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	05/07/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the staff timely documented and report to a physician when one of three Residents (Resident 1) who started experiencing a change of condition (COC - a communication tool used by healthcare workers when there is a change of condition among the residents) on 4/22/2026 according to the facility's policy and procedures (P&P) titled Change in Resident Condition with approval effective date of 2/10/2026 for one of three sampled residents (Resident 1). This deficient practice resulted in one day delay in providing the necessary care, diagnostic tests and treatment for Resident 1. On 4/23/2026 timed at 8:20 p.m., the facility transferred Resident 1 to a general acute care hospital (GACH) via ambulance where the resident was diagnosed with urinary tract infection (UTI - an infection in the bladder/urinary tract). Findings: A review of Resident 1's admission Record indicated the facility admitted Resident 1 on 4/11/2026 and readmitted Resident 1 on 4/24/2026 with diagnoses including dysphagia (difficulty swallowing) protein calorie malnutrition (a severe, life-threatening condition caused by a lack of enough calories and protein in the diet), and malignant neoplasm of liver (cancerous liver tumor). A review of Resident 1's History and Physical (H&P -) dated 4/13/2026 indicated that Resident 1 had the capacity to make decisions. A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/17/2026, indicated Resident 1is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 had no potential indicators of psychosis or overall presence of behavioral symptoms. Residents 1 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care, however, was independent with eating. A review of Resident 1's care plan (CP) titled Episode of false Accusation that her needs are being ignored was initiated on 4/17/2026. The CP goal indicated the facility to determine and why, behavior is problematic and identify underlying causes. A review of the facility's census indicated that Resident 1 had a room change on 4/22/2026 at 5:58 p.m. A review of Resident 1's facility Progress Note dated 4/22/2026 timed at 7:04 p.m., indicated Resident 1's family member reported to a RN Supervisor (RNS) that Resident 1 had complained that the facility staff were not taking care of Resident 1. The progress note indicated that the RNS contacted that family member who agreed to a room change possibly [NAME] to noise from Resident 1's roommate. The progress note further indicated that 2 (two) staff members should provide care to Resident 1 at all times due to Resident 1 false accusation. A review of Resident 1's facility Progress Note dated 4/22/2026 timed at 11:07 p.m., indicated that a physician ordered for Resident 1 to receive normal saline (NS-fluids to correct dehydration) one time at 75 cubic centimeters (CC-unit of measurement) for dehydration and poor intake, noted and carried. The progress note indicated the facility attempted to start (insert) intravenous (IV-inside a vein) without success and that Resident 1was unable to Resident 1 refused IV catheter (flexible tube inserted inside a vein to administer fluids and or medications) and was endorsed to night shift nurse. There was no documentation that staff were not able to start IV access and that Resident 1had refused to have IV access. A review of Resident 1's facility Progress Note dated 4/23/2026 timed at 7:43 a.m., indicated the facility will monitor Resident 1 for poor oral (PO- (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	per mouth) consumption and for any COC. A review of Resident 1's CP titled Acute (of sudden onset) Confusion Related to (R/T) Older Age as Evidenced by Delirium was initiated on 4/23/2026. The CP short term goal indicated that Resident 1 will cooperate with care and assessments. The CP approach included to assess laboratory (labs) and send lab results to MD, assess resident for consciousness and orientation, interview Resident 1's family regarding baseline behavior, transfer to GACH emergency department for delirium. A review of Resident 1's Progress Note dated 4/23/2026 timed at 2:24 p.m., indicated IV catheter inserted to Resident 1's right forearm and IV NS at 75 cc per hour (cc/hr) was started on Resident 1. The progress note indicated Resident 1's family member was at the resident's bedside. A review of Resident 1's Progress Note dated 4/23/2026 timed at 8:20 p.m., indicated an ambulance picked up and transported Resident 1 to a general acute care hospital (GACH). The progress note indicated that Resident 1 was alert to self and place. However, the progress note did not indicate the reason why Resident 1 was picked up by ambulance. A review of GACH Medical Decision Making dated 4/24/2026, indicated Resident 1 was brought in by ambulance and presented to the emergency department (DE) with dysuria and . concerns for delirium (is an acute (of sudden onset), fluctuating disturbance in attention, awareness, and cognition. It develops rapidly (over hours or days) and is almost always a reversible symptom of an underlying physical illness, infection, or medication effect rather than a primary disease). A review of GACH Laboratory (lab) Results dated 4/24/206, indicated that Resident 1's urine test was abnormal and tested positive for leukocyte esterase, nitrite, white cell count, and bacteria present. A review of GACH ED Course dated 4/24/2026 timed at 6:53 p.m., indicated Resident 1 was diagnosed with acute cystitis (inflammation of the urinary bladder) with hematuria (presence of blood in urine) received IV Ceftriaxone and was discharged back to the facility on Vantin (antibiotic-Medication to treat UTI) A review of Resident 1's Progress Note dated 4/24/2026 timed at 11:21 a.m., indicated Resident 1 returned from the GACH alert and verbally responsive. The progress note indicated that GACH diagnosed Resident 1 with UTI and that Resident 1 received IV antibiotic was administered in the emergency department. The progress note indicated Resident 1 was prescribed to received cefpodoxime (antibiotic-medication to treat UTI) 200 milligrams (mg-unit dose measurement) by mouth two (2) times daily for 7 (seven) days. During a concurrent interview and record review, on 5/7/2026, at 12:10 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's medical records were reviewed. LVN 1 stated that he (LVN 1) was familiar with Resident 1. LVN 1 stated that Resident 1's cognitive baseline was that the resident was alert and oriented (name and place), calm and quiet. LVN 1 stated that on 4/22/2026, Resident 1 was alleging that she (resident 1) had a bruise on the face and that someone was attacking her. LVN 1 stated that when he asked Resident 1 who was attacking her, Resident 1 stated staff as a collective, no one person in particular was attacking her (Resident 1). LVN stated that upon assessment, Resident 1 did not have a bruise on her. LVN 1 stated that, the behavior (Resident 1) was exhibiting that day, on 4/22/2026, was odd and not her baseline, and she was more confused. LVN 1 stated that due to Resident 1's change in behavior, Resident 1 was moved from the room she was already in, to a room that was closer to the nursing station. LVN 1 stated that Resident 1's behavior was a COC and needed to be documented in the resident's medical record and to notify the physician for possible additional orders as confusion in elderly resident may be a sign of a UTI which if left untreated can lead to sepsis (a life-threatening blood infection). During an interview, on 5/7/2026, at 12:31 p.m., with Registered Nurse (RN) 1, RN 1 stated that she was familiar with Resident 1's cognitive baseline was that she was alert and that the resident was orientated to name and place, forgetful, quiet, with no behaviors or hallucinations. RN 1 stated that she worked with Resident 1 on 4/22/2026 and during her (RN 1) rounding, Resident 1 reported to RN 1 that she (Resident 1) had a bruise/mark on her right side of the face. RN 1 stated that she assessed Resident 1, and she did not see any bruise on the resident's face. RN 1 stated that Resident 1 seemed a little anxious, confused, a bit of maybe delirium and this was a COC in Resident 1. RN 1 stated she did not do a COC documentation on 4/22/2026 on Resident 1. RN 1 stated a COC in a residents' mentation (continued on next page)

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