the order for the amount of insulin. 11. Double check the order for the amount of insulin. 14. Re-check that the amount of insulin drawn into the syringe matches the amount of insulin order.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 9's admission Record, the admission record indicated the facility admitted the resident on 3/03/2014 and readmitted the resident on 1/03/2025 with diagnoses that included neuromuscular dysfunction of the bladder (the nerves controlling the bladder are not working properly), peptic ulcer (a condition that causes ulcers (open sores) to develop in the lining of your digestive tract), gastroesophageal reflux (GERD - digestive disorder where stomach acid flows back into the esophagus), tracheostomy (a surgical procedure that creates an opening in the neck, directly into the windpipe, to assist breathing), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), dependence on supplemental (extra) oxygen, gastrointestinal hemorrhage (a type of bleeding in the gut), and persistent vegetative state (a severe neurological condition characterized by a lack of awareness of oneself and the environment, despite the presence of sleep-wake cycles and basic reflexes).</p> <p>During a review of Resident 9's History and Physical (H&P - a physician's complete examination) dated 1/04/2025, the H&P indicated Resident 9 did not have capacity to understand or make medical decisions.</p> <p>During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had severely impaired cognition. The MDS indicated Resident 157 was completely dependent on facility staff for all self-care (the act of attending to one's physical or mental health) needs.</p> <p>During a review of Resident 9's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for June 2025, the MAR indicated an MD ordered to give Resident 9 Polyethylene Glycol 1450 (laxative) powder 17 milligram (mg - unit of measure) with 8 oz of water and stir with disposable spoon via gastrostomy tube (G-Tube - a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and meds) two times a day for constipation.</p> <p>3. During a review of Resident 157's admission Record, the admission record indicated Resident 157 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis that included atherosclerotic heart disease (damage or disease in the heart's major blood vessels), idiopathic hypotension (low blood pressure that develops without a known, identifiable cause), benign prostatic hyperplasia with lower urinary tract symptoms (frequent urination, a sudden urge to urinate, waking up at night to urinate), resistance (the act or power of resisting, opposing, or withstanding to multiple antibiotics), and history of other infectious and parasitic diseases (previously experienced infections or parasitic infestations that are not specified elsewhere in their medical history).</p> <p>During a review of Resident 157's H&P dated 5/27/2025, the H&P indicated Resident 157 did not have the capacity to make medical decisions.</p> <p>During a review of Resident 157's MDS dated [DATE], the MDS indicated Resident 157 had severely impaired cognition. The MDS indicated Resident 157 was completely dependent on staff for all self-care needs.</p> <p>During a review of Resident 157's MAR for June 2025, the MAR indicated an MD ordered to give Resident 157 Psyllium Husk Powder to give 1 tablespoon (tbsp) via gastrostomy tube one time a day for bowel management, hold if loose stool, add 8 oz of fluid, and stir well.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 157's MD Progress Notes dated 6/24/2025, the notes indicated Resident 157 did not have the capacity to make medical decisions.</p> <p>During a concurrent medication preparation observation and interview on 6/25/2025 at 8:27 AM with LVN 11, LVN 11 was observed using a white plastic spoon to scoop out fiber powder (psyllium husk) medication from the medication container then placed the fiber powder in a 30 mL measuring cup. LVN 11 was then observed transferring the fiber powder into a 9 oz clear cup then added water without using any measuring tools to accurately measure 1 tbsp of fiber powder and 8 oz of water as ordered by the MD. When LVN 11 was asked why LVN 11 did not use any measuring tools to measure 1 tbsp of fiber powder and 8 oz of water as ordered by the MD, LVN 11 was quiet and did not provide any answers. When LVN 11 was asked how much mL was in a tbsp (correct answer 15 mL), LVN stated I don't know. When LVN 11 was asked how many mL was in an ounce (correct answer 30 mL), LVN 11 continued to be quiet. LVN 11 never provided the surveyor with any answers. LVN 11 was asked why it was important to follow MD's order by measuring 1 tbsp of fiber powder and 8 oz of water prior to administering the medication to Resident 157, LVN 11 stated for accuracy.