STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555039	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fireside Health Care Center	947 3rd Street Santa Monica, CA 90403

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 interview and record review for one of three sampled residents (Resident 1), the facility failed to report an allegation of suspected abuse to the correct agencies within the time frame specified by the facility policy. This deficient practice had the potential to leave Resident 1 at risk of further suspected alleged abuse.A review of Resident 1's admission Record indicated the facility admitted this [AGE] year old female on 12/1/2025 with diagnoses including spinal stenosis (narrowing of the spinal cavity), hyponatremia (low sodium in the blood), hydronephrosis with urethral stricture(condition causing urine to back up into the kidneys), venous insufficiency(damaged valves in veins cause blood to back up), adult failure to thrive (syndrome identified by decreased appetite, weight loss, physical inactivity and impaired physical function), chronic lymphocytic leukemia of b cell in remission (cancer of the blood that is not active), chronic kidney disease (irreversible kidney damage) and glaucoma (eye disease).A review of Resident 1's History and Physical (H&P- the physician assessment and plan of care) dated 12/4/2025 indicated Resident 1's cognition (mental ability to make decisions for daily living) was intact.A review of Resident 1's Interdisciplinary Team Conference (IDT- meeting conducted with resident, family, nursing staff, rehabilitation and dietary staff to discuss the Resident 1's plan of care) note dated 12/3/2025, indicated Resident 1's family member (FM) was adamant about performing perineal care (the cleaning of the genital area) for Resident 1 when Resident 1 needed a diaper change. Both the Resident and the FM were informed that perineal care would be performed by trained staff members, and the FM could standby assist. The note indicated Resident 1 was agreeable to this plan.A review of Resident 1'a Minimum Data Set (MDS- a resident assessment tool) dated 12/4/2025 indicated Resident 1 was dependent (helper does all the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair. In addition, Resident 1 was always incontinent (having no control) of bowel and bladder).On 12/8/2025 The California Department of Public Health (CDPH) received a report from the Adult Protective Services (APS) indicated the facility reported allegations of abuse to their department against the FM.During an interview on 12/9/2025 at 11:11am with the Registered Nurse (RN 1), RN 1stated on 12/6/2025 during the 3:00pm to 11:00pm shift was RN 1's first encounter with Resident 1 and the FM. RN 1 stated, I went to see Resident 1 when I got there, and Resident 1 seemed to be at Resident 1's baseline level of functioning that was reported to me during shift change. RN 1 stated at around 9:00 pm the FM requested to transfer Resident 1 to the general acute care hospital (GACH) alleging Resident 1 seemed lethargic and began to request them to give Resident 1 specific antibiotics (medications used to treat infection). RN 1 started at around 11:00pm, Resident 1 was assessed, and Resident 1 seemed lethargic, however it was late, and Resident 1 had been up all day and Resident 1's vital signs were normal. RN 1 called the attending physician and received an order to transfer Resident 1 to GACH; then arranged transportation. Transportation arrived and loaded Resident 1 onto the gurney (transport bed with wheels). At this time the Certified Nursing Assistant (CNA 1) informed RN 1 that earlier before CNA 1 went to change Resident 1's diaper, Resident 1 told CNA 1 that Resident 1 did not want the FM to perform perineal care during Resident 1's diaper change. CNA 1 went on to tell RN 1 during the diaper change; the FM was insistent, put on gloves and performed perineal care for Resident 1. CNA 1 stated the FM seemed to be wiping aggressively for a longer period than was necessary. RN 1 stated CNA 1 seemed very concerned. After which RN 1 went to the room where Resident 1 was on the gurney ready to go and the FM was at the bedside. RN 1 stated the FM would not step out for RN 1 to speak with Resident 1, so RN 1 was unable to interview Resident 1 nor assess Resident 1's perineal area. After Resident 1 left the facility at 11:30 pm RN 1 assured CNA 1 the incident would be reported. RN 1 then called APS and waited on hold for an hour and a half before no one answered. Then RN 1 called the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) and no one answered. RN 1 came back to work the next day and called APS again and verbally reported then completed abuse report and faxed to their office. RN 1 stated the incident was reported to the Director of Nursing (DON) on the same day the verbal report was made to APS followed by the written report. RN 1 stated on the following Monday RN 1 was informed of a different reporting process; RN 1 was not sure how to report or to whom to report as RN 1 had never done the report before. RN 1 was told they usually go through the abuse coordinator, which RN 1 was not aware of who the abuse coordinator was