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	04/13/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview and record review, the facility failed to ensure that resident specific information for payment and quality measures were electronically transmitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, an Minimum Data Set (MDS - a resident assesment tool) record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record for three of twenty sampled residents (Residents 40, 48, and 50). This deficient practice resulted in the late submission of MDS assessments for Residents 40, 48, and 50. Findings: During a record review, Resident 40's Admission Record indicated the facility admitted Resident 40 on 5/27/2021 and readmitted Resident 40 on 12/3/2024 with diagnoses including cerebral infarction (stroke, loss of blood flow to a part of the brain), hypertension (HTN-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a record review, Resident 40's MDS dated [DATE], indicated Resident 40 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 40 required partial/moderate from staff with activities of daily living (ADL -tasks of everyday life). During a record review, Resident 48's Admission Record indicated the facility admitted Resident 48 on 8/28/2023 and readmitted Resident 48 on 11/30/2023 with diagnoses including anxiety (feeling of worry or fear, often in anticipation of a stressful situation), atrial fibrillation (an irregular often rapid heartbeat caused by a problem with the hearts electrical system), and dementia (a progressive state of decline in mental abilities). During a record review of Resident 48's MDS - dated 2/17/2025, indicated Resident 48 is cognitively impaired. The MDS indicated Resident 48 required staff assistance with ADL. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 50's Admission Record indicated the facility admitted Resident 50 on 11/15/2024 with diagnoses including chronic kidney disease (CKD -a condition where the kidneys gradually lose their ability to filter waste products from the blood, leading to a buildup of toxins and other substances in the body), altered mental status (AMS-a condition that impacts a person's cognitive function, level of consciousness, or behavior, deviating from their normal state), and dementia (a progressive state of decline in mental abilities). During a record review, Resident 50's MDS dated [DATE], indicated Resident 50 is cognitively impaired. The MDS indicated Resident 50 required staff with ADL. During a concurrent interview and record review, on 4/13/2025, at 10:05 A.M., with the Minimal Data Set Nurse (MDSN), Resident 40, 48 and 50's electronic charts and the facility Internet Quality Improvement and Evaluation System (IQIES) were reviewed. MDSN stated MDS assessments are done quarterly, with change of condition, annually, and then submitted to IQIES within 14 days of the assessment being completed. MDSN stated Residents 40,48, and 50's MDS assessment were not submitted to IQIES within the 14 days after the assessments were completed per regulations. MDSN stated Resident 40's MDS was completed on 3/11/2025 and submitted 4/12/2025, Resident 48 MDS was completed on 2/17/20-25 and submitted 4/12/2025, and Resident 50 MDS was completed 2/22/2025 and submitted 4/12/2025. MDSN stated CMS warned MDSN about submitting MDS assessments late for Resident 48. During an interview, on 4/13/2025, at 11:05 A.M., with the Director of Nursing (DON), the DON stated MDS assessments need to be submitted to CMS within 14 days after completion of the assessment to adhere to the regulations and to notify CMS if there are any changes that have occurred with the resident's care. During a record review of the facility provided CMS's Resident Assessment Instrument (RAI) Version 3.0 Manual dated 10/2024, the Manual indicated, 5.1 Transmitting MDS Data All Medicare and/or Medicaid certified nursing homes and swing beds, or agent's pf those facilities, must transmit required MDS data records to CMS Internet Quality Improvement and Evaluation System (IQIES). . Completion Timing: -For all non-admissions Omnibus Budget Reconciliation Act (OBRA-a series of Congress acts) and post-post script (PPS -a payment system used by Medicare) assessment, the MDS completion date must be no later than 14 days after the assessment references date (ARD).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview and record review, the facility failed to develop a comprehensive care plan for one of five sampled residents (Resident 64) in accordance with the facility's policy and procedures (P&P) titled Comprehensive Plan of Care with approval effective date of 12/13/2024, by failing to initiate a care plan for Resident 64's incontinence (an accidental loss of urine or feces) of bowel (intestine - long, tube-like organ that's part of your digestive system, where food travels and waste is produced) and bladder (a bag-like organ that stores urine, the liquid waste the body produces). This deficient practice had the potential to negatively affect the delivery of necessary care and services needed for Resident 64. Findings: During a record review, Resident 64's Admission Record indicated the facility admitted Resident 64 on 3/14/2025 with diagnoses including Muscle wasting (shrinking or loss of muscle tissue), difficulty walking, and hypertension (HTN-high blood pressure) During a record review, Resident 64's bowel and bladder assessment dated [DATE], indicated . Resident 64 is incontinent of bowel, had inadequate control, incontinent all or most of the time. The assessment further indicated that Resident 64 was also had urinary