STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555027	A. BUILDING _____ B. WING _____	03/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACHSIDE NURSING CENTER	7781 GARFIELD AVENUE HUNTINGTON BEACH, CA 92648

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to promote the dignity and respect by failing to answer the residents' call lights timely for two of 16 final sampled residents (Residents 14 and 309) and three nonsampled residents (Residents 31, 359, and 362). These residents resided in different rooms located throughout the facility. This failure resulted in the residents feeling neglected, frustrated, upset, uncomfortable, and sad. Findings: 1. Medical record review for Resident 362 was initiated on 3/10/2020. Resident 362 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Change in Condition progress notes dated 2/28/2020, showed Resident 362 was washing her hands in the bathroom with the assistance of a CNA and without warning, Resident 362 lost consciousness. The CNA was able to grab a hold of Resident 362 and assisted her to the floor. Review of Resident 362's history and physical examination [REDACTED]. Review of Resident 362's Hospitalist Discharge Summary dated 2/29/2020, showed Resident 362 had a recent history of multiple syncopal episodes ([MEDICAL CONDITION] or sudden temporary loss of consciousness). On 3/11/2020 at 1212 hours, an interview was conducted with Resident 362. Resident 362 stated she was admitted to the facility approximately two weeks ago. Resident 362 stated when she was first admitted to the facility she fainted in the bathroom. She stated when she fainted, luckily a staff was present, and staff caught her when she fainted. Resident 362 stated the rehabilitation staff educated her on the need to utilize her call light and request staff assistance when transferring in and out of bed. Resident 362 stated she utilized the call light when she needed to use the bathroom, however, sometimes the staff at the facility were very busy. Resident 362 stated on approximately six occasions since her admission to the facility, it took staff approximately twenty minutes to respond to her call light. Resident 362 stated she knew she was not supposed to get out of bed without assistance, however, she did on several occasions when she needed to use the bathroom. Resident 362 was asked how it made her feel having to wait up to 20 minutes for staff assistance to use the bathroom, to which she replied, I got used to it, at my age I try not to get upset. Resident 362 stated she used the clock located on the wall in her room to determine how long she had waited. On 3/12/2020 at 0931 hours, an interview and concurrent medical record review was conducted with PT 1. PT 1 stated a physical therapy evaluation and plan of treatment was conducted for Resident 362 shortly after admission to the facility. PT 1 stated based on Resident 362's physical therapy evaluation dated 3/1/2020, staff supervision was recommended for Resident 362 when transferring in and out of bed to use the bathroom. 2. Medical record review for Resident 359 was initiated on 3/10/2020. Resident 359 was admitted to the facility on [DATE]. Review of Resident 359's History and Physical dated 3/8/2020, showed Resident 359 was cognitively intact. On 3/10/2020 at 1530 hours, an interview was conducted with Resident 359. Resident 359 stated this morning after having ambulated with her front wheeled walker, she returned to her room. Once inside of her room she then sat on her bed and pressed her call light in order to request staff assistance. Resident 359 stated she needed staff assistance to get back into bed due to a recent injury and a knee brace which limited her range of motion. Resident 359 stated after having utilized her call light she waited approximately 25 minutes for staff to arrive. Resident 359 stated several staff members had passed by her room and she attempted to get their attention by calling out to them, however, they did not assist her. Resident 359 was asked how the incident made her feel to which she replied, I felt neglected. Resident 359 stated she used the clock located on the wall in her room to determine how long she had waited. On 3/12/2020 at 0950 hours, and interview and concurrent medical record review for Resident 359 was conducted with PT 1. PT 1 stated a physical therapy evaluation and plan of treatment was conducted for Resident 359 shortly after admission to the facility. PT 1 stated based on Resident 359's physical therapy evaluation dated 3/6/20, staff assistance was recommended for Resident 339 when transferring in and out of bed. 3. Medical record review for Resident 31 was initiated on 3/12/2020. Resident 31 was admitted to the facility on [DATE]. On 3/12/2020 at 0835 hours, an observation and concurrent interview was conducted with Resident 31. Resident 31 was observed sitting on her wheelchair and had a cast on her left arm. Resident 31 stated she used her call light for assistance; however, it took more than 20 minutes for the staff to respond. Resident 31 stated this morning, she pressed her call light for because she needed assistance to use the bathroom. Resident 31 stated a CNA came and told her she had to wait because she had another resident to attend to. Resident 31 stated she felt frustrated and upset because she took a diuretic and she wanted to use the toilet before she ate breakfast. . Review of the MDS dated [DATE], showed Resident 31 had no cognitive impairment. Resident 31 required extensive assistance of one person for toilet use, and extensive assistance of two persons for transfers. Review of the plan of care showed a care plan problem to address Resident 31's high risk for falls initiated on 2/16/2020. The interventions included to anticipate encourage the resident to use the call light for assistance. The resident needed prompt response to all requests for assistance. 4. Medical record review for Resident 14 was initiated on 3/10/2020. Resident 14 was readmitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 14 had no cognitive impairment. Resident 14 required extensive assistance of two persons for transfers and toilet use. On 3/10/2020 at 1348 hours, an interview was conducted with Resident 14. Resident 14 stated he used the call light when he needed assistance, however, he had to wait approximately 30 minutes for the staff to respond. Resident 14 stated he knew the time by looking at the clock in his room. Resident 14 stated one example was when his urine leaked from his incontinence briefs, it took 30 minutes for the staff to respond to the call light. Resident 14 stated his wheelchair cushion got wet from urine. Resident 14 stated he felt frustrated, upset, and sad when he had to sit on his urine. 5. Medical Record review for Resident 309 was initiated on 3/10/2020. Resident 309 was admitted to the facility on [DATE]. Review of Resident 309's Bowel and Bladder assessment dated [DATE], showed Resident 309 needed the assistance of one person to get to the bathroom or transfer to the toilet. On 03/10/2020 at 1335 hours, an interview was conducted with Resident 309. Resident 309 stated when she pressed her call light for assistance during the night shift (2300 to 0700 hours), she had to wait for 30 minutes for the staff to respond. Resident 309 stated she knew the time by looking at the clock in her room. Resident 309 stated she needed help to go to the bathroom and had to hold her urine or bowel movement. Resident 309 stated it was uncomfortable to hold her urine or bowel movement for a long time. This made her because she had a urinary tract infection before she was admitted to the facility.
