

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. Based on interview, and record review, the facility failed to complete the Quarterly Minimum Data Set (MDS-a resident assessment tool) Assessment timely for five of five sampled residents (Resident 23, 33, 39, 41 and 43) reviewed under the Resident Assessment task. This deficient practice had the potential to negatively affect the provision of necessary care and services needed Resident 23, 33, 39, 41 and 43. Findings: During a concurrent interview and record review with Minimum Data Set Coordinator (MDSC) on 12/15/2022 at 1:22 PM Residents 23, 33, 39, 41 and 43's most recent quarterly MDS assessments were reviewed. MDSC stated that every three months a quarterly MDS must be completed. MDSC stated that residents' MDS assessments were due to the workload. MDSC further stated the following: Resident 23's last quarterly MDS was submitted on 1/19/2025. The quarterly assessment was started on 12/12/2025 and should have been submitted by 12/26/2025. Resident 33's quarterly MDS was submitted on 1/19/2025 and should have been completed and submitted by 12/30/2025. Resident 39's quarterly MDS was submitted on 1/19/2025 and should have been completed and submitted by 12/30/2025. Resident 41's quarterly assessment was started on 12/22/2025 and was not completed. Resident 41's quarterly assessment should have been completed and submitted by 1/5/2026. Resident 43's quarterly assessment was started on 12/19/2025 and has not been completed. During an interview on 1/23/2026 at 11:58 AM, the Director of Nursing (DON) stated the MDS tells the complete story of the resident and should be submitted within CMS timeframes. The DON stated also stated It is so important for the quarterly MDS be done because it identifies the information that is needed to care for the resident. A review of the facility's policy and procedures (P&P) titled, Resident Assessments, revised 8/2025, indicated: The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conduct timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents in the facility: 1. Initial Assessment (Comprehensive) - Conducted within fourteen (14) days of the resident's admission to the facility; 2. Quarterly Assessment- Conducted not less frequently than three (3) months following the most recent OBRA assessment of any type; 3. Significant Change in Status Assessment (Comprehensive)- Conducted when there has been a significant change in the resident's condition; 4. Annual Assessment (Comprehensive)- Conducted not less than once every twelve (12) months; and 5. Discharge Assessment- Conducted when a resident is discharged from the facility.		

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: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, interview, and record review, the facility failed to ensure that food was stored under sanitary condition and that food preparation equipment was clean when:An open whole egg mayonnaise and butter milk ranch dressing did not have the use by date on them.Ice scoop did not have a cleaned date on it and ice scoop cleaning logs for the month of 1/2026 had dates Saturday and Sunday blocked, blackened out and no initials noted. These failures had the potential to result in harmful bacteria growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 59 of 60 medically compromised residents who received food and ice from the kitchen.Findings: During a concurrent observation and interview on 1/20/2026 at 8:10 A.M., with Dietary Supervisor (DS), the DS stated the whole egg mayonnaise and butter milk ranch were opened 12/1/2025 however, there was no use by date noted on the containers. The DS stated open items in the refrigerator need to have a delivery date, open date and use by date. The DS stated that the use by date is for knowing the storage time and to make sure that the food item is not used beyond the use by date. The DS stated if the food items are used beyond the use by date, it may lead to residents being sick.During a concurrent observation and interview on 1/20/2026 at 8:23 A.M., with Dietary Supervisor (DS), the DS stated ice scoops are cleansed, washed through the machine every day and staff cleaning the scoop put a date on the ice scoop when it was cleaned and staff initials on the dietary department cleaning and sanitization schedule once it is done. The DS stated that on 1/1/2026 to 1/20/2026 the log had no initials on Saturdays and Sundays, the spot for putting initial was blocked, with no initials meaning it was not done. The DS stated ice scoops are cleaned every day to prevent bacteria for the safety of the residents. The DS stated if the ice scoop is not cleaned, it can lead to spread of infection causing the residents to have stomach aches and diarrhea. During an interview, on 1/23/2026, at 12:17 P.M., with the Director of Nursing (DON), the DON stated that ice scoops need to be cleaned daily to prevent infection control that may lead to symptoms such as diarrhea and documentation should be done with the date, initials of the staff performing the task. The DON stated if there is no documentation of ice scoop cleaning, then it was not done. The DON stated that open items in the refrigerator should be have a used by date which alerts staff that after that date, items need to be discarded and not be used to prevent food borne illnesses. A review of the facility's Policy and Procedures (P&P), titled Recommended Food Storage Practices with review date of 1/29/2025 indicatedRefrigerated: Label all cooked and opened items with open and use by dates (00/00/00) . A review of the facility's P&P, titled Scoops with review date of 1/29/2025 indicated: Procedure: .2. The scoop will be washed and sanitized on daily basis. Staff will initial the cleaning log schedule as the task is completed. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At any time when contamination may have occurred;(2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles;(3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and(4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment:(a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 28 out of 32 rooms met the 80 square feet (sq. ft.) per resident in multiple resident rooms. These 28 rooms consisted of twenty-five 2-bed rooms, two 3-bed rooms and one 4-bed room. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. On 1/21/2026, the Administrator provided a copy of the Client Accommodation Analysis, dated 1/20/2026 and the facility letter requesting for continuation of room waiver. A review of the Client Accommodation Analysis indicated that 28 of 32 rooms did not have at least 80 square feet per resident. The room waiver request and Client Accommodation Analysis showed the following: Rm# # of Beds Sq. Ft. Sq.Ft./Res 1 2 140 702 2 140 703 2 140 704 2 140 705 2 140 706 2 140 707 2 140 708 2 140 709 2 140 7010 2 140 7011 2 140 7012 2 140 7013 2 140 7014 2 140 7015 2 140 7017 2 133 66.518 4 294.5 73.621 2 140 66.523 3 196 65.324 2 140 7025 2 140 7026 2 140 7027 2 140 7028 2 140 7029 2 140 7030 2 140 7031 2 140 7032 3 217 72.3 The minimum requirement for a 2 bed-room should be at least 160 sq. ft. The minimum requirement for a 3 bed-room should be at least 240 sq. ft. The minimum requirement for a 4 bed-room should be at least 320 sq. ft. During the initial tour on 1/20/2026, at 8:30 AM, the evaluators inspected the aforementioned rooms and observed that nursing staff had enough space to provide care to the residents; there were curtains to provide privacy for each resident and the rooms had direct access to the corridors. During the group Interview with the residents on 1/22/2026 at 10:33 AM, Resident 21 stated the equipment in her room included a BiPAP (bilevel Positive Airway Pressure - an non-invasive breathing device that delivers two different levels of air pressure through a mask to help one breathe), oxygen concentrator and wheelchair and the room was a bit cramped. Resident 21 further stated she believed the room size was adequate she just had a lot of equipment. During this group interview, Resident 59 stated when he stayed in room [ROOM NUMBER], the Hoyer lift (a mechanical device used to lift and/or transfer a person), which he required to move from the bed to a wheelchair would not fit, so the resident was moved to a different room. The resident's did not have any complaints regarding the room sizes.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide one of three sampled residents (Resident 77) the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN - provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility). This deficient practice had the potential to result in the facility not giving Resident 77 the information needed to decide if he or she would like to continue or refuse receiving the specific skilled services and have those options honored. Findings: A review of the admission Record indicated the facility re-admitted Resident 77 on 5/13/2025 with diagnoses including difficulty walking, high blood pressure and lack of coordination. A review of Resident 77's SNF Beneficiary Protection Notification Review Form indicated the resident's last covered Medicare Part A Skilled Services was 8/12/2025. The form also indicated SNFABN form was not provided to the resident. A review of Resident 77's Transfer/Discharge Report indicated the facility discharged the resident on 9/26/2025. During an interview and record review on 1/23/2026 at 10:09 AM, the Social Services Director (SSD) stated Resident 77 was not given the SNF ABN. The SSD stated Resident 77's last covered day was 8/12/2025. The SSD further stated the facility discharged Resident 77 on 9/26/2025. During an interview on 1/23/2026 at 10:17 AM, the Minimum Data Set Coordinator (MDSC) stated Resident 77 was not given a SNF ABN form. The MDSC also stated Resident 77 should have received a SNF ABN form. The MDSC stated not receiving the SNF ABN may result in the resident not knowing about their right to appeal. During an interview on 1/23/2026 at 12:02 PM Director of Nursing (DON) stated beneficiary notices should be given when required. The DON further stated beneficiary notices tell residents of their right to appeal if not given, the may not know they have the right to appeal. A review of facility's policy and procedures (P&P) titled, Advance Beneficiary Notice, revised 5/13/2025, indicated advanced beneficiary notice of non coverage will be completed and delivered to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. The P&P also indicated Original Medicare Part A eligible residents will receive a SNF Advance Beneficiary Notice(SNF ABN) on the basis of the following exclusions:a. Not reasonable and necessary (medical necessity) for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member;b. Custodial care (not a covered level of care);c. Services/items that may not be covered.