STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555039	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fireside Health Care Center	947 3rd Street Santa Monica, CA 90403

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1) who has severe cognitive impairment with no capacity to make decisions in accordance with facility's abuse policy and procedures. By failing to: 1. Implement the facility's policy and procedures (P&P) Abuse Prevention and Prohibition Program to protect residents from abuse by screening and training caregivers (a person who tends to the needs or concerns of a person with short- or long-term limitations due to illness, injury, or disability) two of two caregivers (CG1 and CG2). 2. Implement the facility's P&P Caregiver Policy that all caregivers for resident will undergo an orientation with the Director of Staff Development (DSD) which includes education on abuse, facility policy and procedures, and safety in the facility for two of two caregivers (CG1 and CG2). 3. Ensure the facility's Guest Liaison 1 (GL1- a person that ensures a seamless flow of communication and facilitates efficient utilization of resources) did not leave Resident 1 alone in the facility's patio on 7/23/2024 at 1:09 PM with Care Giver 1 (CG1- another resident's caregiver). 4. Ensure Activities Director 1 (AD1) who entered the facility's patio on 7/23/2024 at 1:13 PM and having heard a verbal altercation (a heated or angry dispute: noisy argument) and witnessed CG1 argue with Resident 1, AD1 did not leave Resident 1 alone with CG1. AD1 did not separate CG1 from Resident 1. AD1 left the patio and allowed the altercation to continue between CG1 and Resident 1. These deficient practices resulted in Resident 1 being subjected to physical abuse by CG1 while under the care of the facility. On 7/23/2024 at 1:15 PM, CG1 slapped Resident 1 on the face twice placing Resident 1 at increased risk to suffer severe pain, emotional distress (a highly unpleasant emotional reaction, severe body injury, serious impairment and/or death. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 947 3rd Street Santa Monica, CA 90403	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/13/2024 at 2:07 PM, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) situation in the presence of the Administrator (ADM), Director of Nursing (DON) and Infection Preventionist Nurse (IPN- a certified nursing professional who specializes in preventing and controlling infections in healthcare settings) due to the facility's failure to ensure Resident 1 was free from physical abuse and for the facility's failure to: 1. Implement the facility policy by acquiring and maintaining necessary records caregivers including background checks, abuse training, competency, and complete identifiable and contact information. 2. Ensure the facility's GL1 did not leave Resident 1 alone in the facility's patio on 7/23/2024 at 1:09 PM with CG1. 3. Ensure AD1 did not leave Resident 1 alone with CG1, did not separate CG1 from Resident 1, left the patio, and allowed the altercation to continue between CG1 and Resident 1. On 8/15/2022 at 5:05 p.m., the IJ was removed after the ADM and the DON submitted an acceptable removal plan (interventions to correct the deficient practices) which was verified and confirmed through observation, interview, and record review, and determined the IJ situation was no longer present. The acceptable removal plan was as follows: 1. On 8/13/24, the Caregiver for Resident 3 was removed until a background check, orientation, and abuse training could be completed. 2. On 8/13/2024, 8/14/2024, and 8/15/2024, the facility's Nurse Consultant Director Registered Nurse conducted in-service to all schedule staff (Nursing, housekeeping, dietary, rehab, laundry, maintenance, and administration) on types of abuse and screening, and abuse prevention, intervention, investigation, reporting and monitoring. 3. On 8/13/24, the facility created a Caregiver Logbook which was placed at the receptionist desk, whereby all future caregivers will be directed by the receptionist to verify or complete a background check, abuse training, and orientation. Visitors, vendors, family, and transport drivers will check-in at the kiosk. 4. Effective 8/14/24, Social Services shall conduct room rounds 5 days a week, at least 10 residents a day to monitor residents for concerns, grievances, or allegations of abuse. Any report of allegations of abuse will be documented and reported to the administrator immediately. All alleged abuse shall be investigated immediately for proper and appropriate reporting to required agencies. All findings shall be presented and discussed in the QA&A Committee Meetings. QAPI committee shall review and monitor the effectiveness of these processes monthly and then quarterly after three months or until 100% compliance is attained. 5. On 8/13/2024, AD1 was provided in-service by the Nurse Consultant Director RN by phone regarding abuse prevention and abuse policies including not to leave a resident alone after hearing a verbal altercation and must separate caregiver from resident as to not allow the alteration to continue. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. On 8/13/2024 and 8/14/2024, the Nurse Consultant RN in serviced AD1 regarding not leaving a resident alone during resident-to-resident altercation, 7. On 8/13/2024 and 8/14/2024, the Nurse Consultant RN in-serviced to all working and on-coming staff regarding abuse prevention, review of abuse policy, and the caregiver/visitor log. 8. On 8/13/24, an audit was performed by Medical Records Director for all residents to identify any residents utilizing caregivers - none were found. 