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	01/23/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's policy and procedure (P&P) titled, Care Plan Conference, to develop the plan of care based on resident's comprehensive assessment and notify and inform residents and its legal representative for three of four sampled residents, (Resident 1, Resident 3 and Resident 4). This deficient practice violated the resident and legal representative the right to participate in the planning process and establish expected goals and outcomes of care.1.During a review of Resident 1's Face Sheet (FS), the FS indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart), peripheral vascular disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). During a review of the Minimum Data Set (MDS -a resident assessment tool) dated 12/30/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS also indicated Resident 1 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Medical Record as of 1/23/2026, there was no Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) meeting and care plan conference upon Resident 1's admission. During an interview with Resident 1's Care Coordinator (CC 1) on 1/23/2026 at 8:36 a.m., CC1 stated, she visited Resident 1 in the facility and tried to inquire about Resident 1's plan of care and goals during her stay in the facility and no staff was able to provide her with the care plan and documentation. CC 1 stated, she contacted facility's staff in the social services department and no one had contacted her back and no staff was able to answer her questions. During a concurrent interview and record reviews with Director of Staff and Development (DSD) on 1/23/2026 at 12:04 p.m., DSD stated, Resident 1's CC 1 came to the facility and inquire about Resident 1's plan of care but she was unable to provide her with any information regarding Resident 1. SSD stated that she notified social services department regarding CC 1's inquiries. SSD stated, upon admission, an IDT meeting must be held to discuss resident's plan of care during the stay in the facility, and the resident and/or resident's representative (RR) should be included in the care conference meeting. SSD reviewed Resident 1's medical record and stated and confirmed, there was no IDT meeting documentation and no meeting was completed that discussed Resident 1's plan of care. During an interview with Social Services Director Interim (SSDI) on 1/23/2026 at 12:19 p.m., SSDI stated, she had just started as a SSDI and works part time. SSDI stated, she is still getting acquainted with her role and has not seen all the residents in the facility. SSDI stated, upon admission, an IDT meeting must be (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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	held and set up with residents/RR to discuss the plan of care. SSDI stated, she did not have an IDT meeting with Resident 1/RR and there was no documentation for any care conference held with Resident 1 and RR.2.During a review of Resident 3's FS, the FS indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and muscle weakness (weakening, shrinking, and loss of muscle).During a review of the MDS dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decisions were intact. The MDS also indicated Resident 3 are totally dependent on staff for ADLs.During a review of Resident 3's Medical Record as of 1/23/2026, there was no IDT meeting and care plan conference upon Resident 3's admission.During a concurrent interview and record review with Minimum Data Set Nurse (MDSN) on 1/23/2026 at 12:52 p.m., MDSN stated, Resident 3 does not have any IDT meeting care conference done and discussion held regarding Resident 3's plan of care. 3.During a review of Resident 4's FS, the FS indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia (BPH - is a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream), atrial fibrillation and muscle weakness.During a review of the MDS dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decisions were intact. The MDS also indicated Resident 2 required maximal assistance to total dependent from staff for ADLs.During a review of Resident 2's Medical Record as of 1/23/2026, there was no IDT meeting and care plan conference upon Resident 4's admission.During a concurrent interview and record review with MDSN on 1/23/2026 at 1:13 p.m., MDSN stated, Resident 4 does not have any IDT meeting care conference done and discussion held regarding Resident 4's plan of care.During an interview with Director of Nursing (DON) on 1/23/2026 at 1:16 p.m., DON stated, a care conference must be conducted with IDT team which also included the residents and/or RR regarding their plan of care. DON stated, they should discuss what the plans are, what services they will provide and discharge planning. DON stated, it is resident's right to have a comprehensive plan of care and to include the residents and/or RR if inquired.During a review of the facility's P&P titled, Care Plan Conference, the P&P indicated that, The Interdisciplinary Team (IDT), in conjunction with the resident, surrogate or representative will develop the plan of care based on the comprehensive assessment. The Care Plan Conference is held to identify resident needs and establish obtainable goals. Care Plan conferences are held within 7 days of completion of the initial MDS assessment; at intervals every 90 days thereafter; with any subsequent completed assessments; and when there is a change in resident status or condition. The company must encourage residents, surrogate or representatives, and families to participate in care planning to include their attendance at the care planning conference. Care Plan reviews will include the following, at a minimum, completed MDS and CAAs, problem list, long-term goals, short-term goals, approaches/interventions, barriers, rehabilitation potential, and discharge plan.