STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. Building B. Wing	03/17/2026

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** Based on interview and record review the facility failed to ensure the facility's policy and procedures (P&P) for indwelling urinary catheter (foley catheter, is a flexible tube inserted into the bladder to drain urine, held in place by a small, water-filled balloon) were followed for two of four sampled residents (Resident 1 and 4) by failing to ensure:1. Urine characteristics were documented on the Weekly Summary Note for Resident 1 and 4, and2. A foley catheter change procedure was documented in the medical record for Resident 1.These failures resulted in incomplete and inaccurate documentation in the medical record and had the potential to affect the residents' foley care and monitoring for signs and symptoms of infection.1. During a review of Resident 1's admission Record, dated 3/17/26, indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), hyperlipidemia (high levels of fats (lipids), such as cholesterol and triglycerides, circulating in the blood), congestive heart failure (CHF - chronic, progressive condition where the heart muscle cannot pump blood efficiently, causing blood to back up and fluid to accumulate in the lungs, liver, and extremities), muscle weakness, difficulty in walking, and chronic kidney disease (CKD - progressive loss of kidney function), and obstructive and reflux uropathy (conditions where urine flow is blocked or flows backward, causing urine backup, kidney swelling (hydronephrosis), and potential renal damage).During a review of Resident 1's History and Physical (H&P) dated 2/1/26 indicated, Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 3/11/26 indicated, Resident 1 had minor memory problems and was dependent to needing partial/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). The same MDS further indicated Resident 1 had an indwelling urinary catheter.During a review of Resident 1's care plan for: indwelling catheter r/t (related to) obstructive uropathy, initiated on 1/29/26, indicated interventions including; Monitor/record/report to MD for signs symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness. deepening of urine color.foul smelling urine.During a review of Resident 1's Weekly Summary notes dated 2/28/26 and 3/14/26 the Urine color, consistency, odor and clarity sections were left blank.During a review of Resident 4's admission Record, dated 3/17/26, indicated the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), fracture of left lower leg, non-displaced fracture of head of left radius (forearm bone), acute respiratory failure with hypoxia (low oxygen), endocarditis (infection of the heart), dysphagia (difficulty swallowing), atrial fibrillation (Afib - irregular heart rate, characterized by disorganized electrical activity causing the upper chambers (atria) to quiver or fibrillate instead of beating effectively)During a review of Resident 4's MDS dated [DATE] indicated, Resident 4 had minor memory problems and was dependent on staff for all Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and bed mobility. The same MDS further indicated Resident 4 had an indwelling urinary catheter.During a review of Resident 4's care plan for: indwelling catheter r/t (related to) obstructive (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: 555700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026

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	uropathy, initiated on 3/4/26, indicated interventions including; Monitor/record/report to MD for signs symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness. deepening of urine color.foul smelling urine.During a review of Resident 4's Weekly Summary notes dated 3/7/26 and 3/14/26 the Urine color, consistency, odor and clarity sections were left blank.During an interview on 3/17/26 at 9:14 am, the MDS Nurse (MDSN) stated the Weekly Summary notes are documented by licensed nurses and should be complete including urine characteristics.During a concurrent interview and record review on 3/17/26 at 3:00 pm with the Director of Nursing (DON), Resident 1 and 4's Weekly Summary notes indicated above were reviewed. The DON verified the urine characteristics were not documented and stated the monitoring for the urine would be a risk from this omission in the documentation.During a review of the facility's P&P titled, Catheter Care, Urinary, dated January 2026, the P&P indicated Purpose. Ther purpose of this procedure is to prevent infection of the resident's urinary tract. Documentation. The following information should be recorded in the resident's medical record. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.During a review of the facility's P&P titled, Charting and Documentation, revised January 2026, the P&P indicated All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.2. During a review of Resident 1's admission Record, dated 3/17/26, indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), hyperlipidemia (high levels of fats (lipids), such as cholesterol and triglycerides, circulating in the blood), congestive heart failure (CHF - chronic, progressive condition where the heart muscle cannot pump blood efficiently, causing blood to back up and fluid to accumulate in the lungs, liver, and extremities), muscle weakness, difficulty in walking, and chronic kidney disease (CKD - progressive loss of kidney function), and obstructive and reflux uropathy (conditions where urine flow is blocked or flows backward, causing urine backup, kidney swelling (hydronephrosis), and potential renal damage).During a review of Resident 1's History and Physical (H&P) dated 2/1/26 indicated, Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's MDS dated [DATE] indicated, Resident 1 had minor memory problems and was dependent to needing partial/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). The same MDS further indicated Resident 1 had an indwelling urinary catheter.During a review of Resident 1's care plan for: indwelling catheter r/t (related to) obstructive uropathy, initiated on 1/29/26, indicated interventions including; Monitor/record/report to MD for signs symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness. deepening of urine color.foul smelling urine.During a telephone interview on 3/17/26 at 2:36 pm with Licensed Vocational Nurse (LVN) 2, LVN 2 stated when she came on her 3pm-11pm shift on 3/3/26 she was told the treatment nurse had changed out the foley catheter on Resident 1 and she was tasked with giving him pain medication. LVN 2 further stated the nurse who changes the foley should document it in the chart.During a concurrent interview and record review on 3/17/26 at 3:00 pm with the Director of Nursing (DON), Resident 1's progress notes for 3/3/26 were reviewed. The DON verified there was no documentation for the foley catheter change on 3/3/26 and if the catheter is changed the nurse should have documented it.During a review of the facility's P&P titled, Catheter Care, Urinary, dated January 2026, the P&P indicated Documentation. The following information should be recorded in the resident's medical record. The date and time that catheter care was given. The name and title of the individual(s) giving the catheter care. All assessment data obtained. any problems or complaints made by the resident related to the procedure. How the resident tolerated the procedure.During a review of the facility's P&P titled, Charting and Documentation, revised January 2026, the P&P indicated All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.