

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 07/30/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45528</p> <p>Based on observation, interview, and record review, the facility failed to implement its policy on infection control to prevent the spread of coronavirus 2019 (COVID-19, a respiratory (organs involved in breathing) disease that is highly contagious thought to spread mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes, or talks) and other diseases as evidenced by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Certified Nursing Assistant 1 (CNA 1), Licensed Vocational Nurse 1(LVN 1) and Central Supply staff (CS) performed hand hygiene by washing hands using soap and water or use alcohol-based hand rub (ABHR) after contact with residents and their environment. 2. Ensure visitors were screened before entry into the facility. <p>These deficient practices had the potential to spread infection to the residents, staff, and visitors.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 7/30/2024, at 9:35 A.M., with LVN 1, by resident rooms, LVN 1 was observed entering and leaving a resident's room without performing hand hygiene. LVN 1 stated, I need to wash my hand with hand sanitizer before going into the room and after coming out of the room. LVN 1 stated potential adverse outcome of not performing hand hygiene is may spread infection.</p> <p>During a concurrent observation and interview on 7/30/2024, at 9:40 A.M., with CNA 1, by residents' room, CNA 1 was observed coming out of a resident's room into another resident's room without performing hand hygiene between rooms. CNA 1 stated, I need to wash my hands between rooms to prevent infection.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 7/30/2024, at 10:23 A.M., on the fourth floor, two Central Supply (CS 1 and CS 2) staff were observed entering a resident's room, without performing hand hygiene, left the room, did not perform hand hygiene, entered another resident's room without performing hand hygiene, touched the residents bed, left the room, did not perform hand hygiene and then entered another residents room without performing hand hygiene and again exiting the room without performing hand hygiene. CS 1 stated, we are going to do a test in the facility today, so we are checking the air mattresses, unplugging, and plugging beds, making sure the beds are plugged in the red outlet in all the rooms. CS 1 stated, sorry we didn't use hand sanitizer, we are supposed to use hand sanitizer. CS 1 staff stated adverse outcome of not observing hand hygiene between resident rooms and resident is that It could transfer infection and cause more infection on the residents.</p> <p>During an observation on 7/30/2024, at 12:55 P.M., in the facility's lobby, there was no staff member at the front desk.</p> <p>During an observation on 7/30/2024, at 1:03 P.M., in the lobby, there was no staff member at the front desk. Visitor 1 was observed assisting Visitor 2 with screening for covid. Visitor 3 entered the facility, had no face mask, did not perform hand hygiene, did not check his own temperature, did not fill out the covid questionnaire, or put on a face mask. Visitor 3 was seen entering the elevator that indicated going up.</p> <p>During an interview on 7/30/2024, at 1:10 P.M., with the Admissions Coordinator (AC), the AC stated, No one is here (front desk/lobby area) for the next 30 minutes. I just have an open door to my office so that if I can hear the visitor then I can help them.</p> <p>During a concurrent observation and interview on 7/30/2024, at 1:15 P.M., with the Administrator (ADM) at the front desk/lobby area, Visitor 2 was in the lobby and there was no staff member at the front desk/lobby area. The ADM stated, there is no one at the front desk, they (front desk staff) have gone to lunch. The ADM stated, there is no one covering for their lunch. Visitors are screened so we (facility) know if they have a fever or are having sign and symptoms of covid. When asked if visitors coming into the facility while the facility is still in an active covid outbreak need to be screened by staff, the ADM stated, you are asking me leading questions; I am not answering any of your questions anymore. The ADM became verbally belligerent, got up and walked away.</p> <p>During an interview on 7/31/2024, at 1:47 P.M., with the Infection Preventionist Nurse (IPN), the IPN stated, hand hygiene should be observed at all times between residents' rooms and between resident care to prevent transmission of infection which can lead to illness that are more infectious and even lead to death. Visitor screening needs to be done before entry into the facility to prevent the spread of covid or any other infection that can affect our patients.</p> <p>During an interview on 7/31/2024, at 2:15 P.M., with the Director of Nursing (DON),the DON stated, hand hygiene needs to be observed at all times, between resident rooms and in between resident care to prevent the spread of infection which may lead to illness that can cause harm to the resident, even hospitalization . The DON stated, visitor screening for covid needs to be done at all times especially now that there is a covid outbreak that has not been cleared yet. Potential adverse outcome of not screening visitors before entry into the facility is that visitor may bring in more covid and pass it on to our residents. We want to know that they do not have symptoms of covid before they can come in. The DON stated facility has not received a clearance letter for covid from the Department of Public Health.</p> <p>(continued on next page)</p>		

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