9. The Director of Staff Development (DSD) will provide caregiver training for future caregivers starting 8/14/24 and will be on-going. 10. On 8/14/2024 at 2 PM, GL1 was in serviced by phone regarding not leaving a resident alone during resident-to-resident altercation. 11. The Medical Records Director (MRD) will audit monthly compliance of Caregiver Logbook and Visitor check in and report to the ADM all findings. All findings of noncompliance shall be presented and discussed in the QA& A (a systematic method used to ensure that a product or service meets the desired standards and requirements) Committee Meetings. QAPI committee (an interdisciplinary [combination of multiple academic disciplines into one activity] team that is responsible for developing and implementing plans to improve quality and safety in a healthcare organization) shall review and monitor the effectiveness of these processes monthly and then quarterly after three months. QAPI Committee shall focus and discuss further actions by developing a Performance Improvement Plan for areas or issues identified as recurring or trending negatively to implement a new or more effective plan of actions. Findings: During a review of Residents 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), hypertension (HTN - elevated blood pressure), and generalized muscle weakness (lack of physical or muscle strength). During a review of Resident 1's Minimum Data Set (MDS - a standard assessment and care screening tool) dated 7/15/2023, indicated Resident 1 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 was dependent on staff for toileting, shower, chair to bed transfer and personal hygiene. The MDS further indicated Resident 1uses a manual wheelchair for mobility and was dependent on staff to wheel and make turns. During a review of Resident 1's Change of Condition (COC -a sudden deviation from person/patient's baseline in physical, cognitive, behavioral or function) dated 7/23/2024 at 2:08 P.M., indicated Licensed Vocational Nurse 1 (LVN 1) documented that the administrative assistant saw . the caregiver (CG1) allegedly got up and slapped [Resident 1] in the face. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 8/3/2024 indicated Resident 1, does not have capacity for medical decision making due to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During an interview on 8/12/2024, at 7:30 A.M., with the Infection Preventionist Nurse (IPN), the IPN stated the facility had two caregivers who provided directed care to one resident (Resident 3). The IPN stated both caregivers were hired privately by the resident's family members. The IPN stated I don't know the full name and phone number of the caregiver who was involved in the incident or the second caregiver coming in (facility) later that is now taking care of [Resident 3]. During an interview on 8/12/2024, at 8:50 A.M., using public health translation services with Resident 1, Resident 1 was unable to recall the abuse incident by Resident 3's caregiver. Resident 1 was unable to confirm or deny if she felt safe in the facility. During an interview on 8/12/2024, at 9:45 A.M., with GL1, GL1 stated Resident 1 is mostly Farsi speaking. She used to speak some English when I first started working here. GL1 stated Resident 1, likes to spend the day on the patio and will typically seat with [Resident 3] and his [Resident 3's] caregiver who are both Farsi speaking. GL1 stated GL1 has been working at the facility for six months and that Resident 3's caregiver (CG1) has been there longer than that [CG1] was there (working in the facility) when I started. GL1 stated that on 7/23/2024 at around 1 P.M., Resident 1 was seating on the patio with other residents and watching television. GL1 stated Resident 1 was sharing a table with Resident 3 and CG1. GL1 stated Resident 1, Resident 3, and CG1's table, table was in the back, so the other residents didn't see what was going on when it (CG1 had the altercation with Resident 1 and then slapped Resident 1). GL1 stated LVN 1 came to the patio to give medications in a cup to Resident 1, but Resident 1 took the cup of medications and threw them in the air. GL1 stated GL1 picked up the medications and LVN 1 took the medications inside the facility. GL1 stated Resident 1 and CG1 started speaking to each other in Farsi, I don't know what they were talking about, but I could tell the conversation was heated (a discussion or quarrel where the people involved are angry and exited). GL1 stated AD1 had heard the commotion between Resident 3 and CG1 and came outside and helped to calm the situation. GL1 stated, [CG1] is gaslighting (a form of emotional abuse where one person manipulates another person into doubting their own perception, memories, and sanity) [Resident 1]. GL1 stated CG1 would normally help translate what Resident 1, is saying, but because the conversation seemed heated, I went into the building to get another Farsi speaking person because I didn't trust that [CG1] would translate the right information in that moment. GL1 stated that when CG1 was inside the facility and on the way back to the patio, I heard the caregiver slap [Resident 1] and then saw [CG1] slap [Resident 1]. GL1 stated when CG1 arrived at the patio, Resident 1 was no longer at the same table with Resident 3 and CG1. GL1 stated, [CG1] had moved [Resident 1] to the back of the patio which is further behind the tables that the residents' seat to watch television, is where she [CG1] slapped her [Resident 1]. GL1 stated she separated CG1 and Resident 1. GL1 stated GL1 informed the ADM who instructed her to inform the social worker about the incident. GL1 stated the social worker