F 0583 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Keep residents' personal and medical records private and confidential.** Based on observation and interview, the facility failed to ensure the privacy was provided during care for one nonsampled resident (Resident 310). * The facility failed to ensure visual privacy was provided for Resident 310 during the medication administration. This had the potential to violate the resident's rights to privacy. Findings: On 3/12/2020 at 0839 hours,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0583 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) an observation of the medication administration for Resident 310 was conducted with LVN 3. Resident 310 was observed in bed in a shared room. LVN 3 administered Resident 310's medications, including eye drops and application of a patch to Resident 310's left upper arm. Resident 310's privacy curtain was observed partially open, leaving Resident 310 visible to the resident in the next bed and anyone passing by in the hallway. On 3/12/2020 at 0920 hours, an interview was conducted with LVN 3. LVN 3 stated she forgot to close the privacy curtain and stated it should have been closed.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to administer the medication in accordance with the physician's order for one nonsampled resident (Resident 310). * LVN 3 was observed administering an eye drop solution to Resident 310 more than the amount prescribed by the physician. This failure had the potential for the resident to experience adverse effects. Findings: On 3/12/2020 at 0839 hours, a medication pass observation for Resident 310 was conducted with LVN 3. LVN 3 was observed administering medications including [MEDICATION NAME] (eye drop medication for [MEDICAL CONDITION]) solution into Resident 310's right eye. LVN 3 was observed administering one drop of the [MEDICATION NAME] solution into Resident 310's right eye, however, the medication did not go into the eye. LVN 3 repeated the process and this time, some of the medication went into the eye and some trickled out. LVN 3 was observed administering another drop of the [MEDICATION NAME] solution to resident 310's right eye for the third time, when the resident stated, why are you doing it again, I felt the drop in my eye. LVN 3 proceeded to administer another drop of the [MEDICATION NAME] solution into Resident 310's right eye. On 3/12/2020 at 0920 hours, an interview was conducted with LVN 3. LVN 3 verified she administered more than one drop of the [MEDICATION NAME] solution to Resident 310's right eye. Review of Resident 310's Order Summary Report showed an order dated 3/6/2020, for [MEDICATION NAME] solution 0.2-0.5%, instill one drop in both eyes two times a day for [MEDICAL CONDITION].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure safe storage of medications. * Resident 44 was observed with medications at the her bedside even though she had been assessed and determined unsafe to self-administer the medications. This failure had the potential to result in unsafe administration of medications. Findings: On 3/11/2020 at 0900 hours, a medication cup containing medications mixed in apple sauce was observed on top of Resident 44's over bed table. Resident 44 was in the room with a family member. The family member stated LVN 1 left the medications for Resident 44 to take. Medical record review for Resident 44 was initiated on 3/11/2020. Resident 44 was readmitted to the facility on [DATE]. Review of the Baseline Care Plan dated 2/19/2020, showed Resident 44 could not self-administer the medications. On 3/10/2020 at 1045 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated he left the medication at bedside and the family member would administer the medication to Resident 44. LVN 1 stated there were eight pills mixed in apple sauce inside the medication cup left at Resident 44's bedside. LVN 1 verified she should not have left the medications at bedside.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and facility document review, the facility failed to ensure food safety and sanitation requirements were met in the kitchen as evidenced by: * The facility failed to ensure the ice machine was clean. This failure posed the risk for food-borne illnesses and cross contamination. Findings: Review of the CMS 672 Resident Census and Conditions of Residents completed by the facility dated 3/10/2020, 56 of 56 residents residing in the facility received food prepared in the kitchen. During the initial tour of the kitchen on 3/10/2020 at 1400 hours, an observation and concurrent interview was conducted with the DSS/RD. The ice machine was checked with the DSS/RD. The ice chute inside the ice machine was wiped with a clean tissue. The clean tissue was observed with black residue. The DSS/RD verified the findings. The DSS/RD stated the ice machine was last cleaned by the Maintenance Supervisor on 2/28/2020. On 3/17/2020 at 1130 hours, a telephone interview was conducted with the DSS/RD regarding the black residue observed from the ice machine during the initial tour of the kitchen. The DSS/RD was asked what the black residue was. The DSS/RD stated it was dirty. On 3/17/2020 at 1347 hours, a telephone interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he cleaned the ice machine every month, and followed the manufacturer's guidelines. The Maintenance Supervisor stated he was aware of the black residue that was observed from the ice machine on the initial tour. The Maintenance Supervisor stated it might have been a dirt, and he missed wiping it.