</p> <p>During a concurrent observation and interview on 6/25/2025 at 8:27 AM with LVN 11 and LVN 13, LVN 11 was observed not comparing the medication on hand to what the MD ordered for Resident 9, which was as written on the MAR. LVN 11 was asked what the medication on hand indicated, LVN 11 stated Polyethylene Glycol 1450 and what MD order indicated on the MAR, LVN stated Polyethylene Glycol 3350. The surveyor asked LVN 11 if the medication LVN 11 prepared for Resident 9 was the correct medication, LVN 11 remained quiet. LVN 13 stated the went to check if the facility had Polyethylene Glycol 1450 in stock and returned and stated we don't have that in stock, our house stock is always the 3350 . we never had [1450].</p> <p>During an interview on 6/25/2025 at 11:35 AM with LVN 13, LVN 13 was asked how many mL was in a tbsp, LVN 13 answered 16 mL (correct answer 15 mL). LVN 13 was asked how much mL was in an oz, LVN 13 was not able to provide any answers (correct answer 30 mL).</p> <p>During an interview on 6/25/2025 at 12 PM with LVN 9, LVN 9 was asked for a how much mL was in a tbsp, LVN 9 answered 2.5 mL (correct answer 15 mL).</p> <p>During an interview on 6/25/2025 at 2:58 PM with Interim (temporary) Director of Nursing (IDON), the IDON stated licensed nurses who administered medications to residents were expected to follow MD orders as written and to use their resources they have to measure properly.</p> <p>During a follow up interview on 6/25/2025 at 3:42 PM with the IDON, the IDON stated if the nurse staff notices the MAR is different from what they have on hand, then they need to reach out to the MD for clarification. The IDON stated licensed nurses should reach out to MD to clarify and state what we have on hand and what we have as an order and to clarify with the MD how [MD] would like us to proceed.</p> <p>During a review of the facility policy and procedure (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 Administering Medications with a revision date of January 2025, indicated, medications shall be administered .as prescribed and medications must be administered in accordance with the orders.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure unopened insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) vials requiring refrigeration were stored in a refrigerator according to the manufacturer's requirements in one of five inspected medication carts (3rd Floor East Medication Cart).</p> <p>This deficient practice of failing to store medication per the manufacturer's requirements had the potential to lead the medication to reduced potency, making the medication less effective or even causing adverse reactions.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 06/27/2025 at 07:56 AM, of (3rd Floor East Medication Cart), with Licensed Vocational Nurse (LVN) 7, one vial of insulin Lispro (a medication used to control blood sugar) for Resident 39 and another one for Resident 17 were observed unopened and stored in the medication cart. LVN 7 confirmed the observation and stated the medications should be stored in the refrigerator. LVN 7 stated it is important to follow manufacturer's instructions because the medication may become ineffective. LVN 7 also stated nurses are to store unopened vials of insulin in the refrigerator and they will place the insulin inside the medication refrigerator. LVN 7 further stated staff are to follow manufacturers' guidelines to maintain the effectiveness of the medication.</p> <p>During an interview on 06/27/2025 at 5:03 PM, the Interim Director of Nursing (IDON) stated unopened insulin vials are stored in the refrigerator until they are opened. The IDON stated not adhering to the manufacturer's recommendations might affect the medication's effectiveness.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Storage of Medications, revised 1/2025, the P&P indicated medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility facility failed to ensure the kitchen staff stored food in a sanitary manner to prevent growth of microorganisms that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food), as well as toxins when:</p> <ol style="list-style-type: none"> 1. a. Food was not appropriately stored b. Food was not labeled c. Prepared leftover tuna was not stored in the refrigerator d. Dietary staff did not follow cool down method e. Multiple food items were not labeled with expiration dates f. The ice machine and the kitchen stove were dirty with old, dried food, and debris. g. Clean water pitchers for the residents were stored on a cart with dirty dishes stored on the bottom of the cart. h. Employee water bottle sitting next to the clean cups on the counter top. <ol style="list-style-type: none"> 2. The walk in freezer floor in the kitchen had brown/blackish stains 3. The dish washing sink had a leaking pipe and green corrosion. 4. Four of Four residents outside food storage refrigerators had multiple food items not labeled properly, had no thermometer in the refrigerator freezers, and with expired dates. 5. A container of strawberry yogurt & granola parfait (written keep refrigerated observed at bedside) for one of one residents (Resident 73). <p>These deficient practices had the potential to result to expose Resident 73 and all residents at increased risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and unnecessary hospitalization.