

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  03/19/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45037</p> <p>The facility failed to take the appropriate corrective action to address grievances for two of two sampled residents (Residents 1 and 2) when:</p> <ol style="list-style-type: none"> <li>1. Resident 1 complained about a missing cellphone and clothing</li> <li>2. Resident 2 complained about missing clothing.</li> <li>3. Facility failed to complete inventory list for Resident 1 upon admission to the facility.</li> <li>4. The facility failed to investigate reports of missing property for Residents 1 and 2.</li> </ol> <p>As a result:</p> <ol style="list-style-type: none"> <li>1. Resident 1 was angry about missing clothing and cellphone, and felt disconnected from the outside world</li> <li>2. Resident 2 was angry about missing clothing.</li> </ol> <p>Findings:</p> <p>1. During a record review, Resident 1's Admission Record indicated Resident 1 (Resident 2's roommate) was readmitted to the facility on [DATE], with the diagnoses of cognitive communication deficit (difficulties in communication arising from impairments in cognitive process like attention, memory, and executive functions), and generalized muscle weakness (lack of physical or muscle strength throughout the body).</p> <p>During a record review, Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/8/2025, indicated Resident 1s [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 1 needed moderate to substantial/maximal assistance with ADL's (bathing, showering, toileting, and mobility).</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
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation, interview, and concurrent record on 3/18/2025 from 12:52 p.m., Resident 1 in his room sitting in a wheelchair. Resident 1 stated approximately a week ago a certified nursing assistant (CNA-unable to recall the name) was his bed linen, and the CNA rolled his personal cell phone up in the linen and took the linen and the cellphone to the laundry. Resident 1 stated the cell phone got damaged and was no longer working. Resident 1 stated he has been requesting to speak to the social worker for about 6 or 7 days, but the social worker will not come and talk with the resident about replacing the cellphone and multiple missing clothing. Resident 1 stated his 2 pairs of blue jean pants, 1 pair of beige casual pants, 4 sets of sweat suits black, blue, burgundy, and brown, 1 pair of special white tennis shoes, 4 pair of underwear (stated he can't remember the color), 6 pairs of white diabetic socks, and 1 pair of metal frame glasses were missing. During a record review, Resident 1's medical chart indicated there was no inventory list developed/created for Resident 1.</p> <p>During an interview on 3/18/2025 at 1:35 p.m., certified nursing assistant (CNA) 2 stated a resident inventory list is supposed to be completed by a CNA or a License Nurse on the date of admission. CNA 2 Stated if a resident reports missing clothing, CNA 2 she checks with the laundry first and then reports about missing clothing to the LVN Charge Nurse if unable to find the resident's missing clothing.</p> <p>During an interview on 3/18/2025 at 3 p.m., Director of Social Service (DSS) stated Resident 1 reported to more than one facility staff that a CNA rolled the resident's cellphone up in bedsheets and that the cellphone got washed in the laundry, and about missing clothing, shoes, and eyeglasses. DSS stated the facility is going to replace Resident 1's cellphone and will follow up with Resident 1 about the missing clothing, shoes, and eyeglasses. DSS stated she did not document in Resident 1 ' s chart about the arrangements for the replacement of his cell phone.</p> <p>During an interview and concurrent record review on 3/18/2025 at 5:11 p.m., with Director of Medical Records (DMR), DMR stated there was no inventory list in Resident 1's medical chart.</p> <p>2. During a record review, Resident 2's Admission Record indicated Resident 2 (Resident 1's roommate) was readmitted to the facility on [DATE], with diagnoses of obstructive sleep apnea (breathing is interrupted during sleep), and type 2 diabetes mellitus with hyperglycemia (a condition where your body either doesn't produce enough insulin or can't properly use the insulin it does produce, leading to high blood sugar levels).</p> <p>During a record review, Resident 2's MDS dated [DATE], indicated Resident 2 cognitive skills was moderately intact.</p> <p>During an observation and interview on 3/18/2025 at 1:15 p.m., Resident 2 (roommate for Resident 1) noted in his room sitting up on the side of the bed. Resident 2 stated his 2 pair of khaki pants, 2 dress shirts blue and yellow, 3 pair of white underwear, 3 pair of white diabetic socks, 1 grey sweatpants, and 2 pair of athletic shorts were missing. Resident 2 stated he has requested to speak with the social worker for over a month about his missing clothing and follow up doctor ' s appointments at the Veterans Hospital, however, the social worker has not come to talk to him. Resident 2 stated he is angry because his missing clothing having missed his follow-up doctor's appointments.</p> <p>During an interview on 3/18/2025 at 3 p.m., DSS stated DSS will follow up with Resident 2 about the missing clothing items.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/2025 at 10:27 a.m., Administrator stated he was not informed of the missing clothing, shoes, and eyeglasses for Resident 1 nor was Administrator aware of missing clothing items for Resident 2.</p> <p>During an interview on 3/19/2025 at 3:26 p.m., Director of Nursing (DON) stated she was not aware about Resident 1's damaged cell phone or missing clothing items, shoes, and eyeglasses, or Resident 2's missing clothing items. DON stated that upon a resident's admission, the CNA assigned to the resident along with the license nurse are supposed to complete the resident inventory list. DON stated she will follow up on Residents 1 and 2 's missing personal belongings and cell phone replacement.</p> <p>During a record review, the facility policy and procedures titled Theft Prevention dated 1/25/2022, indicated: . Purpose: To assist residents in safeguarding their personal property. Policy: The facility is committed to preventing the misappropriation of resident property. The facility will exercise reasonable care for the protection of the resident ' s property from theft or loss. The facility investigates all reports of lost or stolen property. Upon admission, facility staff provides the resident sections of the health and safety code. All inquires regarding lost or stolen items are reported to the administrator.</p> <p>During a record review, the facility policy and procedures titled Residents Rights-Personal Property revised on 5/1/2023, indicated: . Procedure: V. the Resident ' s personal belongings and clothing are inventoried and documented upon admission. VI. Facility failed to promptly investigate any complaints of misappropriation, theft, or mistreatment of resident property.</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>45037</p> <p>Based on observation, interview, and record review, the facility failed to display and provide a copy of the current Administrators license as per regulation.</p> <p>This failure had the potential for residents, families, and Department of Public Health to be provided the wrong information regarding the current Administrator.</p> <p>Findings:</p> <p>During an unannounced visit tour and observation of the facility on 3/18/2025 at 11:20 a.m., the facility posted the license of a former Administrator and did not the license of the current Administrator.</p> <p>During an interview on 3/19/2025 at 10:57 a.m., Administrator stated he did not have a current copy of his Administrators License because the license was mailed to the wrong address and had no way of printing another copy. Administrator stated he has only been employed with the facility for 1 month. Administrator stated he is aware that his Administrators license is supposed to be posted on the first day of employment. Administrator stated if the current Administrator ' s License is not posted the staff, residents ' family, or Department of Public Health will not know who the current Administrator is.</p> <p>During a record review of a letter that was sent to the Department of Public Health dated 2/19/2025, indicated, effective 1/29/2025 Administrator was the Administrator of the facility.</p> <p>During an interview on 3/18/2025 at 5:11 p.m., Director of Medical records stated the facility does not have a policy for Administrator.</p>		