called the police officers who came to the facility about 10 minutes later. GL1 stated CG1 left the facility after CG1 spoke with the police officers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/12/2024, at 12:50 P.M., with the DON, the DON stated that caregivers coming into the facility are provided with orientation which includes abuse training, safety in the facility and provision of credentials such as background check, certificate, or license. The DON stated CG1 and caregiver 2 (CG 2), both have no documented evidence of a background check (search), and orientation which includes abuse training. The DON stated, It's my fault. I should have checked, I don't' have any background or orientation training on her (CG1) or the one (CG2) that is here now. The DON stated the facility did not have CG1 or CG2's last name or contact information. The DON stated, We only have Resident 3's family phone number. We called them (Resident 3's family), and they said they do not have her (CG1's) phone number or last name. The caregiver (CG 2) that is here right now, I will go and ask here for that information for you. The DON stated CG1 has been coming to the facility as Resident 3's caregiver for one year. During a concurrent record review and interview on 8/13/2024, at 2:45 P.M., with the ADM in the ADM's office, the facility's video surveillance (no sound) dated 7/23/2024, was reviewed. The video surveillance indicated the following: 1. On 7/23/2024 at 1:11 P.M., Resident 1 was seating at a table with Resident 3 and CG1, and GL1 was talking to Resident 1. 2. On 7/23/2024 at 1:12 P.M., LVN 1 was seating at the table next to Resident 1, handed Resident 1 a small cup and placed a glass of water on the table in front of Resident 1. Resident 1 then tossed out into the air and onto the ground, white looking particles. GL1 then picked up the white looking particles from the ground. 3. On 7/23/2024 at 1:13 P.M., the AD showed up at the table where Resident 1, Resident 3, CG1, GL1 and LVN 1 were at. The AD spoke to Resident 1 and then CG1. 4. On 7/23/2024 at 1:13 P.M., LVN 1 left and went inside the facility table. 5. On 7/23/2024 at 1:14 P.M., GL1 and the ADS both left the patio leaving Resident 1, Resident 3, and CG1 at the same table. 6. On 7/23/2024 at 1:14 P.M., Resident 1 stretched her right arm with closed fist toward CG1. 7. On 7/23/2024 at 1:15 P.M., Resident 1 was observed picking up a cup in front of her, on the table, and threw a clear liquid substance in the direction of the caregiver and it landed on the caregiver. 8. On 7/23/2024 at 1:15 P.M., CG1 unlocked the brakes of Resident 1's wheelchair (WC), pulled and wheeled Resident 1 on the WC backwards, turned the WC to Resident 1's left and around, and pushed the WC forward toward the patio furniture, that was a few feet away directly opposite the table where Resident 1 was seating, CG1 then locked the left side of Resident 1's WC and slapped the resident twice on the left cheek. During the same record review and interview, the ADM stated the incident between CG1, and Resident 1 could have been avoided by separating CG1 and Resident 1 immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 8/12/2024, at 9:54 A.M., with AD1, AD1 stated he was coming from the activities room and noticed that Resident 1 was escalated, (when someone becomes more agitated, angry, or violent in a situation) was very, very upset, her body gestures were a little larger than they usually are, her voice was more elevated. She (Resident 1) was yelling which I did not understand what she (Resident 1) was yelling at but apparently it was directed at the caregiver (CG1) that was there for the other resident. I talked to her (Resident 1), she seemed to have come down a little bit, so I continued to assist the residents in the activity room. During a review of facility's undated policy and procedures (P&P) title Caregiver Policy, indicated, Purpose: To ensure staff and caregivers are aware of expectations of the facility and care of resident. All Caregivers for resident will undergo an orientation with the Director of Staff Development. This orientation will include education on abuse, facility policy and procedures, and safety in the facility. In addition, DSD will check caregiver credentialing with appropriate agency. Caregivers on the facility will only be allowed to interact with the resident whom they have been hired for. During a review of facility's P&P dated 10/24/2022, title Abuse Prevention and Prohibition Program, indicated, Purpose: To ensure the facility establishes, operationalizes, and maintains an abuse prevention and prohibition program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. II. The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. A.Covered individuals will be trained through orientation and ongoing training sessions, no less that annually .