</p> <p>Findings:</p> <p>During an observation on 24/25 at 8:31 a.m., of the refrigerator in the kitchen with Dietary Supervisor (DS), there was no label:</p> <p>On the brown box or the bag containing corn tortillas</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On broccoli covered with a plastic wrap on a tray</p> <p>On pieces of bread in a tray</p> <p>On meat in a pan; and</p> <p>On cold cooked sliced cut turkey.</p> <p>During an interview on 6/24/25 at 8:49 a.m., DS stated that food must be labeled with the food item, delivery date, best by or expiration date to make sure that the food being used is not expired. DS stated not labeling food can place the resident's health in danger by vomiting, indigestion, possibly food poisoning.</p> <p>During an observation and concurrent interview with License Vocational Nurse (LVN) 10 on 6/24/2025 at 9:03 a.m., the residents refrigerator for outside food storage on the 5th floor, the following were observed:</p> <ul style="list-style-type: none"> -A clear food storage container with cooked food in it without a name received date, or expiration date or used by date -A brown paper container with no resident name or used by date -A plastic container with open cheese without a used by date or resident name -A container of whole milk without a residents name or expiration date -A bag of assorted candies without a residents name or expiration date -A bottle of grape juice without a residents name -A bottle open bottle of health aide kombucha without a residents name or expiration date -2 containers of activia yogurt without a residents name on the container. <p>LVN 10 stated it is the license nurse's responsibility to label and store the resident's food in the residents outside food storage refrigerator. LVN 10 stated the housekeeper is responsible to discard food that have expired, are not labeled, or have been in the refrigerator no longer than 3 days. LVN 10 stated if the residents consume expired foods, they can become very sick and can become septic (is a life-threatening medical emergency where the body's response to an infection spirals out of control, damaging its own tissues and organs).</p> <p>During an observation and concurrent interview with Registered Nurse Supervisor (RNS) 3 on 6/24/2025 at 9:33 a.m., the residents refrigerator for outside food storage on the 4th floor, the following were observed:</p> <ul style="list-style-type: none"> - No thermometer in the freezer. - Vanilla ice cream without a name or expiration date <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Beachwood Post-Acute & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15th Street Santa Monica, CA 90404	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- A container of sour cream container with no open date or resident name</p> <p>- A container of sour cream with expiration date of 5/14/2025.</p> <p>RNS 3 stated it is the license nurse's responsibility to properly store, date, and label all the resident's food that is brought in from the outside. RNS 3 stated if any of the residents consume expired foods, they can acquire food borne illness, have vomiting, stomach aches, and become very ill. RNS 3 stated it is the duty of the housekeeper to clean and discard old foods from the residents outside food storage refrigerators.</p> <p>During an observation and concurrent interview with LVN 16 on 6/24/2025 at 10:13 a.m., the residents refrigerator for outside food storage on the 3rd floor, observed three clear containers not labeled or dated. LVN 16 stated that it is the license nurse's responsibility to store, date, and label all foods brought in from the outside and stored in the resident refrigerator. LVN 16 stated if the residents consume expired foods, they can become very ill.</p> <p>During an observation and concurrent interview with Maintenance Supervisor on 6/24/2025 at 12:26 p.m., the residents refrigerator for outside food storage on the 2nd floor, the following were observed:</p> <p>-A container of caviar with no residents name and date</p> <p>-CMAK drink with no resident's name or open date</p> <p>-ABC/[NAME] drink without resident's name or open date.</p> <p>Maintenance Supervisor stated if the residents consume expired foods the residents could get food poisoning, severe stomachache, and vomiting.</p> <p>During a followup observation of the kitchen with the DS on 6/25/2025 at 8:04 a.m., a large amount of water in the dish washing area was observed on the floor. A pipe under the kitchen sink was covered in a green substance/corrosion and was also leaking water. The DS stated it is the responsibility of the Maintenance Supervisor to monitor and repair the leaking pipes in the kitchen. DS stated the maintenance Supervisor is aware of the leaking pipe in the kitchen.