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 06/06/2024
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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 42342 Based on interview and record review the facility failed to accurately perform a neuro check (assessing mental status and level of consciousness, pupil response, motor strength, sensation, and walking) after a fall for one of five sampled residents, (Resident 3). This deficient practice had the potential to result in a delay to transport Resident 3 to the general acute care hospital (GACH) where he was diagnosed with a mild displaced mildly comminuted subcapital fracture of the right femoral neck (right hip fracture). Findings: A review of the Resident 3 ' s Admission Record indicated the facility originally admitted Resident 3 on 10/05/2023 with a subsequent admission on 5/14/2024 with diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), congestive heart failure (CHF- A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), nonrheumatic mitral valve insufficiency (when blood leaks from an improperly closed mitral valve back to the heart), non-displaced fracture of the sixth and seventh cervical vertebra(C6 and C7-broken neck), low blood pressure, Benign Prostatic hyperplasia (BPH- enlarged prostate), Gastroesophageal reflux disease (GERD-indigestion), abnormalities with walking and moving around and repeated falls. A review of Resident 3 ' s history and physical (H&P) dated 3/28/2024 indicated, Resident 3 has limited capacity to understand and make decision depending on complexity of decisions that need to be made. Resident 3 required family assistance with making complex medical decisions. A review of Resident 3 ' s Minimum Data Set (MDS-a standardized assessment and care planning tool), dated, 4/3/2024 indicated Resident 3 ' s cognition (mental ability to make decisions for daily living) was moderately impaired. Resident 3 was totally dependent (helper does all the effort) with toileting hygiene and transfers (moving between surfaces) from bed to chair. Resident 3 ' s ability to get on and off a toilet or commode was not attempted due to medical condition or safety concerns. A review of Resident 3 ' s Morse Fall Risk Screen (assessment tool for prediction of a patient ' s potential for experiencing a fall while in a facility) dated 3/27/2024 Indicated Resident 3 had a history of falling and was at high risk for recurrent falls. (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: 555748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s Change in Condition Evaluation form dated 5/9/2024 timed at 6:45 p.m. indicated Resident 3 was found sitting on the bathroom floor. Resident 3 was able to move both arms and legs and denied any pain. During an interview on 6/3/2024 at 12:53 p.m. LVN 2 stated on 5/10/2024 she first saw Resident 3 at 7:30 a. m. sleeping in bed; she asked the resident if he had any pain and he said no so she did not give any medications for pain she just gave him his regular medication. I knew he had a fall the day before and we were doing neuro checks (assessment of level of consciousness, blood pressure, heart rate, pupil response and strength in arms and legs) to monitor and monitoring his vital signs and pain level which is what we do whenever a Resident has a fall. We do that every 15 minutes for the first hour and then it ' s done every 30 minutes. I don ' t know the exact time frames I just follow what is on the form. I did do a neuro check that morning. During a concurrent interview and record review on 6/3/2024 at 12:53 p.m. with LVN 2, the Change in Condition Evaluation form dated 5/10/2024 was reviewed. The Change in Condition form indicated at 11:00 a. m. the physical therapist informed LVN 2 Resident 3 was having pain in the right thigh and could not complete therapy session due to the pain. LVN 2 stated when she touched the right thigh Resident 3 cried out in pain so she notified the MD and received an order to transfer Resident 3 out to the GACH for evaluation. During a concurrent interview and record review on 6/3/2024 at 12:56 p.m., with LVN 2; the neurological assessment form dated 5/10/2024 timed at 9:30 a.m. was reviewed. The neurological assessment form indicated a legend to document the extremity (arms and legs) assessment indicating S=strong, W=weak, F=flaccid, R=rigid. The form indicated an S for lower right extremity and a check mark next to the pain category. LVN 2 stated yes that is my signature next to the assessment for 9:30 a.m. LVN 2 stated, when I did the neuro check I just asked him if he had pain and he said no. LVN 2 further stated I did not ask him to move his legs and I did not try to move his legs. LVN 2 was asked how she knew the right lower leg was strong and stated, yes you are right I probably should have moved it. LVN 2 further stated, If I would have moved his leg we would have known about his pain before the physical therapist told me an hour and a half later and maybe we could have gotten him to the hospital sooner. During an interview on 6/3/2024 at 2:21 p.m. the certified nursing assistant (CNA) 2 & 3; CNA 2 stated she was assigned