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure that dignity of the resident was maintained for one of seven sampled residents (Resident 3) in accordance with the facility's policy and procedures (P&P) titled Quality of Life -Dignity, revised 2/2025, by failing to maintain and protect residents privacy, including bodily privacy during assistance with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. This deficient practice violated the rights for privacy for Resident 3. Findings: A review of Resident 3's admission Record indicated the facility admitted Resident 3 on 7/22/2025 and the facility readmitted Resident 3 on 8/18/2025 with diagnoses including atrial fibrillation (a heart condition where the upper chambers of the heart beat irregularly and rapid causing racing sensation), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). A review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 10/29/2025, indicated Resident 3 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 3 required partial/moderate to dependency on staff with activities of daily living (ADL-activities such as bathing, dressing and toileting a person performs daily). During an initial tour of the facility on 1/20/2026, at 9:23 A.M., Resident 3 was observed in bed and Certified Nursing Assistant (CNA) 3 was in the room assisting the resident with ADL care, while the privacy curtain was partially closed. CNA 3 then fully closed the curtain after seeing the surveyor. During an interview on 1/20/2026, at 9:23 A.M., with CNA 3, CNA 3 stated that she did not fully/completely close the privacy curtains when providing ADL care to Resident 3 and closed the privacy curtain when surveyor was in the room. CNA 3 stated that privacy curtains need to be fully closed all the way for privacy and dignity of the residents. During an interview on 1/23/2026, at 12:34 P.M., with the Director of Nursing (DON), the DON stated that facility staff need to pull the privacy curtain/s all the way when providing ADL care to the residents so that no other people can see the resident during care. The DON stated leaving the dignity curtain partially open may make the residents feel that their privacy has been invaded/violated. A review of the facility's P&P, titled, Quality of Life -Dignity, revised 2/2025, indicated, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Policy interpretation and implementation 1. Residents are treated with dignity and respect at all times. 4. Residents' private space and property are respected at all times. 10. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on interview and record review, the facility failed to develop a comprehensive care plan for one of seven sampled residents (Resident 7) in accordance with the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered with revised date of 8/2025, by failing to have a care plan for Resident 7's apixaban (a medication that prevents dangerous blood clots from forming or getting bigger). This deficient practice had the potential to negatively affect the delivery of necessary care and services needed for Resident 7. Findings: A review of Resident 7's admission Record indicated the facility admitted Resident7 on 6/2/2025 and readmitted Resident 7 on 10/28/2025 with diagnoses including paroxysmal atrial fibrillation (A-fib -irregular heartbeat where episodes start and stop suddenly), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and atherosclerosis of coronary (buildup of fats, cholesterol and other substances on the artery wall) artery bypass graft (surgery that restores blood flow to the heart by creating a detour around the blocked arteries). A review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 12/10/2025, indicated Resident 7 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 7 required supervisory/touch to setup/clean up assistance from staff with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 7's order summary report with order date of 10/7/2025 and start date of 10/8/2025 indicated Apixaban oral tablet 5 milligrams (mg -unit of measure), give 1 tablet by mouth two times a day for A-fib. During a concurrent interview and record review, on 1/22/2026, at 2:22 P.M., with Registered Nurse Supervisor (RNS) 1, Resident 7's medical chart was reviewed. RNS 1 stated that Resident 7 did not have a care plan for the apixaban anticoagulant (blood thinner). RNS 1 stated that Resident 7 should have a care plan because the apixaban is an anticoagulant which places the residents at high risk for bleeding and if there are any sign and symptoms of bleeding they need to be reported to the doctor. RNS 1 stated the care plan is important because it allows the interdisciplinary team to know how to care for the resident, including their needs and preferences. RNS 1 stated she I will add the care plan now. During an interview, on 