</p> <p>During an observation and concurrent interview on 6/25/2025 at 8:24 a.m., Dietary [NAME] was noted preparing raw fish and cooking bacon, onions, chicken broth using the same gloves. Dietary [NAME] stated he is not supposed to use the same gloves to cook food and prepare raw fish. Dietary [NAME] stated it is important to change gloves and wash my hands after preparing raw fish. The Dietary cook stated he caused cross contamination by not changing gloves and not washing hands after preparing raw fish and it could make the residents very sick and the residents could get an infection.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and concurrent interview on 6/25/2025 at 8:55 a.m., with the Dietary Supervisor state the cooks are not supposed to use the same gloves to prepare raw foods and cook hot foods because the practice will cause cross contamination and can make the residents very sick. During an observation of the kitchen stove noted to be dirty, old, dried food and debris. An employee personal water bottle was also observed located next to the juice machine and clean cups. The Dietary Supervisor stated staff are not supposed to have their personal water bottles in the kitchen or in the work area due to infection control. The Dietary Supervisor stated employee personal water bottles should be kept in the employee lounge.</p> <p>During an observation and concurrent interview on 6/25/25 at 9:46 a.m., with the Maintenance Supervisor, a large amount of water was observed on the kitchen floor. Also observed was water leaking from the pipe under the kitchen sink for washing dishes, and a large orange industrial fan in the kitchen that was blowing air on high speed. Maintenance Supervisor stated he fixed the leaking pipe one year ago and that he had sanded the green corrosion from the pipe under the sink in the kitchen. Maintenance Supervisor stated none of the kitchen staff notified him that the pipe was leaking water.</p> <p>During a record review, the facility policy and procedures (P&P) titled Outside food Storage and Refrigerator Policy with a revised date of 1/2025, indicated: Purpose:</p> <p>To provide a safe and sanitary process for the storage, labeling, and monitoring of outside food items brought into the facility by family, friends, or residents themselves, in accordance with federal (42 CFR &sect;483.60) and California Title 22 requirements for food safety in Skilled Nursing Facilities. Policy Statement: Beachwood Post-Acute & Rehab supports residents' rights to receive and consume food from outside sources. However, for the health, safety, and infection control of all residents, any outside food stored in the facility must be handled, labeled, and stored appropriately in designated food-safe conditions. 2. Labeling Requirements:</p> <p>All outside food must be clearly labeled with Residents full name, Date received, and Use-by date. Unlabeled or improperly stored food will be discarded.</p> <p>3. Refrigeration and storage Guidelines:</p> <p>Perishable food must be refrigerated within 2 hours of arrival. Items stored in the resident refrigerator must be:</p> <ul style="list-style-type: none"> -Kept in sealed leak proof containers -Labeled as described above -Discarded after 3 days, unless otherwise specified by nursing or dietary. <p>During a record review, the facility P&P titled Ice Machines and Ice Storage Chest revised on 1/2025, indicated:</p> <p>Policy Statement: Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review, the facility P&P titled Maintenance Service revised on 1/2025 indicated: Policy Statement: Maintenance services shall be provided to all areas of the building, grounds, and equipment.</p> <p>b. During a record review, Resident 73's admission record indicated Resident 73 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included heart failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), pneumonia (an infection that affects one or both lungs), dysphagia (difficulty swallowing), tracheostomy status (a surgical procedure to create an opening through the neck into the trachea (windpipe) to help with breathing), lack of coordination (muscle control problem that causes an inability to coordinate movements), type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high) and morbid obesity (chronic disease in which you have a body mass index [BMI-ratio of your height to your weight] of 40 or higher).</p> <p>During a record review, Resident 73's Minimum Data Set (MDS - a resident assessment tool) dated 3/24/2025, indicated Resident 73's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 73's ability to eat was not attempted and Resident 73 did not perform this activity prior to the current illness, exacerbation, or injury, Resident 73 required partial to moderate assistance with oral hygiene.</p> <p>During a record review of Resident 73's Order Summary dated 6/27/2025, indicated Resident 73 was on a regular diet, dysphagia mechanical soft texture, thin liquid consistency.</p> <p>During a tour observation of Resident 73's room on 6/25/25 at 10:18 AM, Resident 73 was observed asleep in bed. A container of strawberry yogurt & granola parfait (written keep refrigerated) was also observed at the resident's bedside table.