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	01/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49390 Based on observation, interview and record review, the facility failed to ensure to protect resident right's to be treated with respect and dignity for one of two sampled resident (Resident 390). 1.Resident 390 was not provided bathroom assistance during mealtimes, was told that she will eat after she was provided incontinence care but was not provided care timely. 2.Resident 390 was not turned and repositioned when requested. These failures of not getting timely assistance resulted in Resident 390 felt she was treated like a child, had to eat with soiled incontinence (inability to control the release of urine or stool) brief, was left uncomfortable, upset, frustrated, and helpless. Findings: a. During a concurrent observation and interview on 1/21/2025 at 4:22 p.m., in Resident 390's room, Resident 390 appeared upset and stated the staff were quick to answer the call light and turn the call light off, but she had to wait a long time for the CNAs to respond to her request for assistance. Resident 390 stated CNA 3 and CNA 4 (unable to recall exact day) would ask her What do you need? in elevated and harsh tone of voice. Resident 390 stated she informed them she just wanted to know who was her CNA and they will tell her Why do you want to know? Resident 390 stated she is not a kid for CNAs to raise their voice at her. During an interview on 1/21/2025 at 4:25 p.m. Resident 390 stated on 1/19/2025 morning, she requested CNA 3 to clean her because she had a bowel movement, but CNA 3 told her she needed to wait for CNA 3 to finish passing meal trays before CNA 3 would clean her. Resident 390 stated this happened several times in December to January 2025. Resident 390 stated the longest time she had to wait to be cleaned was 40 minutes. Resident 390 questioned if passing meal trays was more important than cleaning her. Resident 390 stated the delayed in care made her feel uncomfortable, upset, frustrated, and neglected. Resident 390 stated she felt helpless when CNA 3 and CNA 4 ignored her request for assistance, and she have no choice but to tolerate how they treat her like a child because she was sick, unable to walk and care for herself. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2025 at 2:39 p.m., CNA 1 stated on Sunday (1/19/2025) morning at 8:30 a.m. Licensed Vocational Nurse (LVN) 5, CNA 3 and another CNA (unidentified) were talking about how Resident 390 did not want CNA 3 to clean her. CNA 1 stated she volunteered to take care of Resident 390 for the rest of the day. CNA 1 stated she did not know why Resident 390 refused CNA 3. CNA 1 stated she volunteered to take care of Resident 390 so that the Sunday can be a day of peace. CNA 1 confirmed Resident 390 was incontinent and had large bowel movement when she cleaned Resident 390. During a telephone interview on 1/22/2025 at 2:52 p.m., LVN 5 stated on 1/19/2025 at 8 a.m., CNA 3 was busy passing meal trays, had to feed another resident (unidentified), and was not able to change Resident 390's incontinence brief right away. LVN 5 stated CNA 3 informed her when CNA 3 returned to Resident 390's room to clean the resident, Resident 390 refused to be cleaned. LVN 5 stated she talked to Resident 390 and the resident was upset because she waited too long for CNA 3 to clean her. LVN 5 stated Resident 390 refused CNA 3 to clean her and would rather be cleaned by the next shift 3-11 p.m., or someone else. LVN 5 stated she explained to Resident 390 she cannot keep Resident 390 wet all day and she cannot have her wait for the 3 to 11 p.m. shift. LVN 5 stated she had to reassigned Resident 390 to CNA 1. LVN 5 stated CNA 3 should have asked another CNA to helped pass the meal trays. LVN 5 stated the facility was not short staffed and have enough staff to assist with passing meals trays or cleaning residents. During a telephone interview on 1/23/2025 at 8:30 a.m., CNA 3 stated in an elevated tone of voice, Resident 390 was very demanding, frequently used her call light to request to be cleaned, repositioned, fed, and showered. CNA 3 stated her voice sounded usually rough and strong but when she speaks to the residents, she would tone down her voice. CNA 3 stated on 1/19/2025 at 7:30 a.m., while CNA 3 was passing meal trays, Resident 390 pressed the call light and requesting to change her soiled incontinence brief. CNA 3 stated she asked Resident 390 to wait until she (CNA 3) finished passing the meal trays and she would return back to clean Resident 390. CNA 3 stated she did not know who passed Resident 390's meal tray but told Resident 390 after she clean Resident 390 then she (Resident 390) could eat. CNA 3 stated after passing meal trays to other residents, she went back into Resident 390's room and Resident 390 was already eating and refusing to be cleaned. CNA 3 stated she called LVN 5 (charge nurse) because Resident 390 was refusing to be cleaned and LVN 5 told her the assignment would be changed. CNA 3 stated when they were passing meal tray, they cannot do fecal or urinary incontinence care because of an infection control rule which was no cleaning resident to prevent contamination of food and prevent foul odor during mealtime. CNA 3 stated the food would get cold if there was a delay in passing the meal trays. CNA 3 stated she did not ask help to pass the meal trays or clean Resident 390 because she was assigned to the resident and no one else was going to clean her. During an interview on 1/23/2025 at 9:42 a.m., the Director of Staff Development (DSD) stated, CNA 3 told him on 1/22/2025, CNA 3 was going to distribute the meal trays first on 1/19/2025 before cleaning and changing Resident 390's incontinence brief because of infection control concern and cleaning Resident 390 was dirty and she does not want to contaminate the food. The DSD stated when staff were passing meal trays, they can stop passing meal trays and provide incontinence care to residents. The DSD stated the infection control rule that applies after you perform incontinence care was to ensure to do proper hand washing. The DSD stated resident requests needed to be addressed right away. