STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055540	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Monica Health Care Center	1320 20th Street 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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055540	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Monica Health Care Center	1320 20th Street 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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident 2 received the necessary behavioral health care and services for mental and psychosocial well-being as part of Resident 2's comprehensive assessment. These deficient practice of failing to provide one of five residents (Resident 2) a behavioral health care and services caused physical harm to another resident during a physical altercation. During a review of Resident 2's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 2 was admitted to the facility on [DATE] with the following diagnoses: autoimmune thyroiditis (an illness caused by the immune system attacking healthy tissues), hyperlipidemia (high cholesterol [fat] in the body), gastroesophageal reflux disease (a common condition where the stomach acid repeatedly flows back into the esophagus [a tube that connects your mouth and stomach]), muscle weakness, and unsteadiness on feet. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 11/07/2025, indicated, Resident 2 is cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired) and did not require mobility devices (helps a person walk or move from place to place when one has a disability or injury) to ambulate (walk). During a review of Resident 2's Physician Order Report (a condensed, organized document summarizing a patient's key medical information, including diagnoses, treatments, current medications, test results, and follow-up instructions) dated 11/17/2025 with open ended as the end date, indicated Resident 2 can go on pass for 4 to 6 hours. During a review of Resident 2's Psychology Notes (a standardized tool used by psychologists to record resident's mental and emotional state, behavior and any changes in their condition, to inform care planning and treatment) dated 11/21/2025, 12/11/2025 and 12/17/2025 indicated, Resident 2 declined to be seen. During a review of Resident 2's history and physical (H&P - a physician's complete patient examination) dated 11/30/2025 indicated, Resident 2 had the capacity to make medical decisions. During a review of Resident 2's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on verbal and physical aggression dated 12/09/2025 indicated, Resident 2's CP approach was to refer Resident 2 to a psychologist or psychiatrist to allow Resident 2 verbalization in a managed and controlled environment to prevent reoccurrence of aggression. During a review of Resident 2's Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 12/09/2025 at 8 PM, indicated, Resident 2 refused to go to the hospital for mental health evaluation after a physical altercation with Resident 1. During a review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) titled Resident to Resident Altercation sign-in sheet dated 12/09/2025 and 12/10/2025 indicated, education was provided to several nursing staff. During a review of Resident 2's Physician Order Summary Report dated 12/10/2025 with open ended as an end date, indicated, Resident 2 has to have a 1:1 sitter (a caregiver provides dedicated, focused attention and assistance to a single individual, ensuring their needs and well-being are met with personalized support) for safety every shift - 7AM to 3PM, 3PM to 11PM, and 11PM to 7AM. During a review of Resident 2's physician progress notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 12/13/2025 indicated, Resident 2 need to have a sitter but allowed to go out of facility. During an interview on 12/24/2025 at 10:57 AM with Certified Nurse's Aide (CNA) 1, CNA 1 stated Resident 2 gets aggressive, agitated, frustrated when [Resident 2] doesn't get [Resident 2's] way. [Resident 2] is not calm. CNA 1 stated the potential harm that may come to Resident 2 while out on pass (OOP - a patient has temporary, authorized leave from the facility for a short period [hours to a day or two] to go home or elsewhere, often for family visits or personal needs, with arrangements for their return, requiring physician and nursing approval and documentation) may cause physical contact with others like argue with another civilian.might argue too much and start fighting but only when [Resident 2] doesn't get [Resident 2's] way. During an interview on 12/24/2025 at 11:12 AM with a licensed vocational nurse (LVN) 1, LVN 1 stated [Resident 2] doesn't get along with roommates.[Resident 2] causes problems so roommates will be moved to another room. LVN 1 stated Resident 2 needed to be on a 1:1 with a sitter because [Resident 2] might hurt a staff or other residents here.unpredictable behavior. LVN 1 stated the potential harm that may come to Resident 2 while out on pass without a staff member was physical harm - fall, break arm or leg, and Resident 2 may come in contact with someone where [Resident 2] does not agree