</p> <p>During an interview on 06/25/25 at 10:22 AM Respiratory Therapist (RT) 2 stated Yogurt is not supposed to be at bedside, it should be kept refrigerated.</p> <p>During an interview with Director of Nursing (DON), DON stated Yogurt should not be left at bedside because yogurt is a dairy product and is at high risk for spoilage and/or contamination from pathogens that cause food borne illnesses such as stomach infection, which if consumed can lead to food borne illness, leading to unnecessary hospitalization, poor outcomes and even death.</p> <p>During a record review, the facility policy and procedures titled Food Receiving and Storage dated 01/2025, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices, Refrigerated foods must be stored below 41 degrees Fahrenheit unless otherwise specified by law, Food items and snacks kept on the nursing units must be maintained as indicated below, All food items to be kept below 41 degrees Fahrenheit must be placed in the refrigerator located at the nurses' station and labeled with a use by date.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment by failing to implement standard precautions (a set of infection control practices used to prevent the transmission of diseases) in the provision of care for two of two sampled residents (Residents 10 and 131).</p> <p>This deficient practice placed residents at a higher risk of acquiring and transmitting infections to other residents, staff and visitors in the facility.</p> <p>Findings:</p> <p>During a review of Resident 131's admission Record, the admission Record indicated Resident 131 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included asthma (a chronic [long-term] condition that affects the airways in the lungs), epilepsy (a condition that affects your brain and causes seizures [abnormal electrical activity in your brain that temporarily affects your consciousness, muscle control and behavior]), pneumonia (an infection/inflammation in the lungs) chronic pulmonary obstructive disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included malignant neoplasm of larynx (a cancerous tumor that develops in the larynx [voice box]), Malignant neoplasm of the esophagus (a cancerous tumor that develops in the esophagus, the tube connecting the throat to the stomach), gastrostomy status (presence of a gastrostomy tube surgically placed into the stomach for feeding or medication administration), pneumonitis (inflammation of the lung tissue, often triggered by inhaled irritants) due to inhalation of food and vomit, lack of coordination (lack of voluntary muscle coordination) and chronic respiratory failure (when the lungs are unable to adequately exchange gases).</p> <p>During a review of Resident 131's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 05/27/2025, the MDS indicated Resident 131's cognition (the mental ability to make decisions of daily living) was intact. Resident 131's could not ingest food orally and required supervision or touching assistance with oral hygiene.</p> <p>During a review of Resident 131's history and physical (H&P) dated, 6/11/2025, the H&P indicated Resident 131 had the capacity to understand and make decisions.</p> <p>During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10's cognition was intact. Resident 10's could not ingest food orally and required supervision, or touching assistance with oral hygiene.</p> <p>During a facility tour on 6/24/2025 at 10:10 AM, a partially used sterile saline solution for nebulizer (a device that turns the liquid medicine into a mist) inhalation vial was observed at Resident 131's bedside.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/24/25 10:16 AM, Respiratory Therapist (RT1) stated the partially used saline inhalation vial was not supposed to be at bedside. RT1 stated that once the saline solution is open and used, any unused residual saline solution left in the vial must be discarded to prevent re-use and respiratory infections.</p> <p>During a facility tour on 6/25/2025 at 8:34 AM, the following items were observed in Resident 10's bedside drawer:</p> <ul style="list-style-type: none"> a. an open water pitcher with Jevity (a medical product, specifically a tube feeding formula used for nutritional support in individuals who cannot eat or have difficulty eating). b. piston syringe (a medical device used for injecting fluids into or withdrawing fluids from the body) inside the water pitcher. c. urinal (a portable container used for urination, typically by individuals who have difficulty accessing traditional toilet facilities) with urine (the yellowish liquid waste that is released from the body when you urinate). e. an open can of soft drink. f. drinking cup with soft drink. g. and a bottle of sterile water. <p>During an interview on 6/25/2025 at 8:43 AM, Licensed Vocational Nurse (LVN 14) stated the Jevity bolus in an open water pitcher cup, the carbonated soft drink and saline bottle should not be placed next to a urinal with urine. LVN 14 further stated there is a risk of contamination from bodily fluid that could cause infection.