1/23/2026, at 12:38 P.M., with the Director of Nursing (DON), the DON stated that a care plan is a plan of care for the resident care in the facility. The DON stated that a care plan should be initiated upon admission, as needed, quarterly and annually. A care blood for the blood thinner is a guide on how the facility should care for the residents which includes monitoring and care approach. The DON stated that potential adverse effects of not having a care plan for a blood thinner is that care for a resident may not be coordinated and there is no guidance on the resident's care and Resident 7 should have a blood thinner care plan. A review of the facility's P&P, titled Care Plans, Comprehensive Person-Centered with review date of 8/2025 indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain physician's orders to treat and provide treatment to one of one sampled resident's (Resident 73) right and left buttock pressure ulcers from 1/9/2026 to 1/13/2026. This deficient practice placed Resident 73 at risk for worsening of the pressure injury and infection. Findings: A review of the Resident 73's admission Record indicated the facility admitted the resident on 1/9/2026, with diagnoses that included left femur fracture (broken thigh bone), pressure-induced tissue damage of left and right buttock and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) . A review of Resident 73's Admission/readmission Screener, dated 1/9/2026, indicated Resident 73 had pressure ulcer present and the screener indicated there was open areas on the resident's left and right buttocks. A review of Resident 73's pressure injuries care plan, created on 1/14/2026, indicated the resident had pressure injuries on the left and right buttock. The goal was for Resident 73's pressure ulcers will show signs of healing and remain free from infection. The interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) included to Administer treatments as ordered and monitor for effectiveness, monitor dressing every shift to ensure it is intact and adhering and follow facility policies/protocols for the prevention/treatment of skin breakdown. A review of Resident 73's Minimum Data Set (MDS - a resident assessment tool), dated 1/16/2026 indicated the resident's cognition was intact. The MDS indicated the resident required substantial assistance with showering, dressing and personal hygiene. The MDS indicated the resident was at risk to develop pressure injuries, had two unstageable pressure injuries. A review of Resident 73's Physician's Orders dated 1/13/2026, indicated the resident was to receive the following treatments: For the right buttock deep tissue injury (DTI) - cleanse area with normal saline (NS - is a mixture of salt and water), pat dry, apply Medihoney (medical-grade honey used to treat wounds) to open areas then follow with zinc barrier cream to surrounding areas then cover with dry clean dressing daily for 30 days and as needed for soiled or dislodged bandage For the left buttock DTI - cleanse with NS, pat dry apply zinc barrier cream to wound bed then cover with dry clean dressing daily for 30 days every day shift for wound care During an interview and concurrent record review on 1/23/2026 at 8:06 AM, Resident 73's January 2026 Treatment admission Record (TAR - a log used by healthcare staff to track every treatment provided to a resident) was reviewed. Licensed Vocational Nurse (LVN) 5 stated Resident 73's right and left buttock pressure ulcers were present at admission on [DATE]. LVN 5 stated the nursing staff did not obtain treatment orders for the resident's wound at admission. LVN 5 stated physician orders were not obtained for Resident 73's pressure ulcers until LVN 5 returned to work. LVN 5 stated there was no documentation of Resident 73's wounds until 1/14/2026. LVN 5 stated the admitting nurse should have obtained orders for Resident 73's wounds when Resident 73 was admitted . LVN 5 also stated not providing wound care to Resident 73's pressures ulcers had the potential to lead to an infection of the wounds or the wounds becoming worse. During an interview on 1/23/2026 at 12:05 PM, the Director of Nursing (DON) stated Resident 73's right and left buttock pressure ulcers treatment orders should have been obtained upon Resident 73's admission. The DON stated not receiving orders meant the resident's wounds were not addressed and could lead to increased skin breakdown. A review of the facility's policy and procedures titled Pressure Ulcers/Skin Breakdown Clinical Protocol, revised 4/2025, indicated: The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interview and record review, the facility failed to provide the correct liters of oxygen per physician order according to the physician order for one out of three sampled residents (Resident 2). This deficient practice had the potential to result in Resident 2 experiencing respiratory complications. Findings: A review of Resident 2's admission Record indicated the facility admitted the resident on 4/13/2024 with diagnoses including but not limited to, respiratory failure (condition in which there's not enough oxygen in one's body) with hypoxia (low levels of oxygen in the body tissues), kidney failure