to Resident 3 on 5/10/2024 from 7:00 a.m. to 3:00 p.m. CNA 2 went on to say on 5/10/2024 at 9:00 a.m. she went in to change Resident 3 ' s brief and give him a bed bath. CNA 2 stated she went to turn him, and he screamed out in pain when she touched his right thigh. CNA 2 stated she stopped and went and got CNA 3 to assist because the Resident had too much pain. CNA 3 stated when entering the room Resident 3 was on the bed complaining of right hip pain. CNA 3 stated he helped CNA 2 reposition Resident 3 then went to report the pain to LVN 2 at approximately 9:30 a.m. During an interview on 6/3/2024 at 3:30 p.m. LVN 2 stated she did not recall CNA 2 nor CNA 3 informing her of Resident 3 ' s right thigh pain. During an interview on 6/6/2024 at 11:28 a.m. the Director of Nursing (DON) stated, To assess the strength in the arms and legs when doing a neuro check you should have the resident squeeze your hands to assess arm strength and have them push their feet against you to assess leg strength. Lastly, the Don stated, asking about pain does not tell you the strength of an arm or leg and is not the correct way to perform a neurocheck. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedures (P & P) titled, Falls Management Program reviewed 1/2024 indicated: To provide residents with hazard free environment, adequate supervision and reduce risk factors leading to falls and injury .When a resident, family member or staff member said a fall occurred; When a person was found on the floor, regardless of whether any injury resulted; An occasion on which residents lowered themselves to the floor; When the resident had to be lowered to the floor by a staff member to prevent a fall . The same P & P indicated, It is the policy of this facility to provide residents with a safe environment which is free from accident hazard as is possible. The facility will provide residents with adequate supervision and assistive device to prevent accidents. It is also the policy of the facility to investigate the circumstances surrounding the resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury. The same P & P further indicated, 1.The Licensed nurse will observe the resident and review risk factors that may potentially contribute to the occurrence and reoccurrence of a fall on admission, quarterly thereafter, and following incident of fall and when a significant change of condition is identified to determine if he/she is at risk for falls using the Morse Fall Scale. 2.During schedule or unscheduled down time the Licensed Nurse will complete the Morse Fall Scale form in paper and later on enter in PointClickCare the information written in paper using the same date of completion as directed by the Director of Nursing Services once the Licensed Nurse is able to access PointClickCare. 3. The completed Morse Fall Scale form will be uploaded in PointClickCare by Medical Records to show original date of completion. 4.The Licensed Nurse will initiate a plan of care within 24 hours from admission and readmission on residents identified as high risk for fall. The plan of care will be updated by the Licensed Nurse and Interdisciplinary Team as indicated; 5.The Interdisciplinary Team will reassess the risk factors contributing to falls and interventions to minimize recurrence of falls and injury during the initial, quarterly and annual assessment, post fall and when a significant change of condition is identified; 6.After a fall incident, the Licensed Nurse will check the resident for a change in the level of consciousness, change in the range of motion, functional mobility and ADL function and for presence of visible injury; 7.The Licensed Nurse will notify the Attending Physician and the resident ' s responsible party regarding the fall incident and the status of the resident; 8.The Licensed Nurse will determine the cause of the fall and provide interventions to manage the falls and the reduce the risk of additional falls and injury; 9.A neuro-check will be initiated by the Licensed Nurse on unwitnessed fall and when there is identified head injury.10.72 hours observation of the resident post fall will be initiated by the Licensed Nurse.

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	555748	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley East Healthcare Center	2021 Arizona Ave Santa Monica, CA 90404

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42342

Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 3), who was assessed as a high risk was not left unattended in the bathroom unsupervised.

This deficient practice resulted in Resident 3 falling while in the bathroom on 5/9/2024 at 6:45 p.m. and sustained a mild displaced comminuted subcapital (is a difficult hip injury that can have serious complications) fracture (a break in a bone) of the right femoral neck (right hip fracture). Resident 3 was transferred to General Acute Care Hospital (GACH) on 5/10/2024. Resident 3 underwent a closed reduction percutaneous fixation (a procedure to set [reduce] a broken bone without cutting the skin open) of the right femoral neck fracture resulting from a right non-displaced femoral neck fracture.

