DEPARTMENT C.F HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

accepted \$\frac{10}{10} \rightarrow PRINTED: 05/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AN IMPED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		056334	B. WING				C 05/02/2016
NAME OF PROVIDER OR SUPPLIER BEACHWOOD POST-ACUTE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1340 15TH STREET SANTA MONICA, CA 90404			,022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION S		BE	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		\$	
F 514 SS=D	The following reflects the findings of the Department of Public Health during the investigation of a complaint Complaint number: CA00482705. Representing the Department: Surveyor 11912, RN, HFEN The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number CA00482705 at Ftag 514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document a change of condition for one		F 5	t t t C s c s c s c s c s c s c s c s c s c s	MAY	pages 1 through 3, an admission or der of the truth of dusions set forth in nices. This Plan of and/or executed ired by provisions, and Health and so. In response to gs we submit the cition which shall Post Acute and an of compliance. Post in the compliance of condition was urse (LN) prior to on 4/3/16 per nurse conducted	

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.

ADMINISTRATOR

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 05/02/2016	
		056334					
NAME OF I	PROVIDER OR SUPPLIER	0000-		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			02/2010
BEACHWOOD POST-ACUTE & REHAB					340 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 PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From page 1		F5	14			
	of four sampled residents (1), which had the potential to result in a delay in treatment and services. Findings: During a review of the clinical record for Resident 1, the admission facesheet, indicated Resident 1 was readmitted to the facility on March 13, 2016, with diagnoses that included chronic				On 5/11/16 Medical Records staff authe clinical records of other resitransferred to the acute hospital due change of condition between 4/11	dents e to a	5/11/16
					5/11/16 and no similar findings were fo	-	
	obstructive pulmona disease gets worse) difficult to breathe),	ary disease (a progressive [the e] lung disease that makes it diabetes mellitus (high blood ension (high blood pressure). Set (MDS) Resident are Screening dated March Resident 1 as being d in cognition, with no and required limited ing and extensive assistant			Licensed Nurses (LNs) and medical re staff were in-serviced by the DOI 5/11/16 and 5/12/16 regarding facility p and procedure titled "Change	N on policy	5/11/16
	Assessment and Ca 21, 2016, identified moderately impaired behavior problems a				Resident's Condition or Status." Me Records staff will conduct daily (Mo thru Friday) audits of Resident's chan condition or status to ensure docume evidence of an assessment of the residence condition prior to transfer. Any change resident's condition are reviewed	onday nge in ented dent's ges in	
	A review of the Progress Notes dated April 3, 2016, at 2 p.m., indicated, the responsible party requested to transfer Resident 1 to the acute mospital due to the resident being confused. Further review of the record did not contain				(Monday thru Friday) by the IDT durin facility activity Matrix report review d stand up, any findings will be correct necessary.	uring	
	or information of the re- condition or status. At documented the reside emergency medical tec responsive, and had a l a pulse rate of 112 bear	resident's being confused resident's medical/mental at 2:31, the licensed nurse lent was transported by echnician (EMT), was alert, a blood pressure of 124/76, eats per minute, a respiratory ture of 97 degrees, and an 97 per cent.			Recapitulation of findings will be reported by Medical Records Director on a most and quarterly basis to the QA committee for further review recommendations to counteract patterns or trends. Licensed nurses implement recommendations as necessing	nthly & A and any will	

PRINTED: 05/11/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ B. WING 056334 05/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1340 15TH STREET BEACHWOOD POST-ACUTE & REHAB** SANTA MONICA, CA 90404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 2 F 514 The Final Licensed Nurses Progress Note dated April 3, 2016, indicated the licensed nurse documented the resident was discharged to the acute hospital for evaluation. During an interview and record review with the director of nurses on May 2, 2016, at 10:15 a.m., she was unable to locate documented evidence of an assessment of the resident's condition prior to transfer. The facility policy and procedure titled "Change in a Resident's Condition or Status" dated September 2013, indicated 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.