

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2024
NAME OF PROVIDER OR SUPPLIER  Berkley East Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2021 Arizona Ave Santa Monica, CA 90404	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42342</p> <p>Based on interview and record review the facility failed to develop a care plan for discharge planning for one of three sampled residents (Resident 1).</p> <p>This deficient practice had the potential to place Resident 1 at risk of needs not been met and delay in necessary intervention during discharge.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the facility admitted Resident 1, a [AGE] year-old male on [DATE] with diagnoses including Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), chronic kidney disease (gradual, prolonged loss of Kidney's ability to filter fluids and waste from the body), Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), Anxiety (a feeling of worry, nervousness or unease), adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity and dysphagia).</p> <p>A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE] indicated Resident 1's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident 1 was totally dependent (full staff performance) with bed mobility (how resident moves to and from lying positions, turns side to side, and positions body while in bed), dressing, toilet use, personal hygiene, and dressing. Transfer (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position) did not occur during this assessment and requires two- person assist. Resident 1 did not walk.</p> <p>A review of Resident 1's physician order dated [DATE] indicated to admit Resident 1 under hospice routine level of care.</p> <p>A review of Resident 1s physician order dated [DATE] indicated anticipated discharge (lateral transfer) to facility when bed available.</p> <p>A review of Resident 1's physician order dated [DATE] indicated DNR (do not resuscitate-a type of advance directive in which a person states that health care providers should not perform CPR) Selective treatment, trial period of artificial nutrition, including feeding tubes.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on [DATE] at 12:15 p.m. with the director of nursing (DON), Resident 1's care plan titled, Discharge Planning initiated [DATE] was reviewed. The care plan indicated Resident 1 was issued a 2nd 30-day eviction/transfer/discharge notice and included a goal that resident will be discharged to appropriate placement which will meet individualized care needs through the next review date. The care plan does not mention the first eviction letter. The care plan does not mention the appealed discharges. The DON stated, Discharge planning starts when we have the first care plan meeting upon admission. During that meeting we find out their goal or where they want to go after their stay here. Along the way if their plan changes, we should have another meeting and update the care plan to reflect the current plan. This resident was issued an eviction notice I believe last year, and they appealed and won. The second notice was given this year for non-payment, but I am not sure of the results, by the previous social worker however she did not document any conversations between herself and the family. The social worker no longer works here so we initiated this care plan based on the social service assistant notes. The DON further stated, we should have started this care plan after the first care plan meeting and revised it after each meeting with the family.</p> <p>A review of the facility's policy and procedures (P &amp;P) titled, Care Planning (IDT) Policy , reviewed ,d+[DATE] indicated Licensed Nurses and other IDT members will develop a preliminary care plan to meet the resident's immediate care needs at the time of admission. The IDT shall complete a comprehensive care plan within seven (7) days of completion of the resident assessment (MDS) .Care plans are revised per RAI schedules and as changes in the resident's condition dictates or in preparation for discharge.</p> <p>A review of the facility's P &amp; P titled, Charting and Documentation, reviewed ,d+[DATE] indicated the following information is to be documented in the resident medical record:</p> <ul style="list-style-type: none"> <li>a. Objective observations</li> <li>b. Medications administered.</li> <li>c. Treatments or services performed.</li> <li>d. Changes in resident's condition</li> <li>e. Events, incidents or accidents involving the resident; and</li> <li>f. Progress toward or changes in the care plan goals and objectives.</li> </ul>		