

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 04/29/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan that met the care/services based on the resident's individual assessed needs for one of five sampled residents (Resident 1) by failing to develop an individualized Care Plan (CP) for Resident 1 ' s behavior of removing his own wound dressing.</p> <p>This deficient practice had the potential to have a negative impact on residents ' health and safety, as well as the quality of care and services received.</p> <p>Cross Reference F686.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including surgical aftercare following surgery on the circulatory system (body's network of blood vessels and heart that delivers oxygen and nutrients to cells and removes waste products), Type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and chronic (a condition that persists for a long time, generally lasting three months or more) non-pressure ulcer (open sores on the skin that are not caused by pressure on the skin) of right ankle. The Admission Record also indicated Resident 1 was discharged /transferred to General Acute Care Hospital 1 (GACH 1) on 4/4/2025.</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 3/28/2025 indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 1 required moderate assistance to maximal 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).</p> <p>During a review of Resident 1 ' s Care Plan as of 4/29/2025, there was no CP developed regarding Resident 1 ' s behavior of removing his own wound dressings.</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 0656</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 with TXN 2 on 4/29/2025 at 1:17 p.m., TXN 2 stated Resident 1 had a behavior removing his own wound dressings and leaving it open to air. TXN 2 stated he would come during the day shift and the wound dressing from the previous day would already been removed. TXN 2 further stated, Resident 1 verbalized, he removed the old wound dressing because it was itchy. TXN 2 stated that the licensed nurses assigned to Resident 1 should have changed the dressing if it was removed by residents. TXN 2 further stated, there was no CP developed for Resident 1 ' s behavior.</p> <p>During an interview with Director of Nursing (DON) on 4/29/2025 at 2:21 p.m., DON stated, any licensed nurses can perform skin treatment at any shift and a CP should be developed on Resident 1 ' s behavior so that may address his behavior. DON stated, if a resident removed the wound dressing on his own, it puts the resident at risk of infection as he might scratch the wound and bleed. DON further stated, it should have been documented in the progress notes as well and notified the physician.</p> <p>During a review of facility ' s policy and procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, reviewed on 1/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan will:</p> <ul style="list-style-type: none"> a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. <p>During a review of facility ' s P&P titled, Nursing Care of the Resident with Diabetes Mellitus, reviewed on 1/2025, the P&P indicated, Skin should be kept as dry and clean as possible.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on interviews and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Obtain a wound consultation in the management of wound and maintain skin integrity for one of five sampled residents (Resident 1). 2. Ensure Resident 1 ' s Treatment Administration Record (TAR) were documented accurately per facility ' s policy and procedure (P&P) titled, Charting and Documentation. 3. Ensure Resident 1 ' s wound dressings are monitored and kept clean and dry per physician ' s order. <p>These deficient practices had the potential to delay the provision of necessary care and services and deterioration of residents ' current wounds.</p> <p>Findings:</p> <p>A. During a review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including surgical aftercare following surgery on the circulatory system (body's network of blood vessels and heart that delivers oxygen and nutrients to cells and removes waste products), Type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and chronic (a condition that persists for a long time, generally lasting three months or more) non-pressure ulcer (open sores on the skin that are not caused by pressure on the skin) of right ankle. The Admission Record also indicated Resident 1 was discharged /transferred to General Acute Care Hospital 1 (GACH 1) on 4/4/2025.</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 3/28/2025 indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 1 required moderate assistance to maximal 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).