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 10:50 a.m., the Director of Nursing (DON) stated she spoke to Resident 390, CNA 1, CNA 3 and LVN 5. The DON stated Resident 390 informed her that on 1/19/2025 at 7:30 a.m., CNA 3 brought the breakfast tray to Resident 390 room but Resident 390 said she needed to be cleaned because she had a bowel movement. The DON stated CNA 3 said she told Resident 390 that she would have to wait to be cleaned after CNA 3 passed the meal trays. CNA 3 said she came back at 8 a.m., saw Resident 390 eating her breakfast and Resident 390 refused CNA 3 to clean the resident. The DON stated they teach the staff if the resident needed to be cleaned, the resident should be cleaned. The DON stated the food temperature was important, but the resident should have been cleaned. The DON stated CNA 3 should have asked for assistance to replace her to pass the meal trays. The DON stated they were not short staffed and have enough staff to assist with meal trays. The DON stated the facility needed to protect residents' dignity. During an interview on 1/23/2025 at 11:14 a.m., the Administrator (ADM) stated Resident 390 should have not been left soiled to pass meal trays. The ADM stated the facility has no infection control rule that prohibit the staff from cleaning the resident during mealtime. The ADM stated an infection control was a concern if the staff did not perform handwashing after doing incontinence care. The ADM stated the facility was not short staffed and CNA3 should have called for help. b. During an interview on 1/21/2025 at 4:36 p.m., CNA 4 stated Resident 390 was very demanding, used the call light a lot and wanted everything to be done promptly. CNA 4 stated Resident 390 was upset when CNA 4 would ask Resident 390 to wait but Resident 390 has to wait when she was busy with other residents. CNA 4 stated the call lights were answered in the order of who pressed the call light first. CNA 4 stated Resident 390 wanted to be repositioned every 30 minutes, was very demanding and would use the call light just to ask what was going on in the activity room (located in front of Resident 390's room) and stated in elevated tone of voice emphasizing That was not an emergency. During an interview on 1/21/2025 at 4:40 p.m., CNA 4 stated she provided incontinence care to Resident 390 before going on break at 7 p.m. (unable to recall date) then after her 30 minutes break, one of the residents (did not specify) requested to be cleaned but at the same time Resident 390 had her call light on. CNA 4 stated she asked what Resident 390 needed, and Resident 390 said she wanted to be repositioned. CNA 4 stated she cancelled Resident 390's call light and told her she would return after answering another resident's call light. CNA 4 stated in her mind Resident 390 was just changed and could wait. CNA 4 stated she did not ask anyone to assist Resident 390 because the other CNAs were busy with their residents. CNA 4 stated it took 10 minutes to do incontinent care for the other resident and then CNA 4 returned to repositioned Resident 390. CNA 4 stated they were not short staff but did not ask anyone for assistance and assumed everybody was busy with their own residents. CNA 4 stated they do not ask for help as they have their own assignment, and the resident would have to wait. During an interview on 1/23/2025 at 9:42 a.m., the DSD stated, the DSD stated the CNA's can call for assistance if there were multiple call lights activated at the same time. The DSD stated that it can take 10-20 minutes to change a resident, so it will be faster for the CNA to turn and reposition Resident 390 first or the CNA can ask for assistance from any staff to turn and repositioned Resident 390, so the resident does not need to wait too long. The DSD stated anyone can turn and reposition the resident including the DSD, LVN or registered nurse (RN). The DSD stated they were not short staff and there should be available help if they asked for help or assistance. The DSD stated that resident requests should be addressed right away. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2025 at 3:18 p.m., the DON stated CNA 4 have a high pitch tone of voice, but staff should tone down their voice and speak to residents respectfully. The DON stated the staff should avoid labeling a resident as Demanding. The DON stated if the resident voiced being uncomfortable and wanted to be repositioned the nurses should check the resident even if they were cleaned 30 minutes ago. The DON stated it would only take few minutes to reposition the resident and CNA 4 should have repositioned Resident 390 as she was probably uncomfortable. The DON stated CNA 4 could have asked for assistance if she cannot reposition Resident 390. The DON stated anybody can assist to help reposition residents and there was no reason for Resident 390 to wait. The DON stated if the resident wanted to know what was going on in the activity area the nurses should inform the resident. The DON stated they were not short staff and there should be enough help to assist Resident 390. During a review of Resident 390's Admission Record (Face Sheet), dated 12/3/2024, the Face Sheet indicated the facility admitted Resident 390 on 12/3/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marketed