</p> <p>During an interview on 06/27/25 04:15 PM, Respiratory Therapist (RT 2) Lead stated once a saline inhalation vial is open and used, residual saline liquids must be discarded; residual saline inhalation vials with liquids should not be left at bedside because it is considered contaminated and must be discarded; leaving a saline inhalation vial with residual saline at bedside places resident at risk of infection if residual saline is used on a resident.</p> <p>During an interview on 6/27/2025 at 5:02 PM, Acting Director of Nursing (ADON) stated Residents are only allowed to self-administer g-tube feeding at bedside if they have been assessed to have cognition and [residents] physically demonstrated they can safely be able to do so and have a physician approval. The ADON stated self-administering without a physician's order and/or assessment and education can lead to negative outcomes from food inhalation leading to adverse reactions, unnecessary hospitalization and possible poor outcomes.</p> <p>During a review of facility policy and procedures (P&P) titled, Infection Control, dated 05/2025 indicated, it is the policy of this facility to prevent the spread of infection. Standard Precautions will be used when always caring for residents regardless of their suspected or confirmed infection status.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility policy and procedure (P&P) titled, Food Receiving and Storage, dated 01/2025, the P&P indicated, foods shall be received and stored in a manner that complies with safe food handling practices. Food items kept on the nursing units must be maintained as indicated below:</p> <p>All food belonging to residents must be labeled with the resident's name, the item and the Use by date. Beverages must be dated when opened . Other opened containers must be dated and sealed or covered during storage.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to maintain the shared shower room on the 5th floor east in a safe and operating condition</p> <p>This deficient practice had the potential to result in resident injury and/or fall due to pieces of broken safety handles on the left side of the shower wall and a loose safety handle on the right side of the shower wall.</p> <p>Findings:</p> <p>During an observation on 6/24/2025 at 10:05 AM, of the East side shower room on the 5th floor in the facility, the safety hand railing on the left side in the shower was broken and the handrail to the right side of the same shower was loose.</p> <p>During a concurrent interview and observation on 06/24/25 10:19 AM, certified nursing assistant (CNA 1) stated the left side handrail was problematic because residents complained about it being in the way when they took showers. Residents primarily use the handrail to the right and in front, not the one to the left. CNA 1 also stated the handrail to the left had been broken for about two months. CNA 1 stated she was not sure how long the handrail on the right of the shower had been loose.</p> <p>During an interview on 6/24/2025 at 11:20 AM, Maintenance supervisor (MS) stated he was not aware of the broken handrail on the left, or the loose handrail on the right in shower room East. The MS stated now that he is aware of the problem which needs to be fixed right away. The MS stated he will have someone remove the remaining pieces of what the handrail was to the left. In addition, he will have someone tighten the siderail to the right.</p> <p>During an interview on 6/24/2025 at 12:22 PM, the Administrator (ADM) stated he has been made aware that the shower room on the fifth floor was fixed. The ADM stated maintenance staff keep a log of items and places in the facility that need to be repaired, and the staff prioritize repairs as they are made aware or as they are discovered upon inspection. The ADM further stated the handrails are very important for resident safety, and they (the handrails) have been fixed promptly.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Maintenance Service dated revised January 2025, the P&P indicated Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: <ol style="list-style-type: none"> a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards . f. Establishing priorities in providing repair service. <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was answered in a timely manner for three of three residents (Residents 23, 62, and 92) when the residents needed assistance with care including personal hygiene.</p> <p>This failure resulted in the residents becoming very upset, angry, and embarrassed. This deficient practice also had the potential for falls, injuries, and accidents.</p> <p>Findings:</p> <p>During a record review, Resident 62's admission record indicated Resident 62 was re-admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnoses of Heart Failure, and lack of coordination.