and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 2's Physician Order, dated 8/9/2024, indicated the physician ordered the resident to receive oxygen at two liter per minute (lpm - a measurement of how fast a gas flows) via nasal cannula (NC - a flexible plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously. A review of Resident 2's Oxygen Therapy care plan, initiated 3/3/2025, indicated the resident received oxygen related to respiratory failure with hypoxia. The care plan interventions included to stay with the resident during episodes of respiratory distress. A review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/30/2025, indicated the resident's cognitive skills for daily decision making was severely impaired (never /rarely made decisions). The MDS also indicated Resident 2 was dependent upon staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an observation on 1/20/2026 at 10:14 AM, at Resident 2's bedside, Resident 2 was observed laying in bed with the head of bed elevated. Resident 2's oxygen concentrator was running and connected to a nasal cannula that was on Resident 2's face but not in Resident 2's nose. Resident 2's oxygen concentrator flow rate was set to one liter per minute (1 lpm-unit of measurement/oxygen flow) During a concurrent observation and interview at Resident 2's bedside on 1/20/2026 at 10:43 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 2's oxygen concentrator was set a one lpm. LVN 1 then went to check the physician order, returned and stated that Resident 2's physician order required Resident 2 to receive two lpm. LVN 1 stated a potential outcome from not receiving the prescribed dosage of oxygen could lead to Resident 2's oxygen level dropping. During an interview on 1/23/2026 at 12:04 PM, the Director of Nursing (DON) stated nurses must follow the doctor's order when administering oxygen to residents. The DON further stated the resident could experience respiratory issues if the order is not followed. A review of the facility's policy and procedures titled, Oxygen Administration, revised 10/2025, indicated the purpose of this procedure was to provide guidelines for safe oxygen administration. The P&P also indicated staff must verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration and turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively manage a resident's pain for one of one (1) sample resident, Resident 74, as evidenced by failing to: Re-assess Resident 74's pain level after administering Tylenol (Acetaminophen- a common over-the-counter analgesic [pain reliever]) used to treat mild-to-moderate pain) according to facility's policy and procedures (P&P) titled Pain Assessment and Management dated 08/2025. Administer Oxycodone HCl (a powerful opioid controlled pain reliever used for moderate to severe pain) Oral (by mouth) Tablet 5mg give 0.5 tablet by mouth every 6 hours as needed for moderate pain 4-7/10 Hold for sedation or RR<12 as ordered on 1/16/2026 when Resident 74 complained of eight out of 10 pain level (8/10-a numerical pain assessment where zero is no pain and 10 is severe pain). These deficient failures resulted in Resident 74 getting angry and complained of inability to get a good night sleep for three nights. Findings: A review of Resident 74's admission information indicated Resident 74 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis of the left knee (artificial knee joint (degenerative joint disease characterized by the progressive breakdown of articular cartilage, the protective tissue cushioning bone ends), atrial fibrillation (rapid, chaotic, and irregular electrical rhythm in the heart's upper chambers (atria), causing them to quiver (fibrillate) rather than contract effectively), protein calorie nutrition (severe nutritional deficiency caused by inadequate intake of protein and calories to meet metabolic needs), and hypothyroidism (underactive thyroid gland [located in the lower front of the neck] producing inadequate hormone levels, resulting in a slowed metabolic rate.) A review of Resident 74's Minimum Data Set (MDS, a resident assessment tool) dated 1/21/2026, indicated Resident 74's mental cognition (skills for daily decision-making) was intact. During an interview during a facility tour on 1/19/2025 at 9:37 a.m., Resident 74 stated she (Resident 74) was admitted to the facility on [DATE] and was not provided with adequate relief pain medication until 1/19/2026 at 0215 on Monday morning, Resident 74 stated for 3 days the medication nurses (unable to recall names) told Resident 74 she was not registered in the computer as an admission, Resident 74 stated her pain level of 8/10 the medication nurse (unable to recall the name) gave her Tylenol which did not provide much relief. Resident 74 stated she was unable to get a good night sleep for three nights and was angry. Resident 74 stated she received her 1st (first) dose of pain-relieving medication on Monday morning, 1/19/2026 at 2:15 a.m. A review of Resident 74's Order Summary Report indicated the following physician orders: 1. Acetaminophen tablet 500 mg (milligrams -unit dose measurement) give two (2) tablets by mouth every 8 hours for pain management for 5 Days, Max (maximum) daily dose 3g (grams - unit of measurement) from all Acetaminophen sources. ordered 1/16/2026. 