

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  11/25/2024
NAME OF PROVIDER OR SUPPLIER  Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45524</p> <p>Based on interview and record review, the facility failed to follow the physician's orders were carried out by failing to provide one of three sampled residents (Resident 1) with a hospice (A program that provides care for people who are near the end of their life and have stopped treatment. Hospice offers physical, emotional, social, and spiritual support for patients and their families) agency during/upon discharge as ordered.</p> <p>This deficient practice resulted in Resident 1 receiving incomplete discharge information which caused confusion.</p> <p>Findings:</p> <p>During a review of the admission record indicated Resident 1 was i admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and hypertension (HTN-high blood pressure).</p> <p>During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2023, indicated Resident 1 had severe cognitive impairments (a condition that makes it very difficult for a person to remember things, learn, concentrate, or make decisions). The same MDS indicated Resident 1 supervision or touching assistance for most of her Activities of Daily Living such as: (ADLs - ADLs- oral hygiene, shower/bathe self, upper and lower body dressing, toileting hygiene)</p> <p>The discharge order dated 1/11/24 at 9:31 am indicated May discharge resident to home on 1/12/2024 with Hospice Care.</p> <p>During an inter with Family Member (FM) 1 on 11/23/2024 at 12:14 pm, FM 1 stated that when she learned that that Resident 1 was going to be on hospice, FM 1 requested to have Resident 1 discharged to her home with hospice services. FM 1 stated that hospice was discussed by facility staff, but no information or options were provided to her while Resident 1 was still in the facility. FM1 stated that she had called the facility and spoke with the Social Worker (SW) after Resident 1 arrived at home with no instructions of what to do to get the services started. FM 1 was then given a phone number to an agency which she felt was not credentialed because none of the forms they provided had a letterhead. FM 1 stated that the discharge process was very tedious and confusing.</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: 555039
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the SW on 11/25/2024 1:22 pm, the SW stated that when a resident is being discharged home with hospice, the resident and/or family members are provided options of agencies which helps the resident/family choose an agency of their choice. The hospice information must be provided during the discharge process for a timely initiation of services. The SW stated that providing the information while Resident 1 could have allowed for better communication. The SW admitted that shh had verified the hospice after the fact when FM 1 complained that the hospice provided was fake.</p> <p>During an interview with the Facility Administrator (FA) on 11/25/24 at 2:30 pm, the FA admitted that the hospice information was provided over the phone to FM 1 after Resident 1 was discharged . The FA stated that the hospice was verified but was unable to provide documentation as well as the specific date when the verification was done.</p> <p>During a review of the Policy and Procedure (P&amp;P) titled Transfer and Discharge, revised 10/24/2022 indicated the purpose 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.</p>		