</p> <p>During a record review, Resident 62's Minimum Data Set (MDS- a resident assessment tool) dated 5/13/2025, indicated Resident 62's cognitive skills [the core skills your brain uses to think, read, learn, remember, reason, and pay attention] for daily decision making was intact. The MDS further indicated Resident 62 needed minimal assistance with Activity of Daily Living (ADL- fundamental skills required to independently care for oneself, such as eating, bathing, and mobility).</p> <p>During a record review, Resident 62's care plan revised on 6/3/2025, indicated; Focus: 8/22/24 (Resident 62) readmitted with a diagnosis of generalized weakness.</p> <p>During a record review of Resident 92's admission record indicated Resident 92 was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnoses of muscle weakness, and Hemiplegia (paralysis that affects only one side of your body) and hemiparesis (is a mild or partial weakness on one side of the body).</p> <p>During a record review, Resident 92's History and Physical dated 2/17/2025, indicated Resident 92 has the capacity to make medical decision.</p> <p>During a record review Resident 92's MDS dated [DATE], indicated Resident 92's cognitive skills for daily decision making is intact. The MDS further indicated Resident 92 needed maximal assistance with ADL (toileting, personal hygiene, bathing, and mobility).</p> <p>During a record review of Resident 92's care plan revised on 6/3/2025, indicated; Focus: Resident 92 has an ADL self-care performance deficit r/t (related to) limited mobility.</p> <p>During a record review, Resident 23's admission record indicated Resident 23 was admitted to the facility on [DATE] and re-admitted on [DATE] muscle weakness, and colostomy status.</p> <p>During a record review, Resident 23's History and Physical dated 5/29/2025, indicated Resident 23 has the capacity to make medical decision.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review Resident 23's MDS dated [DATE], indicated Resident 23's cognitive skills for daily decision making is intact. The MDS further indicated Resident 23 needed maximal assistance with ADL such as toileting, personal hygiene, bathing, and mobility.</p> <p>During a record review, Resident 23's care plan revised on 6/1/25, indicated; Focus: Resident 23 has an ADL self-care performance deficit.</p> <p>During the Resident Council Meeting an interview on 6/25/25 at 11:03 a.m., Resident 23 stated on multiple occasions there was a delay of more than 30 minutes to 1 hour with the nurses answering the call light on the 11PM to 7AM shift. Resident 23 stated at times his call light was on so long that he fell asleep and never received colostomy (a surgical procedure that creates an opening [stoma] in the abdominal wall, connecting the colon [large intestine] to the outside of the body) care from the nurse. Resident 23 stated he would have to get out of bed into his wheelchair and go to the nurses station to get assistance from the nurses. Resident 23 stated this made him very angry and embarrassed because sometimes the colostomy bag would leak due to a delay in changing it.</p> <p>During the Residents Council Meeting on 6/25/25 at 11:28 a.m., Resident 62 stated during the 11PM to 7AM shift, the facility staff delay for more than 1 hour to answer his call light. Resident 62 stated he needed the nurses to empty his full urinal (a receptacle used for collecting urine, typically for patients who are unable to use a regular toilet) and almost urinated (passed urine) on himself due to the nurses not emptying his urinal. Resident 62 stated not answering the call lights makes him very upset to have to try to hold his urine until the nurse empties his urinal.</p> <p>During the Residents Council Meeting on 6/25/2025 at 12:03 p.m., Resident 92 stated on multiple occasions there is a delay in answering his call light on the 3PM to 11PM and 11PM to 7 AM shift. Resident 92 stated he experienced anger with the nurses due to being left soiled for more than 4 hours at times. Resident 92 stated he has reported the delay in answering the calls and to the Charge Nurses, but nothing is being done about it.</p> <p>During an interview on 6/25/25 at 2:36 p.m., the Director of Nursing (DON) stated the residents' call lights should be answered immediately to prevent the residents from falling, prevention of pressure ulcers from being left soiled. The DON stated the DON reminds staff daily of the importance of answering the residents call lights in a timely manner.</p> <p>During an interview on 6/25/25 at 3:03 p.m., License Vocational Nurse (LVN) 1 stated the residents call lights should be answered within 3 minutes or immediately to prevent falls, change in condition, pressure injuries, and for dignity.</p> <p>During a record review, the facility's policy and procedures titled Answering the Call Light with a date of 1/2025, indicated: Purpose:</p> <p>The purpose of this procedure is to respond to the resident's request and needs.</p> <p>General Guidelines:</p> <p>7. Answer the resident's call as soon as possible.</p>		