2. Oxycodone HCl Oral Tablet 5mg give 0.5 tablet by mouth every 6 hours as needed for moderate pain 4-7/10 Hold for sedation or RR<12. ordered 1/16/2026. 3. Oxycodone HCl oral give one (1) tablet by mouth every 6 hours as needed for severe pain of 8-10/10 Hold for sedation or RR<12., ordered 1/16/2026. A review of Resident 74's Electronic Medication Administration record (EMAR) for the month of 1/2026, indicated Resident 74 received Acetaminophen 500mg x 2 tablets for pain on 1/16/2026 at 10 p.m. to 1/19/2026 at 10 p.m. However, the same EMAR indicated that Resident 74 was never offered and/or administered Oxycodone as an alternative pain medications on 1/16/2026, 1/17/2026, and 1/18/2026. The same EMAR indicated that on 1/19/2026 at 2:15 a.m., Resident 74 received the 1st dose 5 mg of Oxycodone HCl 1 tablet oral give one (1) tablet by mouth every 6 hours as needed for severe pain of 8-10/10 and subsequently thereafter as needed. The same EMAR did not indicate any documented evidence that Resident 74 was reassessed for the effectiveness after Acetaminophen 500mg for pain. A review of Resident 74's Controlled Medication Count sheet indicated that Oxycodone HCl 5mg twenty-six (26) was delivered to the facility on 1/19/2026 at 10:15a.m. to give Resident 74 one (1) tablet oral give one (1) tablet by mouth every 6 hours as needed for severe pain of 8-10/10 and subsequently thereafter as needed. A review of Resident 74's (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Controlled Medication Count sheet indicated that Oxycodone HCl 5mg twenty-six (26) was delivered to the facility on 1/19/2026 at 10:15a.m. to give Resident 74 one (1) tablet oral give half (1/2) tablet by mouth every 6 hours as needed for severe pain of 8-10/10 and subsequently thereafter as needed. A review of the nurses Progress Notes from 1/16/2026 to 1/18/2026, did not indicated any documented evidence of a follow-up pain evaluation after Acetaminophen 500mg was administered to Resident 74. During an interview on 1/22/2026 at 3:02 p.m. Licensed Vocational Nurse (LVN) 3 stated during her (LVN3) shift she administered Acetaminophen 500mg as scheduled, LVN3 stated Resident 74 said her (resident) pain level was 3/10. LVN 3 did not re-assess Resident 74's pain after administering Acetaminophen 500mg. During an interview on 1/22/2026 at 3:09 p.m. LVN1 stated during her (LVN1) shift she administered Acetaminophen 500mg as scheduled to Resident 74 and she did not reassess Resident 74's pain after administering Acetaminophen 500mg. During an interview on 1/23/2026 at 1:23 p.m., the Director of Nursing (DON) stated licensed nurses are expected to follow physician's medications orders, offer pain medications as ordered and re-assess the residents pain level after administering pain medication/s to ensure that the resident's pain is relieved. The DON stated that poor pain management can lead to severe consequences, including increased patient morbidity delayed recovery, and the development of chronic, persistent pain and increased falls. A review of the facility's policy and procedures (P&P) titled Pain Assessment and Management dated 08/2025 indicated, Pain management is a multidisciplinary care process that includes monitoring for the effectiveness of interventions. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and re-assessed . until relief is obtained.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 5) who received dialysis (process of removing waste products and excess fluid from the body) treatment received care in accordance with standards of practice, by failing to:1. Administer Epogen per physician order2. Clarify with the physician if the facility or dialysis center was to administer Epogen (is an injectable prescription medicine that stimulates the bone marrow to produce red blood cell) to Resident 53. Communicate with the resident's dialysis center about Epogen being administered during dialysis treatment for Resident 5.A review of Resident 5's admission record indicated the facility re-admitted the resident on 12/15/2025 with diagnoses that included end stage renal disease (ESRD - loss of kidney function in which the kidneys no long work to meet the body's needs) and dependence on renal dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) and diabetes (high blood sugar). A review of Resident 5's Order Summary Report, dated 1/22/2026, indicated the physician ordered the following:- On 12/15/2025, the dressing of the dialysis catheter was to be changed only by dialysis unit. Check site every shift and reinforce site with dressing as needed.