

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056334	(X2) MULTIPLE CONSTRUCTION A. BUILDING 11912  D. WING	(X3) DATE SURVEY COMPLETED  C 03/16/2016
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NAME OF PROVIDER OR SUPPLIER  BEACHWOOD POST-ACUTE & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15TH STREET 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The following reflects the findings of the Department of Public Health during the investigation of an Entity Reported Incident (ERI) during an Abbreviated standard survey.  ERI Number: CA00478820  Representing the Department of Public Health:  Surveyor ID: 11912, RN, HFEN  The inspection was limited to the specific ERI investigated and does not represent the findings of a full inspection of the facility.  One deficiency was issued related to ERI CA00478820  Highest Severity and Scope: D F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING SS=D  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the licensed nurses assess and monitor resident's swollen and discolored left index finger every shift for 72 hours	F 000	Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 3, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Beachwood Post-Acute & Rehab credible allegation of compliance.  F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Identification of other residents and corrective actions:  On March 16, 2016, this resident was reassessed by the DON and found not to be affected by the deficient practice. All other resident in the facility with a change of condition were assessed by the RN supervisor and steps were taken to correct the deficient practice. The residents that were assessed were not affected by the deficient. Corrections action were taken were inservices were given to both RN's, LVN's and CNA's on how to monitor and document on residents with change of condition according to facility's policy. A policy for monitoring and documenting for 72hrs was put in place.	3/16/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE 4/4/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  058334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2016
NAME OF PROVIDER OR SUPPLIER  BEACHWOOD POST-ACUTE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15TH STREET SANTA MONICA, CA 90404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 1</p> <p>for one of one sampled resident (Resident 1). This deficient practice placed Resident 1 at risk for delay treatment and interventions.</p> <p>Findings:</p> <p>On March 16, 2016, at 8:25 a.m., during the investigation of an entity reported incident regarding Resident 1's swollen discolored left index finger.</p> <p>According to the admission record, Resident 1 was admitted to the facility on September 26, 2015, with diagnosis of osteoarthritis.</p> <p>A review of the Licensed Nurses Progress notes indicated on March 2, 2016, at 2:30 p.m., the licensed nurse documented the resident's left index finger was discolored. The resident denied pain and stated the discoloration started the day before.</p> <p>A care plan dated March 2, 2016 for left index finger discoloration. The goal indicated to resolve without complication. The approaches included to monitor for pain every shift, observe careful handling, and to monitor for inflammation (swelling), and skin breakdown.</p> <p>Further review of the Licensed Nurses Progress notes dated March 2 and 3, 2016, for 3 p.m. to 11 p.m. shift and on March 5, 7 a.m. to 3 p.m. shift, Resident 1's left index finger was not assess and/or monitor for swelling, pain and skin breakdown.</p> <p>During an interview and record review with the director of nurses (DON) on March 16, 2016, at 9:20 a.m., she was unable to locate documented</p>	F 309	<p>Systemic Changes and Measures to Prevent reoccurrence.</p> <p>Systemic changes and measures consisted of inservicing of all RN's, LVN's and CNA. Medical Records will audit all residents with a change of conditions charts weekly and will report findings to the DON.</p> <p>Monitoring of Performance</p> <p>The DON will monitor monthly to make sure the practices is done per facility's policy. DON will report any deficient practice to the QA Committee for follow up.</p>	3/16/2016	3/16/2016

# Change in a Resident's Condition or Status

## Policy Statement

Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).

