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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056334	A. BUILDING _____ B. WING _____	C 08/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACHWOOD POST-ACUTE & REHAB	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 000	INITIAL COMMENTS Surveyor: 40541 The following reflects the findings of the California Department of Public Health during an investigation of a complaint. Complaint Number: CA00642225 Representing the California Department of Public Health: Health Facilities Evaluator Nurse: 40541 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. A deficiency was issued for Complaint Number: CA00642225.	F 000	**This plan of correction as submitted shall serve as provider's letter of credible allegation in reference to the survey findings. Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 405.1907.**	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Connie | TITLE: Asst. Administrator | (X6) DATE: 9/27/19

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.

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F 842	Continued From page 1 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	DON in-serviced LN 1 regarding proper skin documentation of Resident 1 upon transfer from the facility. Completed 8/15/19. DON reviewed transfer records for the previous 30 days to ensure that proper skin documentation was completed upon transfer from the facility. Completed 8/17/19. DON completed an in-service with licensed nurses regarding properly documenting residents skin condition upon admission and transfer from the facility. Completed 8/20/19. Medical Records Director or designee to audit transfer from the facility records documented on an audit log at least 3x a week X 4 weeks then 1 X a week X 3 months to ensure that skin assessment is properly documented. Any findings will be reported to the DON and will be corrected immediately. On-going.	8/15/19 8/17/19 8/20/19

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F 842	Continued From page 2 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 40541 Based on interview and record review, the facility failed to maintain complete and accurate skin assessment documentation records for one of three sampled residents (Resident 1). This deficient practice had the potential for the resident's needs not being provided and placed resident at risk to not attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Findings: A. On 6/28/19, at 2:10 p.m., an unannounced visit was made to the facility to investigate a complaint regarding quality of care and treatment. A review of the admission record indicated Resident 1 was admitted to the facility, on 2/11/19, with diagnoses including Type II diabetes mellitus (high blood sugar) without complications and essential hypertension (high blood pressure).	F 842	Findings from the Medical Records audit will be reported to the Administrator and DON for immediate corrections. Director of Nursing to report any findings regarding skin assessment not being completed upon transfer from the facility in the quarterly quality assurance meeting. Any trends will be reviewed using root cause analysis and the Quality Assurance Performance Improvement (QAPI) will be reviewed and revised as necessary for on-going monitoring for maintained substantial compliance. On-going.	

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F 842	Continued From page 3 A review of the nursing progress notes, dated 2/12/19, at 5:36 a.m., indicated Resident 1 had a left shin scab, left elbow wound with dressing intact, and a left great toe wound. A review of the nursing progress notes, dated 2/12/19, at 10:06 p.m., indicated Resident 1 had a healing sacral wound and staples on the abdomen. According to a review of the nursing progress notes, dated 2/23/19, at 3:14 p.m., indicated a comprehensive head to toe skin evaluation was conducted and Resident 1 had a midline abdominal incision with 25 staples intact, dry, no signs or symptoms of infection, no signs or symptoms of skin breakdown noted over any pressure sites at this time. A review of the nursing progress notes, dated 2/26/19, at 7:07 p.m., indicated Resident 1's skin had staples on midline open to air, coccyx (tailbone) were healed, otherwise skin intact. A review of the physician's order, dated 2/27/19, indicated Resident 1 was to receive left shin special instructions: cleanse wound with normal saline, pat dry, paint with betadine solution, cover with dry dressing every day and as needed, if pulled out/soiled x 14 days then re-evaluate. A review of the physician's order, dated, 2/27/19, indicated Resident 1 was to receive right elbow special instructions: paint pressure injury with betadine solution, cover with dry dressing every day and as needed, if pulled out/soiled x 14 days then re-evaluate. A review of the physician order, dated 2/27/19,	F 842		

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F 842	Continued From page 4 indicated for Resident 1 to receive sacrum special instructions; cleanse pressure injury with normal saline, pat dry, apply hydrogel, apply zinc oxide peri-wound (surrounding wound) area, cover with dry dressing every day and as needed if pulled out/soiled x 14 days then re-evaluate. A review of the physician order, dated 2/27/19 and 3/6/19 indicated for Resident 1 to receive coccyx special instructions: cleanse pressure injury with normal saline, pat dry, apply hydrogel, apply zinc oxide to peri-wound (surrounding wound) area, cover with dry dressing every day and as needed, if pulled out/soiled x 14 days then re-evaluate. A review of the physician order, dated 3/6/19, indicated for Resident 1 to receive left shin special instructions: cleanse wound with normal saline, pat dry, apply triple antibiotic ointment, cover with dry dressing every day and as needed, if pulled out/soiled x 14 days then re-evaluate. During an interview, on 8/4/19, at 12:33 p.m., RN 1 stated and confirmed the nursing progress notes documentation did not indicate a complete and accurate representation of Resident 1's skin at that time. RN 1 stated that an accurate and complete documentation indicating the number, size, and location of Resident 1's wounds should have been done. B. A review of the discharge and transfer - hospital transfer form, dated 3/9/19, indicated a head to toe skin check was done at the time of transfer with the only noted skin issue to be a pressure ulcer (wound), right elbow. No other skin issues documented.	F 842		

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F 842	Continued From page 5 During an interview with Licensed Vocational Nurse 1 (LVN 1), on 7/2/19, at 2:00 p.m., LVN 1 stated a complete and accurate skin assessment should have been documented on the discharge and transfer - hospital transfer form because the transfer was a non-emergency transfer and the documentation did not indicate a complete and accurate representation of Resident 1's skin at that time. LVN 1 stated the transfer form should have included all of Resident 1's wounds and not just the elbow wound. A review of the facility's policy and procedure titled, "Charting and Documentation," revised April 2008 indicated all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. The policy indicated interpretation and implementation: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: c. the assessment date and/or any unusual findings obtained during the procedure/treatment.	F 842		