incontinence, had inadequate control, incontinent multiple times a day. During a record review, Resident 64's Minimum Data Set (MDS - a resident assessment tool) dated 3/18/2025, indicated Resident 64 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 64 required partial/moderate to staff dependence with activities of daily living (ADL -tasks of everyday life) and was incontinent urinary and bowel. During a concurrent interview and record review, on 4/13/2025, at 1:20 P.M., with Registered Nurse Supervisor 1 (RNS 1), Resident 64's electronic chart was reviewed. RNS 1 stated Resident 64 was incontinent of both bowel and bladder. RNS 1 stated Resident 64 did not have a care plan for bowel and bladder. RNS 1 stated a care plan contains a nursing assessment, which allows the facility staff based on the assessment to attain improvement and quality of life for a resident on issues that have been identified during the assessment such as incontinence of bowel and bladder. RNS 1 stated when issues identified during the nursing assessment are not addressed, such as incontinence, this may lead to resident being depressed. During an interview, on 4/13/2025, at 3:01 P.M., with the Director of Nursing (DON), the DON stated a care plan is a plan of care that includes goals, interventions, based on a resident's diagnosis. The DON stated the care plan tells the facility staff how to be able to help the residents. The DON stated the bowel and bladder care plan is done to ensure residents are monitored every two hours, to see if residents are candidates for bowel and bladder training and if the care plan is not done, the residents may be at risk for skin breakdown and infection. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, the facility's policy and procedures (P&P) titled Comprehensive Plan of Care approved on 12/13/2024, indicated, Purpose: Each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, the facility failed to create an individualized care for one of three sampled residents (Resident 172) with specific goals and interventions for her dementia (a progressive state of decline in mental abilities) diagnosis. This deficient practice had the potential to result in deterioration of function in Resident 172's quality of life. Findings: During a record review, the admission record for Resident 172 indicated Resident 172 was admitted to the facility on [DATE] with diagnoses including dementia, hypertension (HTN-high blood pressure), and acute kidney failure (a sudden and significant decline in kidney function). During a record review, Resident 172's Minimum Data Set (MDS - a resident assessment tool) dated 3/30/2025, indicated Resident 172 had severe cognitive impairment (a significant decline in thinking, learning, remembering, and reasoning abilities, impacting daily functioning and potentially leading to the inability to live independently). The same MDS indicated, Resident 172 required between substantial/maximal assistance and dependent for most Activities of Daily Living such as: (ADLs- routine tasks/activities such as eating, oral hygiene, toileting hygiene, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During an interview with the Director of Nursing (DON) on 4/18/2025, the DON confirmed that Resident 172 was diagnosed with dementia. The DON stated that care plans are developed for all residents to help direct care that is specific to each resident. The DON stated that things such as high-risk medications, diagnosis must be care planned. The DON admitted there was no care plan developed for Resident 172's dementia diagnosis. The DON admitted the potential of not developing an individualized care plan for dementia could result in staff not knowing the exact interventions to provide to Resident 172. During a review of the facility Policy and Procedures (P&P) titled Dementia Clinical Protocol, with an effective date of 8/2/2024 indicated, as part of the initial assessment, the physician will help identify individuals who have been diagnosed as having dementia and those with otherwise impaired cognition. The same P&P indicated, for the individual with confirmed dementia, the IDT (Interdisciplinary Team- a group of healthcare professionals who collaborate to provide comprehensive and coordinated care for residents, addressing their physical, mental, and emotional needs) will identify a resident-centered care plan to maximize remaining function and quality of life.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45528 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage practices in the kitchen when: a. There were no temperature logs for both refrigerators number 1 and 2. b. There was no thermometer in Refrigerator number 2. c. Food item past it's use by date in Refrigerator number 2. d. Ice machine scoop had no cleaning log. e. Staff food was stored in the resident's refrigerator. