

|   |  |   |  |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555039 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY COMPLETED<br><br>09/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fireside Health Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>947 3rd Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524</b></p> <p>Based on interview and record review, the facility failed to ensure the Notice of Proposed Transfer and Discharge was provided to the resident as soon as practicable. The facility also failed to provide documentation to show that the State Long Term Care Ombudsman (public advocate) was notified of the transfer and discharge from the facility for one out of the three sampled residents (Resident 1).</p> <p>This deficient practice denied the residents additional protections from being inappropriately discharged and caused Resident 1 to have feelings of confusion and become upset.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, post-traumatic stress disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event), and major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts. It's characterized by a depressed mood, loss of interest, and other symptoms that last for at least two weeks).</p> <p>A review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 7/30/2024, indicated Resident 1, moderate cognitive impairment (a condition in which people have more memory or thinking problems than other people their age) and required between substantial/maximal assistance to supervision or touching assistance for Activities of Daily Living (ADLs) such as toilet transfer and chair/beds-to-chair transfer; toilet hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear.</p> <p>During a review of a physician ' s order dated 8/19/2024 indicated, discharge Resident 1 to another Skilled Nursing Facility (SNF- a type of inpatient facility that provides short or long-term skilled nursing care, and rehabilitation services to patients).</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 |
|---|-------|-----------|

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555039   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY COMPLETED<br><br>09/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fireside Health Care Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>947 3rd Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview with the Social Services Director (SSD) on 8/31/2024 at 1:49 pm, the SSD stated that she (SSD) had told Resident 1 had a day or two coverage left for his therapies and that there was a possibility of getting therapies reinitiated if he (Resident 1) was admitted to another SNF. The SSD admitted that had discussed the discharge on 8/19/2024 after which Resident 1 gathered his belongings and was on his way to the new SNF within an hour of the discussion. The SSD acknowledge that she had not given advance notice to Resident 1 nor the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities). The SSD stated that advance notice is given so that residents had time to prepare mentally and make sure that they have their belongings. The SSD stated the ombudsman must be given notice so that they (ombudsman) will do their investigation and ensure residents are getting their needs met.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled Transfer and Discharge, revised 10/24/2022, indicated, To ensure that residents are transferred and discharged from the Facility in compliance with state and federal laws and to provide complete, safe, and appropriate discharge planning and necessary information to the continuing care provider. The same P&amp;P indicated, Facility staff will provide the resident with reasonable advance notice of the transfer or discharge before it occurs. Unless exigent circumstances exist, the notice should be provided 30 days prior to the proposed date of transfer/discharge. Situations that may prevent 30 days' notice include:</p> <ul style="list-style-type: none"> <li>A. The resident poses a threat to the health or safety of other individuals at the Facility.</li> <li>B. The resident's health improves sufficiently to allow for more immediate transfer /discharge.</li> <li>C. The resident is experiencing urgent medical needs; or</li> <li>D. The resident has not resided in the Facility for 30 days.</li> </ul> |   |  |

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555039  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>09/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fireside Health Care Center  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>947 3rd Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45524</p> <p>Based on observation, interview, and record review, the facility failed to develop and/or implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the residents' needs for one of three sampled residents (Resident 1) by failing to:</p> <p>Develop an individualized/person-centered care plan with goals and interventions upon readmission for discharge plan to ensure a smooth and safe transition from the facility to the post-discharge setting.</p> <p>This failure resulted in Resident feeling confused and anxious.</p> <p>Cross reference F623.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, post-traumatic stress disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event), and major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts. It's characterized by a depressed mood, loss of interest, and other symptoms that last for at least two weeks).</p> <p>A review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 7/30/2024, indicated Resident 1, moderate cognitive impairment (a condition in which people have more memory or thinking problems than other people their age) and required between substantial/maximal assistance to supervision or touching assistance for Activities of Daily Living (ADLs) such as toilet transfer and chair/beds-to-chair transfer; toilet hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear.</p> <p>During an interview with the Social Services Director (SSD) on 8/31/2024 at 1:49 pm, the SSD admitted that there was no discharge care plan initiated for Resident 1. The SSD stated that the care plan was important because it helped the resident and the healthcare team work on the discharge goals, allowing for a smooth discharge.</p> <p>During an interview with the Director of Nursing (DOR) on 9/2/24 at 10: 10 am, the DOR confirmed that there was no discharge care plan developed for Resident 1. The DOR stated that discharge planning begins upon admission and admitted that a care plan should have been initiated to ensure that therapists were aware about what interventions to provide for the Resident 1.</p> <p>(continued on next page)</p> |   |  |

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555039  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>09/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fireside Health Care Center  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>947 3rd Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a review of the facility's policy and procedure (P&amp;P) titled Care Planning, revised 10/24/2022 indicated, A culturally competent and trauma-informed Comprehensive Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. The same P&amp;P indicated, Each resident's Comprehensive Care Plan will describe the following which included:</p> <ul style="list-style-type: none"> <li>- Discharge plans as appropriate in accordance with S483.21(c) including: <ul style="list-style-type: none"> <li>i. The resident's preference and potential for future discharge.</li> </ul> </li> </ul> |   |  |