</p> <p>During a review of Resident 1 ' s Order Summary Report, dated 3/25/2025, the OSR indicated the following:</p> <ol style="list-style-type: none"> i. Right dorsal foot (refers to the top or upper side of the foot, opposite the sole or bottom) arterial (blood vessels that distribute oxygen-rich blood to the entire body) wound - cleanse with normal saline (NS - a mixture of salt and water that can be applied directly to the wound site). Pat dry. Apply xeroform (a non-adhering, occlusive gauze dressing [a type of dressing used in wound care that creates a sealed environment to protect the wound and promote healing]), cover with ABD pad (used to absorb discharges) then wrap with kerlix (gauze rolls with open-weave design that provides fast wicking action, aeration and absorbency) every day <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ii. Right femoral (thigh bone) area incision site - cleanse with NS. Pat dry then cover with ABD pad, every day</p> <p>iii. Right foot wound: cleanse with NS. Pat dry then apply mupirocin (used to treat some skin infections), 2 percent (% - unit of measurement) and gentamycin (treat skin infections caused by certain bacteria) 0.1% topical daily.</p> <p>During a review of Resident 1 ' s Medical Record, as of 4/29/2025, there was no consultation and assessment by a Wound Provider Specialist (WPS).</p> <p>During a review of Resident 1 ' s Weekly Non-pressure Ulcer Observation Tool, dated 4/2/2025, Treatment Nurse 1 (TXN 2) documented, Resident (1) was supposed to be seen by wound specialist today, but resident (1) was not in the room. WPS will see resident next visit.</p> <p>During a concurrent interview and record review with TXN 2 on 4/29/2025 at 1:17 p.m., TXN 2 stated, WPS comes in the facility once a week, usually on Wednesdays, but they may also come anytime for new admit residents and if a resident needs a wound consultation. TXN 2 stated, according to Resident 1 ' s medical record, Resident 1 has not been seen by WPS since admitted and Resident 1 ' s wound and skin integrity was not evaluated by WPS. TXN 2 further stated Resident 1 had a behavior removing his own wound dressings and leaving it open to air. TXN 2 stated he would come during the day shift and the wound dressing from the previous days have been removed. TXN 2 further stated, Resident 1 verbalized, he removed the old wound dressing because it was itchy. TXN 2 stated that the licensed nurses assigned to Resident 1 should have changed the dressing if it was removed by residents. TXN 2 further stated, there was no CP developed for Resident 1 ' s behavior.</p> <p>During an interview with Director of Nursing (DON) on 4/29/2025 at 2:08 p.m., DON stated, resident with any skin integrity such as surgical wounds and non-pressure ulcer, there should be a wound assessment and consultation by a WPS upon resident ' s admission so they can validate if the current treatment orders for wounds are appropriate for the residents. DON stated, a WPS can come any day if needed. DON further stated, if a licensed nurse noticed the wound dressing was removed by Resident 1, they need to change and cover the wound and surgical sites to keep it clean and dry as ordered by the physician.</p> <p>B. During a review of Resident 1 ' s TAR on 4/7/2025, the TAR indicated, Licensed Vocational Nurse 1 (LVN 1) documented, all skin treatment was documented as given.</p> <p>During a concurrent interview and record review with DON on 4/29/2025 at 2:21 p.m., DON stated, Resident 1 ' s TAR was not accurately documented and charted as Resident 1 was transferred to GACH 1 on 4/4/2025 and was not in the facility on 4/7/2025. DON further stated, Resident 1 ' s TAR documentation was fraudulent.</p> <p>During a review of facility ' s P&P, titled, Consulting Physician, reviewed on 1/2025, the P&P indicated, It is the policy of this facility that primary physician will be aware of all consulting physician orders.</p> <p>During a review of facility ' s P&P titled, Nursing Care of the Resident with Diabetes Mellitus, reviewed on 1/2025, the P&P indicated, Skin should be kept as dry and clean as possible.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility ' s P&P titled, Charting and Documentation, reviewed on 1/2025, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p> <p>During a review of facility ' s P&P titled, Podiatry/Food Services, reviewed on 1/2025, the P&P indicated, Podiatric services are provided for those residents who need such service for a specified reason and at a frequency determined by the needs of the individual residents; provided in a manner to prevent infections, and consistent with the facility ' s infection control policies and practices.</p>		