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illnesses (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 56 of 56 medically compromised residents who received food from the kitchen. Findings: During an interview on 4/11/2025 at 5:13 P.M., with the Registered Dietician (RD), the RD stated the facility staff check the temperatures in both Refrigerators number 1 and 2, however, there is no documented evidence of the temperature logs. RD stated the facility should have a temperature log for both refrigerators to make sure that the temperatures in the refrigerators are within parameters and lack of the refrigerator temperature logs makes it's hard to track the temperatures for the refrigerators and communication among staff. During a concurrent observation and interview on 4/13/2025 at 5:30 P.M., with the RD, there was no thermometer observed in the Refrigerator number 2. The RD stated that the refrigerator needs to have a thermometer inside to always measure the temperature. RD stated the refrigerator contains perishable foods and the facility needs to maintain the temperature at cold to ensure that the food does not get spoiled and cause the resident to get sick. During a concurrent observation and interview on 4/13/2025 at 5:32 P.M., with the RD, there was a container of black beans with the use by date of 4/10/2025 in Refrigerator number 2. The RD stated the black beans container has an open date of 4/7/2025 and a use by date of 4/10/2025. The RD stated the black beans was past it's use by date and should not be in the refrigerator because it may be given to the residents and cause then to get sick such as vomiting. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/13/2025 at 5:38 P.M., with the RD, the RD stated the facility staff wash the ice scoop daily and document when it is done. However, the RD stated there was no documented evidence that the ice scoop was washed. The RD stated the facility needs to have a log to document when the ice scoop was cleaned to ensure that it is cleaned. The RD stated if there is no cleaning log, there is no telling when the ice scoop was cleaned and if it was cleaned. The RD stated if the ice scoop is not cleaned, it may have bacterial growth which can cause the residents to get sick if used. During a concurrent observation and interview on 4/13/2025 at 12:30 P.M., on the patio with the RD of the residents outside refrigerator, there was a plastic of food, a lunch bag and a water cup. RD stated the plastic of food, the lunch bag and the water bottle belonged to the facility staff. The RD stated the resident's refrigerator needs to contain residents' food only. The RD stated the resident's refrigerator had staff items in there that should not be in there as they would cause cross contamination and possible illness to the residents. During a record review, the facility's policy & procedures (P&P) titled Food Storage Principles approved on 1/11/2024, indicated, Proper food storage is essential for preserving food quality. This applies to food stores prior to preparation, and also to prepared food (leftovers) placed in storage. Storage factors that impact the preservation of quality include holding period, temperature, and humidity . Record storage area temperatures on a temperature log. During a record review, the facility's P&P, titled Food Brought from Outside the Facility approved on 8/2/2024, indicated, Purpose: It is a resident right to obtain foods from outside sources such as ordering takeout, and food brought in by the resident's family and friends . The food and Nutritional services Director and staff will ensure proper safe food handling practices are observed as demonstrated by the departments food safety competencies and education to prevent foodborne illness outbreak. During a record review of Food Code 2022, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, the facility failed to implement its policies and procedures (P&P) for one out of four residents (Resident 31) by failing to ensure that Resident 31's oxygen tubing was changed every seven days. This deficient practice had the potential to cause respiratory infections. Findings: During a record review, Resident 31's admission record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses which included depression (a common mental health condition that affects how you feel, think, and act which is characterized by persistent sadness, loss of interest, and other symptoms that interfere with daily life), HTN, and atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers (atria) beat irregularly and too fast, sometimes causing a rapid and irregular pulse). During a record review, Resident 31's Minimum Data Set (MDS - a resident assessment tool) dated 12/30/2024, indicated Resident 31 had severe cognitive impairment. The same MDS indicated, Resident 31 was dependent for Activities of Daily Living such as: (ADLs- routine tasks/activities such as eating, oral hygiene, toileting hygiene, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a record review, Resident 31's physician's order dated 9/30/2024 indicated, may have O2 (oxygen) inhalation via N/C (nasal canula) PRN (as needed) for SOB (shortness of breath). May titrate O2 to keep O2 saturation above 92% (normal ranges between 92% (percent-unit of measurement) -100%). During a concurrent observation of Resident 31 and interview with the Director of Nursing (DON) on 4/11/2025 at 8:40 pm, Resident 31 was observed lying down in bed and receiving O2 at 2liter per minute (l/m) via nasal canula (NC-oxygen delivery tubing). The NC tubing was dated 3/27/2025. The DON confirmed this finding and stated that the O2 tubing must be changed every seven days. The DON stated that the potential of not changing the tubing could result in a buildup of mucus which may result in respiratory infections. During a record review, the facility policy and procedures (P&P) titled Care and handling of respiratory equipment,' revised 12/13/2024, indicated, Care and Handling of Respiratory Equipment, with an effective date of 9/17/2024 indicated, Care should be exercise in handing respiratory equipment to prevent contamination. In addition, all respiratory and nursing personnel shall follow a regular schedule for cleaning and maintaining equipment. The same P&P indicated equipment such as cannula and humidifier should be changed within every seven days or when obviously contaminated.