STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555748	A. Building B. Wing	03/24/2025

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 0689 Level of Harm - Minimal harm or potential for 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** 49571 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) remained free of recurrent falls by failing to provide supervision of Resident 1 who is a high fall risk. This deficient practice resulted in Resident 1 had an unwitnessed fall on 2/5/2025, and 3/19/2025 while trying to ambulate to bathroom. Findings: A review of Resident 1 ' s admission record indicated, Resident 1 was originally admitted to the facility on [DATE] with a diagnosis that includes multiple fractures of ribs, dysphagia (difficulty swallowing), history of falls, personal history of transient ischemic attack (TIA-a temporary disruption of blood flow to the brain), unspecified dementia (loss of cognitive functioning, thinking, remembering, and reasoning). 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 9/30/2023 Indicated Resident 1 had a history of falling, have more than one diagnosis. A review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment screening tool), dated 1/22/2025, indicated, Resident 1 ' s cognition (the mental ability to understand and make decisions of daily living) was severely impaired, limitations with daily functions affecting lower extremity (hip, knee, ankle, foot) and uses a walker to ambulate. A review of Resident 1 ' s care plan (CP-a plan of care that summarizes a resident ' s health conditions, specific care needs, and current treatment) for High risk falls and injury created on 1/31/2025 indicated, the CP goal for Resident 1included to utilize call lights for assistance during transfers and ambulation until next review date. Resident 1 will not have more than 1 fall incident until next review date.The CP interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of condition) for Resident 1 indicated to orient Resident 1 to person, place, time, routine and event, re-iteratet the importance of using call lights for assistance, and provide assistance needed with ADL (Activities of Daily Living). (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Morse Fall Risk Screen (assessment tool for prediction of patient ' s potential for experiencing a fall while in a facility) dated 2/5/2025 indicated, Resident 1 had a history of falling, have more than one diagnosis, and impaired gait, overestimates or forgets limits. A review of Resident 1 ' s History and Physical (H&P) dated, 2/7/2025, indicated, Resident 1 was admitted to General Acute Care Hospital (GACH) from 2/5/2025 to 2/6/2025 after falling at thenSkilled Nursing Facility. During an interview on 2/24/2025 at 11:25 AM with Licensed Vocational Nurse (LVN) 1 stated, Resident 1 is confused, sometimes uses hand signal to eat or go to bathroom, does not communicate even with his primary language. LVN 1 stated Resident 1 had falls in the past and injured himself. LVN 1 stated, He [Resident 1] had frequent falls; he just gets up and go to bathroom or go out he does not ask for assistance. A review of Resident 1 ' s Physical Therapy Evaluation and Plan of Treatment dated 3/11/2025, indicated, short term goal plan was for Resident 1 to safely ambulate 100 feet using a two-wheeled walker wit supervision or touching assistance with ability, long term goal safely ambulate 150 feet, and prior cognitive assistance constant supervision needed. A review of Resident 1 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/19/2025 indicated, Resident 1 was found by a desk nurse on the floor next to restroom floor in his room. A review of Resident 1 ' s physician ' s order dated 3/19/2025, indicated, Resident 1 may transfer to emergency room via 911 (emergency medical services or ambulance that are dispatched for emergency to provide immediate transport to a hospital). During an observation in front of Resident 1 ' s room on 3/24/2025 at 11:25 AM, Resident 1 suddenly got up from his bed sat at the edge of bed, attempted to get up and go to bathroom, LVN 1 immediately went in Resident 1 ' s room and prevented a fall, assisted Resident 1 sit on a wheelchair to ambulate to bathroom. During an interview on 3/24/2025 at 11:56 with Registered Nurse (RN) stated, Resident 1 is a long-term resident of the facility, confused, uses wheelchair for ambulation, able to stand and walk but not for long time he loses his balance. He does not follow instructions he does not ask for assistance. A one-to-one/sitter observation likely will help to prevent his falls. During an interview on 3/24/2025 at 1:07 PM with Director of Rehabilitation (DOR) stated, Resident 1 has been in the physical therapy program. DOR stated that in the past Resident 1 benefited from the program physically but not psychosocially because the resident has impaired cognition. DOR stated Resident 1 does does not ask for help when the resident gets up and go which leads to falls. DOR stated Resident 1 can benefit from a sitter or having alert enough roommate who can call on the resident's behalf when the resident gets up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/2025 at 1:45 PM with the Director of Nursing (DON) stated, Resident 1 has dementia, confusion, language barrier, is very independent does not like to get help, and likes to do things on his own. The DON stated Resident 1 lately has been refusing physical therapy, the physical therapy helps him maintain strength and the resident's last two falls were unwitnessed. The DON stated tat Bed alarms are not utilized in the facility. The DON stated the facility will establish anticipatory recognition for further fall prevention interventions. The DON stated the next plan to prevent falls is to have a sitter outside Resident 1's room because the resident does not like to have a sitter in the room. A review of the facility policy and procedures (P&P) titled Falls and Fall Risk, managing reviewed 1/2025, indicated, Resident conditions that may contribute to the risk of falls include: delirium and other cognitive impairment; functional impairment, lower extremity weakness; and incontinence. Monitoring subsequent falls and fall risk, if interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and weather it is appropriate to continue or change current interventions. As needed the attending physician will help the staff reconsider possible causes that may not previously have been identified.