## Policy Interpretation and Implementation

1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:
  - a. An accident or incident involving the resident;
  - b. A discovery of injuries of an unknown source;
  - c. A reaction to medication;
  - d. A significant change in the resident's physical/emotional/mental condition;
  - e. A need to alter the resident's medical treatment significantly;
  - f. Refusal of treatment or medications (i.e., two (2) or more consecutive times);
  - g. A need to transfer the resident to a hospital/treatment center;
  - h. A discharge without proper medical authority; and/or
  - i. Instructions to notify the physician of changes in the resident's condition.
2. A "significant change" of condition is a decline or improvement in the resident's status that:
  - a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self-limiting");
  - b. Impacts more than one area of the resident's health status;
  - c. Requires interdisciplinary review and/or revision to the care plan; and
  - d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the *Resident Assessment Instrument* and 42 CFR 483.20(b)(ii).
3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:
  - a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
  - b. There is a significant change in the resident's physical, mental, or psychosocial status;
  - c. There is a need to change the resident's room assignment;
  - d. A decision has been made to discharge the resident from the facility; and/or
  - e. It is necessary to transfer the resident to a hospital/treatment center.
4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.
5. Regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments.
6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

*continues on next page*

Beachwood Post-Acute & Rehab

1340 15<sup>th</sup> St. Santa Monica Ca. 90404

IN-SERVICE STAFF ATTENDANCE

PRINT

SIGN

SHIFT

PRINT	SIGN	SHIFT
Fred Appiah	[Signature]	3-11 (CNA)
Omar Alvarado Ayala	[Signature]	3-11 (CNA)
WILHEMINA EDUARDO	[Signature]	3-11 (CNA)
Carey Ann Bess	[Signature]	7-3 CNA
Arcelia Morales	[Signature]	7-3 CNA
Samer Mafumong	[Signature]	7-3 CNA
PATRICK PETER	[Signature]	3-11 CNA
FLORENCE ONE	[Signature]	7-3 CNA
SENDA IDIEGBE	[Signature]	7-3 CNA
John Kelly	[Signature]	7-3 CNA
Antanika Godfrey	[Signature]	3-11 (CNA)
Jesus Abraham	[Signature]	3-11 (CNA)
Ruel Navarro	[Signature]	7-3 CNA
Dennis Villanueva	[Signature]	7-3 CNA
Monammed Hussein	[Signature]	3-11 CNA
NEVITA D. ASTILLO	[Signature]	3-11 CNA
Shabriel Jenkins	[Signature]	7-3 CNA
Blanca Aguila	[Signature]	7-3 CNA
Ryan Fritz	[Signature]	7-3 CNA
ANTONIA MOZARO	[Signature]	3-11 CNA
RASH GAYSON	[Signature]	3-11 CNA
Aracelly Campos	[Signature]	7-3 CNA
Taina Freidman	[Signature]	3-11 CNA
San of CNA	[Signature]	11-7
Ismael Vasquez	[Signature]	7-3 CNA
Abigail Escobar	[Signature]	3-11 CNA
Martine Cruz	[Signature]	7-3 CNA
Reina Ramirez	[Signature]	7-3 CNA
Catherine Eyango	[Signature]	3-11 CNA

5/29/16 2pm

Beachwood Post-Acute & Rehab

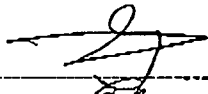
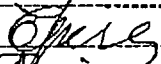
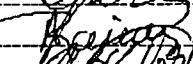
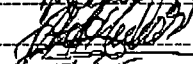

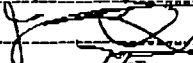
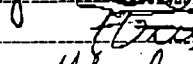
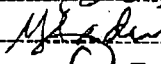
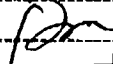
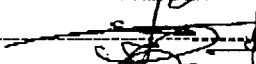

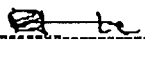
1340 15<sup>th</sup> St. Santa Monica Ca. 90404

IN-SERVICE STAFF ATTENDANCE

PRINT

SIGN

SHIFT

Alemayehu Ayale		3-11
Juan Teodelinda		7-3 CNA
Rosa Ramirez		7-3 CNA
Anna L. Garibay		7-3 CNA
Meseret Asrat		3-11 "
Jenniffer Pereira		3-7 CNA
Omar Manzano Ayala		3-11 CNA
Gladys Vasquez		7-3 CNA
ANNIE MARQUEZ		3-11 RN
SHUTAN LU		11-7 RN
Tamara Montano		3-11 CNA
PATRICIA FOWLER, LVN		3-11 LVN