Findings:

A review of the Resident 3 ' s Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] with a subsequent admission on 5/14/2024 with diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), congestive heart failure (CHF- A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs non-displaced fracture of the sixth and seventh cervical vertebra (C6 and C7-broken neck), low blood pressure, Benign Prostatic hyperplasia (BPH-enlarged prostate), abnormalities with walking and moving around and repeated falls.

A review of Resident 3 ' s Morse Fall Risk Screen (assessment tool for prediction of a patient ' s potential for experiencing a fall while in a facility) dated 3/27/2024 Indicated Resident 3 had a history of falling and was at high risk for recurrent falls.

A review of Resident 3 ' s history and physical (H&P) dated 3/28/2024 indicated, Resident 3 has limited capacity to understand and make decision depending on complexity of decisions that need to be made. Resident 3 required family assistance with making complex medical decisions. The same H & P indicated Resident 3 was admitted to the facility after recent hospitalization for cervical fracture due to recurrent falls in the facility. Assessment and plan included physical therapy (PT- is a healthcare profession, as well as the care provided by physical therapists who promote, maintain, or restore health through patient education, physical intervention, disease prevention, and health promotion) and occupational therapy (OT- a branch of health care that helps people of all ages who have physical, sensory, or cognitive problems. and fall precautions). The plan further included to always wear rigid cervical collar while in bed and in showers and wear cervical thoracic orthosis (CTO- neck brace with piece that extends down to protect the spine) brace when out of bed and during PT and OT.

A review of Resident 3 ' Care Plan titled, High Risk for Fall created on 3/31/2024 indicated Resident 3 was at high risk for falls and injury related to limitation of mobility, repeated falls, and low blood pressure. Interventions to prevent falls included to provide assistance needed with toileting and do not leave the resident unattended in the room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 3 ' s Minimum Data Set (MDS-a standardized assessment and care planning tool), dated, 4/3/2024 indicated Resident 3 ' s cognition (mental ability to make decisions for daily living) was moderately impaired. Resident 3 was totally dependent (helper does all the effort) with toileting hygiene and transfers (moving between surfaces) from bed to chair. Resident 3 ' s ability to get on and off a toilet or commode was not attempted due to medical condition or safety concerns. A review of Resident 3 ' s Change in Condition Evaluation form dated 5/9/2024 at 6:45 p.m. indicated Resident 3 was found sitting on the bathroom floor wearing neck brace. Resident 3 was able to move both arms and legs and denied any pain. A review of Resident 3 ' s GACH X-Ray (are a form of electromagnetic radiation, similar to visible light) result of right femur (thigh) dated 5/10/2024 indicated a mild displaced mildly comminuted subcapital fracture of the right femoral neck. A review of Resident 3 ' s GACH orthopedic (focuses on injuries and diseases affecting your musculoskeletal system [bones, muscles, joints and soft tissues]) record dated 5/11/2024 indicated Resident 3 underwent a closed reduction percutaneous fixation (a procedure to set [reduce] a broken bone without cutting the skin open) of the right femoral neck fracture resulting from a right non-displaced femoral neck fracture. During an interview on 5/15/2024 at 11:10 a.m. Resident 5 (Resident 3 ' s roommate) stated on 5/9/2024 at unknown time an unknown staff member brought Resident 3 to his room in a wheelchair and left him (Resident 3) there watching television. Resident 5 stated he observed Resident 3 wheel himself into the bathroom and close the door. Resident 5 stated, after about 10 minutes, he became concerned because Resident 3 had not come out of the bathroom, so he pushed the call light. Resident 5 further stated an unknown staff responded to the call light and he informed the staff that Resident 3 had been in the restroom for a long time. Resident 5 further stated the unknown staff opened the bathroom door and found Resident 3 on the floor. During an interview on 5/15/2024 at 3:08 p.m. the Licensed Vocational Nurse 1 (LVN 1) stated on 5/9/2024 she had just finished rounding and left Resident 3 in his room sitting in the wheelchair eating dinner. LVN 1 stated after 10 minutes she returned to the nursing station and noticed the call light was on in the room. LVN 1 stated she went to the room and Resident 5 told her that Resident 3 wheeled himself to the bathroom. LVN 1 stated when she opened the bathroom door, she found Resident 3 sitting on the floor with both hands on the floor. LVN 1 further stated she then called for assistance to pick Resident 3 up and put back into the bed. LVN 1 further