STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555054	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Post Acute	1323 17th 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0627 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, the facility failed to provide an effective discharge for one of three sampled residents, (Resident) 1 with a safe and orderly discharge planning by failing to:1.Ensure the facility's policy and procedure (P&P), titled, Discharge Planning Process, was applied by ensuring an effective discharge planning process that addressed the discharge destination met Resident 1's health and safety needs and preferences.2. Ensure Resident 1's care plan for discharge was implemented.3. Ensure that the discharge notice is provided to the resident's representative and Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) in a language and manner in which they can understand at least 30 days prior to discharging Resident 1.These deficient practices resulted in unsafe discharge setting that led to Resident 1's physical harm and hospitalization, Resident 1 was home alone for six days without any necessary care, Resident 1 was found on the floor with injury and was sent to General Acute Care Hospital 1 (GACH 1) on 9/1/2025.During a review of Resident 1's admission Record, it indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including Parkinson's disease (a chronic brain disorder that causes movement problems, and can also affect mental health, sleep, and pain), infection and inflammation reaction due to internal left knee prosthesis (germs have gotten into the joint, causing the body's immune system to attack), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acquired absence of left leg above knee (loss of left leg above the knee due to amputation or other causes), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure). The admission Record also indicated that Resident 1 was discharged home on 8/26/2025.During a review of the medical record from General Acute Care Hospital 2 (GACH 2) indicated the following:i. On 6/30/2025, Resident 1 had a revision left above the knee amputation (to correct any complications that arise after primary amputation surgery).ii. Occupational Therapy Evaluation, dated 7/1/2025, indicated, support available: Friend - has a friend that has historically helped her (Resident 1) as needed but may not be able to provide as much as he used to due to his own health issues; homemaking assistant: needs assistance.iii. Physical Therapy Treatment, dated 7/2/2025, indicated that Resident 1 had a non-weight bearing (you cannot place any of your body weight on an injured limb, such as a leg or arm, for a specific period to allow it to heal) on left lower extremity (left leg).iv. Referral Notes from GACH 2, dated 7/3/2025, it indicated, Resident 1 has physical limitations such as deconditioning (when a person is immobile for an extended period of time), frailty (when your body can't get through and recover from illnesses and injuries on its own), malnutrition (lack of sufficient nutrients in the body) or other physical limitation that impair ability to participate in their care, has poor health literacy (the inability to get, process, and understand basic health information and services needed to make good health decisions) and no patient support with social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care. During a review of Resident's History and Physical (H&P), dated 7/4/2025, it indicated that Resident 1 does not have a decision-making capacity. The H&P also indicated that, Emergency Contact 1 (EC1) is Resident 1's Durable Power of Attorney (POA - authorizes someone else to handle certain matters, such as finances or health care, on someone's behalf. If the power of attorney is durable, it remains in effect if the person becomes incapacitated for any reason, including illness and accidents).During a review of Resident 1's Durable Power of Attorney, indicated Resident 1's EC1 was Resident's 1 appointed POA, signed and dated on 10/10/2024.During a review of the Minimum Data Set (MDS - resident assessment tool) dated 8/26/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS also indicated Resident 1 used a manual wheelchair.During a review of Resident 1's Care Plan (CP) for discharge, initiated on 7/9/2025, the CP indicated a goal of, Resident (1) will move to an appropriate lower level of care without complication and when appropriate. The CP included interventions such as, facility will provide education to resident/family regarding referrals, community resources and resident and/or family will be involved in discharge planning. During a review of Resident 1's Progress Notes, dated 8/22/2025, it indicated that, Per resident (Resident 1) request, she will discharge home on 8/26/2025. HHA 1 will follow-up for nursing, physical therapy (PT) and