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview and record review, the facility failed to investigate and report allegations physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for one out of three sampled residents (Resident 1) to the Department of Public Health, Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and to the local law enforcement in accordance with the facility's policy and procedures (P&P) titled Abuse Prevention and Prohibition Program dated 10/24/2022, by failing to report the unusual occurrence of a resident-to-caregiver altercation to the State Survey Agency (SSA) within 2 hours after the allegation occurred on 7/23/2024. This deficient practice had the potential to place Resident 1 at risk for elder abuse and delay onsite inspection by the Department of Public Health to ensure the residents' allegation of abuse was investigated. Cross Reference F600 Findings: A review of Residents 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), hypertension (HTN - elevated blood pressure), and generalized muscle weakness (lack of physical or muscle strength). A review of Resident 1's Minimum Data Set (MDS - a standard assessment and care screening tool) dated 7/15/2023, indicated Resident 1 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 was dependent on staff for toileting, shower, chair to bed transfer and personal hygiene. The MDS further indicated Resident 1uses a manual wheelchair for mobility and was dependent on staff to wheel and make turns. A review of Resident 1's Neuropsychiatric note dated 7/15/2024, indicated the resident had a 28/28 score for the mini mental state exam (MMSE -a set of questions used to check for cognitive impairment -a score of 25 or higher is said to be normal) A review of Resident 1's Change of Condition (COC -a sudden deviation from person/patient's baseline in physical, cognitive, behavioral or function) dated 7/23/2024 at 2:08 P.M., indicated Licensed Vocational Nurse 1 (LVN 1) documented that the administrative assistant saw . the caregiver allegedly got up and slapped [Resident 1] in the face. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 8/3/2024 indicated Resident 1, does not have capacity for medical decision making due to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During an interview on 8/12/2024, at 8:50 A.M., using public health translation services with Resident 1, Resident 1 was unable to recall the abuse incident by Resident 3's caregiver. Resident 1 was unable to confirm or deny if she felt safe in the facility. During an interview on 8/12/2024, at 9:45 A.M., with Guest Liaison 1 (GL1), GL1 stated Resident 1 is mostly Farsi speaking. She used to speak some English when I first started working here. GL1 stated Resident 1, likes to spend the day on the patio and will typically seat with [Resident 3] and his [Resident 3's] caregiver who are both Farsi speaking. GL1 stated GL1 has been working at the facility for six months and that Resident 3's Caregiver 1 (CG1) has been there longer than that [CG1] was there (working in the facility) when I started. GL1 stated that on 7/23/2024 at around 1 P.M., Resident 1 was seating on the patio with other residents and watching television. GL1 stated Resident 1 was sharing a table with Resident 3 and CG1. GL1 stated Resident 1, Resident 3, and CG1's table, table was in the back, so the other residents didn't see what was going on when it (CG1 had the altercation with Resident 1 and then slapped Resident 1). GL1 stated LVN 1 came to the patio to give medications in a cup to Resident 1, but Resident 1 took the cup of medications and threw them in the air. GL1 stated GL1 picked up the medications and LVN 1 took the medications inside the facility. GL1 stated Resident 1 and CG1 started speaking to each other in Farsi, I don't know what they were talking about, but I could tell the conversation was heated (a discussion or quarrel where the people involved are angry and exited). GL1 stated AD1 had heard the commotion between Resident 3 and CG1 and came outside and helped to calm the situation. GL1 stated, [CG1] is gaslighting (a form of emotional abuse where one person manipulates another person into doubting their own perception, memories, and sanity) [Resident 1]. GL1 stated CG1 would normally help translate what Resident 1, is saying, but because the conversation seemed heated, I went into the building to get another Farsi speaking person because I didn't trust that [CG1] would translate the right information in that moment. GL1 stated that when CG1 was inside the facility and on the way back to the patio, I heard the caregiver slap [Resident 1] and then saw [CG1] slap [Resident 1]. GL1 stated when CG1 arrived at the patio, Resident 1 was no longer at the same table with Resident 3 and CG1. GL1 stated, [CG1] had moved [Resident 1] to the back of the patio which is further behind the tables that the residents' seat to watch television from and that's where she [CG1] slapped her [Resident 1]. GL1 stated she separated CG1 and Resident 1. GL1 stated GL1 informed the ADM who instructed her to inform the social worker about the incident. GL1 stated the social worker called the police officers who came to the facility about 10 minutes later. GL1 stated CG1 left the facility after CG1 spoke with the police officers. During a concurrent interview and record review, on 8/13/2024, at 10:15 A.M., with Social Services Director (SSD), the fax confirmation log was to SSA dated 7/23/2023 was reviewed. The fax cover report to the SSA indicated time 5:33 P.M. The SSD stated, the incident happened around 1 PM, it (Incident report) have been faxed by 3:30 P.M., so that it (incident) can be addressed by the department of public health to make sure that the victim is safe, and the situation (Incident) can be investigated and evaluated timely. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/2024, at 1:47 A.M., with the Administrator (ADM), The ADM stated, GL called me around 1 P.M., and told me that the caregiver for Resident 3 had slapped Resident 1. The ADM stated, abuse allegations need to be reported within two hours to the three agencies to prevent delay in communication, investigation and to prevent noncompliance on our part. A review of facility's policy and procedures (P&P) dated 10/24/2022, title Abuse prevention and prohibition Program, indicated The facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source .immediately, but no later than two hours after forming the suspicion.