stated Resident 3 had a history of fall that resulted in a broken neck and required him to wear a neck brace. LVN 1 confirmed and stated Resident 3 required supervision with walking. During a concurrent interview and record review on 6/3/2024 at 12:53 p.m. with LVN 2, the Change in Condition Evaluation form dated 5/10/2024 was reviewed. The Change in Condition form indicated at 11p.m. the physical therapist informed LVN 2 Resident 3 was having pain in the right thigh and could not complete therapy session due to the pain. LVN 2 stated when she assessed Resident 3, he cried out in pain when she touched the areas, so she notified the Medical Director (MD) and received an order to transfer Resident 3 out to the GACH for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/3/2024 at 2:48 p.m. Certified Nursing Assistant 1 (CNA 1) stated he was assigned to Resident 3 on 5/9/2024 from 3 p.m. to 11 p.m. CNA 1 stated he saw Resident 3 sitting in his wheelchair in his room when he started his shift at 3 p.m. CNA 1 added, he was in another room assisting a different resident to the bathroom when Resident 3 was found on the bathroom floor. CNA 1 did not recall the exact time, however, stated it was after dinner when he last saw Resident 3 still sitting in the wheelchair in his room talking with his roommate. CNA 1 stated it was his first-time taking care of Resident 3, so he was not too familiar with him. CNA 1 stated he was not aware Resident 3 was at risk for fall, but he made sure the call light was within his reach when he was last in the room. CNA 1 stated he asked LVN 1 about the level of assistance needed for Resident 3 and was told Resident 3 was able to stand and assist with transfers and he had in a neck brace. CNA 1 stated he asked because he did not know the resident and there was no huddle (verbal reports on status and needs of the residents) given before the shift. I did not know he was confused and started to sundown (a state on confusion that occurs in the late afternoon and lasts into the night) otherwise I would have checked on him more frequently. I did do more visual checks after the fall for the rest of the evening. CNA 1 further stated when he came out of the other room, he saw LVN 1 flagging him to come to the room and that is when he saw Resident 3 on the bathroom floor and assisted her with getting him up and to bed. During a concurrent interview and record review on 6/3/2024 at 2:50 p.m. with CNA 1, the assignment sheet dated 5/9/2024 3p.m.-11p.m. was reviewed. The assignment sheet indicated CNA 1 was assigned to 3 additional residents on top of his 8 residents for a total of 11 residents. The 3 additional residents indicated 7 p.m. next to the name of the CNA originally assigned to those residents. CNA 1 stated, Oh now I remember we were short on staff that evening so I had to cover those additional residents until the other CNA arrived at 7 p.m. so it must have happened before 7p.m. During a concurrent interview and record review on 6/3/2024 at 4 p.m. with the occupational therapist (OT), the Treatment Encounter Note dated 4/30/2024 was reviewed. The Treatment Encounter Note indicated Resident 3 required contact guard assist (the assisting person has one or two hands on your body but provides no other assistance to perform the functional mobility task) with minimal assist. Resident 3 required mod/max (moderate/maximum) assist for peri care (wipe and clean after using the bathroom) and brief management for safety due to limited balance. The OT stated, He was able to stand with me standing there on guard with minimal assistance because he has severe impairment in balance, so he needed to be cued to hold on to the grab bar while I pulled down his pants and wiped him after he was done. He required 50-75% (percentage) assistance from me and needed 50% rest breaks in between tasks because he would get tired and lose his balance. The OT further stated Resident 3 did follow commands, but he had periods of confusion and poor safety awareness overall due to his cognitive impairment. He required assistance from at least one person to use the bathroom. The Nursing Staff were made aware of this verbally and they have asked us to put our notes under the therapy tab in the electronic medical record system so they can access them and review at any time. During an interview on 6/6/2024 at 11:28 a.m. the Director of Nursing (DON), stated Resident 3 ' s cognition was severely impaired at admission, and he was admitted as a high fall risk. The DON stated Resident 3 required increase supervision due the high risk for fall, so he was moved closer to the nursing station after the unwitnessed fall incident on 5/9/2024. The DON could not state how the facility provided supervision and assistive devices to Resident 1 to prevent avoidable accidents. The DON further stated, When I did meet him after the fall, I saw that he was very confused and forgetful, so we decided to call the family to get a personal sitter to sit with him all day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/6/2024 