- On 1/14/2026, the physician ordered for the resident to receive dialysis every Monday, Wednesday and Friday. A review of Resident 5's Physician's Order, dated 12/15/2025, indicated the resident to receive Epogen 1ml subcutaneously (under the skin) one time every Monday, Wednesday and Friday for ESRD. A review of the Minimum Data Set (MDS - a resident assessment tool), dated 12/22/2025, indicated Resident 5's cognition was intact. The MDS indicated Resident 5 required substantial assistance oral hygiene, toileting hygiene, bathing and dressing. The MDS also indicated Resident 5 was receiving dialysis treatment. A review of Resident 5's dialysis care plan, initiated 12/16/2025, indicated the resident was receiving dialysis for ESRD. at risk for fluid overload related to the kidney's inability to regulate fluid balance and the resident was at risk for hemodialysis (HD) access site infections and bleeding. The care plan goal was for Resident 5 to have no complications from dialysis. The interventions included to monitor/document/report signs of bleeding, hemorrhage, bacteremia and septic shock and staff were to work with the resident to relieve discomfort for side effects of the disease and treatment which included, fatigue, anemia, cramping and headaches. A review of Resident 5's Orders - Administration Notes for the month of January 2026 indicated Epogen was not given on 1/16/2026, 1/14/2026, 1/12/2026, 1/19/2026, 1/7/2026 and 1/5/2026 because the medication was unavailable. A further review of the notes did not indicate that the medication was given in the dialysis center and did not indicate that nursing staff contacted the pharmacy to request the medication. A review of Resident 5's Pre and Post Dialysis Assessments for the month of January 2026 indicated on the following dates: 1/2/2026, 1/5/2026, 1/7/2026, 1/9/2026, 1/13/2026, 1/16/2026, 1/19/2026, 1/21/2026 in the section where the dialysis staff were to write any medications given at the dialysis center were blank indicating no medications were given. On 1/14/2026, the Assessments form indicated Venofer (Iron), protein drink and heparin (a medication that delays blood clotting). A further review of the forms further indicated that Epogen was never given at the dialysis center. During an interview on 1/20/2026 at 8:45 AM, Resident 5 stated she was going to require dialysis for the rest of her life. Resident 5 stated that she had not missed any dialysis appointments since being admitted to the facility. During a concurrent interview and record review on 1/22/2026 at 9:24 AM, Resident 5's electronic medical chart was reviewed with Registered Nurse Supervisor (RNS) 1. RNS 1 stated Resident 5 received dialysis on Mondays, Wednesday, and Friday. During a concurrent review of Resident 5's physician orders, RNS 1 stated the physician ordered the facility to administer Epogen to Resident 5 on dialysis days. Upon a review of Resident 5's January 2026 MAR and order administration notes, RNS 1 stated Resident 5 did not receive Epogen on the following days in January 2006 1/2, 1/5, 1/7, 1/9, 1/12, 1/14 and 1/16. RNS 1 stated the resident not receiving Epogen could lead to anemia. During an interview on 1/23/2026 at 12:08 PM, the Director of Nursing (DON) (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 5's physician order for Epogen indicated the medication would be given in the facility. The DON stated DON called the pharmacy to check what occurred with the Epogen order. The DON stated the pharmacy never sent the Epogen because the pharmacy knew the medication would be given in the dialysis center. When asked if the pharmacy confirmed this with the dialysis center, the DON didn't answer. The DON stated nursing staff should have clarified the order with the physician and pharmacy and confirmed with the dialysis center that the medication would be given there. The DON further stated she checked with the dialysis center and the dialysis center stated the resident wasn't receiving Epogen and instead was receiving Mircera (a long-acting medication used to treated anemia in people with kidney disease, similar to Epogen) because it only needed to be administered every two weeks. A review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, revised 9/2025, indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The P&P also indicated: 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.2. Education and training of staff includes, specifically:a. the nature and clinical management of ESRD (including infection prevention and nutritional needs);b. the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis;c. signs and symptoms of worsening condition and/or complications of ESRD;d. how to recognize and intervene in medical emergencies such as hemorrhages and septic infections;e. how to recognize and manage equipment failure or complications (according to the type of equipment used in the facility);f. timing and administration of medications, particularly those before and after dialysis;g. the care of grafts and fistulas; andh. the handling of waste. A review of the facility's P&P titled, Unavailable Medications, reviewed 6/2025, indicated Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make, every effort to ensure that medications are available to meet the needs of each resident. The P&P also indicated: B. Nursing staff shall:l) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available.a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction.2) Obtain ll new order and cancel/discontinue the order for the non-available medication.3) Notify the pharmacy of the replacement order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on observations, interviews and record review, facility failed to ensure infection control practices were adhered to in accordance with professional standards of practice when: The facility