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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility staff failed to ensure resident received appropriate treatment and services to prevent urinary tract infection (UTI- an infection in the bladder/urinary tract) for two of two sampled residents (Resident 2 and Resident 3) by failing to ensure resident's indwelling urinary (foley) catheters (a hollow tube inserted into the bladder to drain or collect urine) were placed below the level of the bladder at all times. This deficient practice had the potential to result or resulted in urinary tract infections for the residents. Findings: 1. A review of the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia (BPH - is a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream) and obstructive and reflux uropathy (a condition where urine flow is blocked within the urinary tract causing urine to backflow upwards into the kidneys potentially damaging the kidney tissue). A review of the Minimum Data Set (MDS - resident assessment tool) dated 10/7/2024, indicated Resident 2's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions was mildly impaired. The MDS indicated Resident 2 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The same MDS also indicated Resident 2 has an indwelling catheter. A review of Resident 2's Order Summary Report, dated 10/2/2024 indicated, physician ordered foley catheter to bedside straight drainage for diagnosis/history (hx) of obstructive uropathy (a medical condition that refers to any disorder or disease affecting the urinary tract). During an observation of Resident 2 on 12/19/2024 at 12:36 p.m., Resident 2 was observed lying in bed, with a foley catheter bag placed above Resident 2's bladder. Resident 2's indwelling catheter tubing was observed with amber color urine and was not draining into the indwelling catheter drainage bag. (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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Vocational Nurse (LVN 1) on 12/19/2024 at 12:58 p.m., LVN 1 observed Resident 2's indwelling catheter and stated, the indwelling catheter bag was placed too high, and the urine was not draining in the indwelling catheter drainage bag. LVN 1 stated, it (the indwelling catheter bag) should be placed below resident's bladder. LVN 1 further stated, there is urine in the indwelling catheter tubing, and it was draining into the indwelling catheter collection bag. 2. A review of the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood) and retention of urine (a condition that makes it difficult to empty the bladder, either partially or completely). A review of the MDS dated [DATE], indicated Resident 3's cognitive skills for daily decisions was moderately impaired. The MDS indicated Resident 3 required total dependence from staff for ADLs. A review of Resident 3's Order Summary Report, dated 10/30/2024 indicated, physician ordered indwelling catheter to bedside straight drainage for diagnosis/history (hx) of need neurogenic bladder (a condition that causes bladder control issues due to damage to the nervous system). During an observation of Resident 3 on 12/19/2024 at 12:56 p.m., Resident 3 was observed lying in bed, with an indwelling catheter bag placed above Resident 3's bladder. Resident 3's indwelling catheter tubing was twisted and kinked. The urine was observed not draining into the indwelling catheter drainage bag. During an interview with LVN 1 on 12/19/2024 at 12:59 p.m., LVN 1 observed Resident 3's indwelling catheter and stated, the indwelling catheter bag was placed too high, and the urine was not draining in the indwelling catheter drainage bag. During an interview with Director of Nursing (DON) on 12/19/2024 at 2:50 p.m., DON stated if the indwelling catheter drainage bag was not placed below residents' bladder, it may back up in the bladder and cause infection. A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised January 2024, the P&P indicated, The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks.

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NAME OF PROVIDER OR SUPPLIER Beverly Hills Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 580 S San Vicente Blvd. Los Angeles, CA 90048	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure resident assessment and documentation were complete concerning resident's death for one of three sampled residents (Resident 1) by failing to implement facility's policy and procedure (P&P) titled, Death of a Resident when Resident 1 expired on [DATE]. This deficient practice resulted in incomplete assessment and documentation for Resident 1 required per facility's policy and procedure upon death. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including acute on chronic diastolic (congestive) heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), -chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe) and respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide). A review of the Minimum Data Set (MDS - resident assessment tool) dated [DATE], indicated Resident 1's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision to moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 1's Progress Notes dated [DATE] indicated, At 12 a.m., Resident (1) asked for breathing treatment given by Charge Nurse as ordered, tolerated well . At 12:10 a.m., resident has panic attack and nurse with him (Resident 1) trying to comfort him but suddenly he passed out. Checked all vitals, cardiopulmonary resuscitation (CPR - medical procedure involving repeated compression of a patient's chest, performed in an attempt to restore the blood circulation and breathing of a person who has suffered cardiac arrest) initiated right away and called 911 (three-digit telephone number '[DATE]' has been designated as the universal emergency number for citizens throughout the United States to request emergency assistance). At 12:25 a.m., paramedics came and took over the emergency . At 12:56 a.m., paramedics stop the CPR and pronounced resident's (Resident 1) death. A review of Resident 1's electronic medical record and paper medical record as of [DATE], indicated there were no physician's progress notes that was completed, and no death certificate was on file. During an interview with Medical Record Director (MRD) on [DATE] at 3:09 p.m., MRD stated, there were no death certificate on file and NO record of the cause of death in the medical records. MRD also stated she was not aware of their policy regarding requesting death certificate from the physician timely. During an interview with Director of Nursing (DON) on [DATE] at 2:53 p.m., DON stated, a death certificate should have been requested and documented per their policy. (continued on next page)

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	555700	A. Building B. Wing	12/19/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure (P&P) titled, Death of a Resident, revised on revised ,d+[DATE], the P&P indicated, The Attending Physician must record the cause of death and file a death certificate with the appropriate agency within 24 hours of the resident's death or as may prescribed by state law.