at 12:28 p.m. with the DON; the OT Treatment Encounter Note dated 4/30/2024 was reviewed. The Treatment Encounter Note indicated Resident 3 required contact guard assist with minimal assist. Resident 3 required mod/max assist for peri care (wipe and clean after using the bathroom) and brief management for safety due to limited balance. The DON stated, this means he needed at least one person to assist with using the restroom and that one person would need to do most of the task. The DON further stated, The OT will verbally communicate these needs directly to the nursing staff so they will know how much assistance is needed. The DON further stated the resident ' s level of assistance that is needed should continue to be communicated to oncoming staff by outgoing staff and during huddle at change of shift. The DON stated, we should have done a better job of communicating to all staff that Resident 3 was moderately confused and required moderate assistance to use the bathroom that way we could have better anticipated his needs regarding safety and supervision. We could have provided more activities to keep him from getting out of bed unassisted. A review of the facility ' s policy and procedures (P & P) titled, Falls Management Program reviewed 1/2024 indicated: To provide residents with hazard free environment, adequate supervision and reduce risk factors leading to falls and injury .When a resident, family member or staff member said a fall occurred; When a person was found on the floor, regardless of whether any injury resulted; An occasion on which residents lowered themselves to the floor; When the resident had to be lowered to the floor by a staff member to prevent a fall . The same P & P indicated, It is the policy of this facility to provide residents with a safe environment which is free from accident hazard as is possible. The facility will provide residents with adequate supervision and assistive device to prevent accidents. It is also the policy of the facility to investigate the circumstances surrounding the resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury. The same P & P further indicated, 1. The Licensed nurse will observe the resident and review risk factors that may potentially contribute to the occurrence and reoccurrence of a fall on admission, quarterly thereafter, and following incident of fall and when a significant change of condition is identified to determine if he/she is at risk for falls using the Morse Fall Scale. 2.During schedule or unscheduled down time the Licensed Nurse will complete the Morse Fall Scale form in paper .4. The Licensed Nurse will initiate a plan of care within 24 hours from admission and readmission on residents identified as high risk for fall. The plan of care will be updated by the Licensed Nurse and Interdisciplinary Team as indicated; 5. The Interdisciplinary Team will reassess the risk factors contributing to falls and interventions to minimize recurrence of falls and injury during the initial, quarterly and annual assessment, post fall and when a significant change of condition is identified .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on interview, and record review the facility failed to provide enough certified nursing aids (CNA) ' s to provide assistance with toileting for one of five sampled Residents, (Resident 3). This deficient practiced caused Resident 3 to fall while unattended in the bathroom; subsequently develop leg pain that required transport to the general acute care hospital (GACH) where he was diagnosed with a mild displaced mildly comminuted sub capital fracture of the right femoral neck (right hip fracture). Findings: A review of the Resident 3 ' s Admission Record indicated the facility originally admitted this [AGE] year old male on 10/05/2023 with a subsequent admission on 5/14/2024 with diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), congestive heart failure (CHF- A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), nonrheumatic mitral valve insufficiency (when blood leaks from an improperly closed mitral valve back to the heart), non-displaced fracture of the sixth and seventh cervical vertebra (C6 and C7-broken neck), low blood pressure, Benign Prostatic hyperplasia (BPH- enlarged prostate), Gastroesophageal reflux disease (GERD-indigestion), abnormalities with walking and moving around and repeated falls. A review of Resident 3 ' s history and physical (H&P) dated 3/28/2024 indicated, Resident 3 has limited capacity to understand and make decision depending on complexity of decisions that need to be made. Resident 3 required family assistance with making complex medical decisions. Additionally Resident 3 was admitted to the facility after recent hospitalization for cervical fracture due to recurrent falls. Assessment and plan included physical therapy (PT), occupational therapy (OT) and fall precautions. Lastly, the plan included to always wear rigid cervical collar while in bed and in showers and wear cervical thoracic orthosis (CTO-neck brace with piece