failed to isolate (to separate individuals with a known or suspected contagious disease from those who are not infected to prevent the spread of illness) Resident 60 after the resident's urine tested positive (presence of) for Extended spectrum beta lactamase (ESBL - bacteria that produce enzymes making them resistant to many common antibiotics, such as penicillin's and cephalosporins, making infections harder to treat). Resident 60 was on the patio with other residents while she was positive for ESBL. These deficient practices placed the residents and staff at increased risk to contract ESBL, and/or hospitalization. Findings: A review of Resident 60's admission Record indicated Resident 60 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (any condition that causes the brain to function abnormally, leading to mental changes like confusion, memory loss, personality shifts, or drowsiness, resulting from injury, infection, toxins, or other illnesses that disrupt brain activity), hyperlipidemia (high fat levels in the blood), and chronic kidney disease (CKD - when kidneys are permanently damaged and cannot filter waste, toxins, and excess fluid from the blood as well as they should). A review of Resident 60's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2025, indicated Resident 60 had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), and required substantial/maximal assistance from staff with activities of daily living (ADL - activities such as bathing, dressing and toileting a person performs daily). A review of Resident 60's laboratory results with collection date of 1/13/2026 at 3:30 P.M., and reported on 1/16/2026 at 9:08 P.M., indicated that culture ESBL. A review of Resident 60's order summary report with order date of 1/16/2025 indicated contact isolation precaution for ESBL. During an initial tour of the facility on 1/20/2026, at 11:25 A.M., Resident 60 was not in her room and was sharing the room with three other residents. During an interview on 1/20/2026, at 12:30 P.M., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated that Resident 60 was on the patio for activities. During an interview on 1/21/2026, at 8:47 A.M., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that Resident 60 is on contact isolation since 1/16/2026 due to ESBL of the urine. LVN 2 stated that Resident 60 is now in a single room and has been in that room since 1/20/2026 afternoon. LVN 2 stated Resident 60 was transferred to the single room after she left the patio for activities. LVN 2 states Resident 60 needs to be on should not be with the other residents because if she is not doing proper disinfection, she can be in contact with other resident which can lead to them being contaminated and getting infected as well. During an interview on 1/21/2026, at 9:50 A.M., with Infection Preventionist (IP), the IP nurse stated that Resident 60 is currently in a single room and is on contact isolation for ESBL of the urine. IP nurse stated that Resident 60 has been on contact isolation since 1/16/2026 when the urine results came back positive for ESBL of the urine that was collected and provided to the laboratory on 1/13/2026. IP nurse stated that ESBL is a urinary tract infection (UTI) that requires that the resident is isolated, it is not like an ordinary UTI, it can be transmitted if proper standards, precautions are not observed, the resident needs to be in a room by themselves. IP nurse states Resident 60 has been in the single room since 1/21/2026. IP nurse stated that on 1/20/2026 Resident 60 was assigned to a four bedroom however, Resident 60 was on the patio with the other resident all throughout the morning and afternoon. IP nurse stated that a resident with ESBL of the urine should not be around the other residents because ESBL of the urine requires contact isolation because there is a possibility for contamination and if the other resident may come in contact with it they may get infected which may lead to the spread of the infection. During an interview on 1/23/2026, at 12:42 P.M., with the Director of Nursing (DON), the DON stated that ESBL is an infection of the urine and requires resident to be placed on isolation. The DON stated that (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Fireside Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident with ESBL of the urine should not be with other residents to prevent the spread of the infection which could potentially lead to the spread of the infection maybe hospitalization A review of the facility's Policy and Procedures (P&P), titled, Isolation -Initiating Transmission -Based Precautions, revised 8/2025, indicated Policy Statement: Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents.Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions.Policy interpretation and implementation2. Transmission-based precautions are utilized when a resident meets the criteria for a transmissible infection AND the resident has risk factors that increase the likelihood of transmission. These may include (but are not limited to):a. Uncontained excretions/secretions;b. Non-compliance with standard precautions; orc. Cognitive deficits that restrict or interfere with the resident's ability to maintain precautions.		