that extends down to protect the spine) brace when out of bed and during PT and OT. A review of Resident 3 ' s Minimum Data Set (MDS-a standardized assessment and care planning tool), dated, 4/3/2024 indicated Resident 3 ' s cognition (mental ability to make decisions for daily living) was moderately impaired. Resident 3 was totally dependent (helper does all the effort) with toileting hygiene and transfers (moving between surfaces) from bed to chair. Resident 3 ' s ability to get on and off a toilet or commode was not attempted due to medical condition or safety concerns. A review of Resident 3 ' s Morse Fall Risk Screen (assessment tool for prediction of a patient ' s potential for experiencing a fall while in a facility) dated 3/27/2024 Indicated Resident 3 had a history of falling and was at high risk for recurrent falls. A review of Resident 3 ' Care Plan titled, High Risk for Fall created on 3/31/2024 indicated Resident 3 was at high risk for falls and injury related to limitation of mobility, repeated falls, and low blood pressure. Interventions to prevent falls included to provide assistance needed with toileting and do not leave the resident unattended. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s Change in Condition Evaluation form dated 5/9/2024 timed at 6:45 p.m. indicated Resident 3 was found sitting on the bathroom floor wearing neck brace. Resident 3 was able to move both arms and legs and denied any pain. A review of the Daily Assignment Schedule dated 5/9/2024 from 7:00 a.m. to 3:00 p.m. indicated a total of 6 CNA ' s with 7-8 residents. A review of Resident 3 ' s GACH X-Ray result of right femur (thigh) dated 5/10/2024 indicated a mild displaced mildly comminuted sub capital fracture of the right femoral neck. A review of Resident 3 ' s GACH orthopedic record dated 5/11/2024 indicated Resident 3 underwent a closed reduction percutaneous fixation (a procedure to set (reduce) a broken bone without cutting the skin open) of the right femoral neck fracture resulting from a right non-displaced femoral neck fracture. A review of the nurse staffing assignment sheet dated 6/3/2024 indicated 2 CNA call offs for the 3:00 p.m. to 11: 00 p.m. shift. And 2 additional names written. The assignment sheet indicated a total of three CNA ' s assigned to 12-13 residents a piece. During a concurrent interview and record review on 6/3/2024 at 2:48 p.m. with Certified Nursing Assistant (CNA) 1, the Daily Assignment Schedule dated 5/9/2024 3:00 p.m.-11:00 p.m. shift was reviewed. The daily assignment scheduled indicated three CNA assignments with 14-15 residents assigned. This assignment sheet was revised and indicated 3 additional CNA ' s, two with 7:00 p.m. start time and one with an 8:00 p.m. start time. CNA 1 stated, I remember on 5/9/2024 we were short staffed that shift, so they split the resident assignment among the CNA ' s that were there at 3:00 p.m. and I had to cover three additional residents until the CNA arrived at 7:00 p.m. I was in one of those rooms helping that resident to the bathroom when Resident 3 fell . When I started the shift at 3:00 p.m., I first saw Resident 3 sitting in his wheelchair in the room, talking to his roommate. I made sure he had the call light and I thought he was okay. The next time I saw him we were picking him up off of the bathroom floor after he fell I don ' t recall the time, but it was before 7:00 p.m. I did not know he was confused and started to sundown (a state on confusion that occurs in the late afternoon and lasts into the night) otherwise I would have checked on him more frequently. I did do more visual checks after the fall for the rest of the evening. During a concurrent interview and record review on 6/3/2024 at 3:43 p.m. with the director of staff development (DSD), The Daily Assignment Schedule dated 5/9/2024 3:00 p.m.-11:00 p.m. shift was reviewed. The daily assignment scheduled indicated three CNA assignments with 14-15 residents assigned. This assignment sheet was revised and indicated 3 additional CNA ' s, two with 7:00 p.m. start time and one with an 8:00 p.m. start time. The DSD stated, the staffing was projected the day before based on a census of 44 and three possible admissions discussed in the morning stand up meeting at 10:00 a.m. We started with three CNA ' s at 3:00 p.m. assigned to 14 residents, since we had two new admissions coming, I called the registry at 3:00 p.m. to request for two more CNA ' s who were going to arrive later in the shift because I knew they would need some help. They usually have 10 residents sometimes 12 at the most. Having 14 residents assigned might make it harder to answer call lights timely and might put residents at risk for fall or injury because the CNA may not be able to get to them timely. (continued on next page)

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 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley East Healthcare Center	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/2024 at 4:37 p.m. CNA 1 stated, I get called to come in and work extra shifts sometimes once a week and I would usually have between 8-12 residents during the 3:00 p.m. shift to 11:00 p.m. shift. My duties include going to each residents ' room and meeting them and provide diaper change if its needed, taking vital signs, setting up for dinner, assisting with feeding if needed, collecting dinner trays and getting them ready for bed. During an interview on 6/3/2024 at 5:00 p.m. with CNA 4 stated, I have 13 residents today usually I have between 9-10 but today we only had three CNA ' s when we usually have four. I think someone called off today that is why but its harder answer call lights on time when we have more than 10 residents. During an interview on 6/6/2024 at 11:28 a.m. the Director of Nursing (DON) stated projected staffing is done 24 hours before the shift and updated to show new admissions by 10:00 am so by this time we should know the census and the number of staff we need for the 3:00 p.m. to 11:00 p.m. shift. Usually during this shift, we will have 3 CNAs on each side of the floor so a total of 6 CNA ' s. The assignments are made based on acuity so for example Resident 3 required moderate assistance, was cognitively impaired and wore a neck brace constantly so he would be considered high acuity. On 5/9/2024 we had a census of 44 and expecting 2 admissions I don ' t think 3 CNAs would be enough especially if the residents are high acuity level, they will need more help. A review of the facility policy and procedure titled, Staffing reviewed, 1/2024 indicated, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services; 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident ' s plan of care; 3. If needed, nursing agency will be contracted to meet facility staffing needs; 4. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are also staffed to ensure that resident needs are met; 5. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter; 6. Inquiries or concerns relative to our facility ' s staffing should be directed to the Administrator or his/her designee.

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 06/06/2024
NAME OF PROVIDER OR SUPPLIER Berkley East Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2021 Arizona Ave Santa Monica, CA 90404	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on observation, interview, and record review the facility failed to administer antihypertensive (medications to lower blood pressure) medications timely for one of four sampled residents, Resident 4. This deficient practice placed Resident 4 at risk of having elevated blood pressure which can lead to severe Headache, hemorrhagic stroke (bleeding in the brain) or death. Findings: A review of Resident 4 ' s Admission Record indicated the facility admitted this [AGE] year-old female on 5/15/2024 with diagnoses including after care after shoulder joint prosthesis (artificial joint placement), Chronic Obstructive Pulmonary Disease (COPD- lung disease causing mucus and shortness of breath), Diabetes Mellitus (DM- long term disease causing high blood sugar), Asthma, Hypertension (HTN- high blood pressure). A review of Resident 4 ' s Minimum Data Set (MDS-a standardized assessment and care planning tool), dated, 5/19/2024 indicated Resident 4 ' s cognition (mental ability to make decisions for daily living) was intact. A review of Resident 4 ' s physician order dated 5/22/2024 indicated Amlodipine Besylate Oral tab 2.5mg, give 1 tablet by mouth two times per day for HTN hold for systolic blood pressure (SBP) less than 100. A review of Resident 4 ' s physician orders dated 5/15/2024 indicated Lisinopril Oral tab 40mg, give 1 tab by mouth one time a day for HTN hold for SBP less than 100. A review of Resident 4 ' s physician order dated 5/15/2024 indicated Metoprolol Succinate Oral tab 25mg, give 1 tab by mouth one time a day for HTN hold for SBP less than 100. On 5/30/2024 the California Department of Public Health (CDPH) received a complaint against the facility alleging medications were not being given timely. During a concurrent observation and interview on 5/31/2024 at 10:45a.m. with the Licensed Vocational Nurse (LVN) 4 at the medication cart in front on Resident 4 ' s room. Removing Amlodipine, Lisinopril and Metoprolol from bubble pack and placing into a medication cup. LVN 4 stated, Yes, they are late I know I can give them an hour before and up to an hour after they are due at 9:00 a.m. Her blood pressure is 141/71 it was taken at 7:00 a.m. I should take the blood pressure right before I give the medication I will re-check. Honestly some residents take a long time to take their medications so that caused me to be late even though I started med pass at 8:00 a.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedure titled, Administering Medications, revised 4/2019 indicated medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example) before and after meal orders. The following information is checked/verified for each resident prior to administering medications: a. allergies to medications, and b. Vital Signs, if necessary