by tremor, muscular rigidity, and slow, imprecise movements), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), protein-calorie malnutrition (PCM- a condition that occurs when the body does not get enough protein or calories), muscle weakness (a lack of strength in your muscles, making it difficult to move or contract them normally) other abnormalities of gait and mobility (unusual walking patterns that can affect a person's mobility). During a review of Resident 390's Care Plan for Bowel Incontinence, dated 12/5/2024, the Care Plan indicated the resident has bowel incontinence with interventions to check the resident every two hours and assist with toileting as needed. During a review of Resident 390's Minimum Data Set (MDS- a resident assessment tool), dated 12/6/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired and required maximum assistance (helper does more than half the effort) for activities of daily living. During a review of Resident 390's Documentation Survey Report (document used by CNA to chart resident's activities of daily living), dated January 2025, the Documentation Survey Report indicated CNA 1 documented on 1/19/2025 that Resident 390 had an incontinent, large bowel movement. During a review of the facility's policy and procedure titled, Promoting/Maintaining Resident Dignity, dated 12/16/2024, indicated, All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Respond to requests for assistance in a timely manner.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961 Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for two of 25 residents (Resident 21 and 390). This failure had the potential to delay the resident's care. Findings: a. During a review of Resident 21's Admission Record, (not dated), the Admission Record indicated, Resident 21 was admitted on [DATE] with the following diagnoses, but not limited to, cerebrovascular accident(CVA- a stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) with left sided weakness, muscle weakness, left elbow contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 21's care plan (CP) for communication issues, dated 9/12/2023, the CP indicated Resident 21 has communication issues related to unclear speech. The CP interventions indicated Resident 21 will be provided with a safe environment, including a call light placed within reach. During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool), dated 11/1/24, the MDS indicated Resident 21 had severely impaired cognitive skills and required maximal assistance from staff for toileting, dressing, and personal hygiene. During a review of Resident 21's CP for fall risk dated 11/7/2024, the CP indicated Resident 21 was at risk for falls. The CP interventions indicated Resident 21's call light should be within reach and Resident's requests for assistance should be promptly addressed. During an observation on 1/21/25 at 9:30 a.m. in Resident 21's room, Resident 21 was lying in bed with their call light hanging from the right side of the bed, out of reach of the resident while unattended by staff. During a concurrent observation and interview on 1/21/23 at 11:40 a.m. with Certified Nurse Assistant (CNA) 2 in Resident 21's room, Resident 21 was lying in bed with call light cord placed under a pillow elevating Resident 21's upper right arm and shoulder. CNA 2 stated the call light is not within reach of the Resident. CNA 2 also stated it is important for resident to have access to call light to call for assistance when they need care, and to prevent resident injuries such as falls. During an interview on 1/23/25 at 3:42 p.m. with the Director of Nursing (DON), DON stated the call light should be within reach of residents to prevent delay in care and maintain the residents' safety. 49390 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During an observation and interview on 1/21/2025 at 12:26 a.m., in Resident 390's room, Resident 390 was sitting in a wheelchair beside the left side of the bed while eating lunch. Resident 390 stated she was unable to reach the call light to ask for assistance since it was approximately three (3) feet away from her and was wrapped around the right siderail. Certified Nurse Assistant (CNA) 1 unwrapped the call light that was on the siderail and placed it within reach of Resident 390. CNA 1 stated resident's call lights should always be within reach of the resident so the resident could ask for assistance. During an interview on 1/23/2025 at 10:47 a.m., the Director of Nursing (DON) stated the CNA should ensure to place the call light within resident's reach and check the call light placement during rounds. The DON stated it was important for the call light to be within reach so the residents can communicate their needs and for resident safety. During a review of Resident 390's Admission Record (Face Sheet), dated 12/3/2024, the Face Sheet indicated the facility admitted Resident 390 on 12/3/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marketed by tremor, muscular rigidity, and slow, imprecise movements), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), protein-calorie malnutrition (PCM- a condition that occurs when the body does not get enough protein or calories), muscle weakness (a lack of strength in your muscles, making it difficult to move or contract them normally) other abnormalities of gait and mobility (unusual walking patterns that can affect a person's mobility). During a review of Resident 390's Minimum Data Set (MDS- a resident assessment tool), dated 12/6/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired and dependent (helper does all the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The MDS indicated Resident 390's bowel and bladder and were always incontinent (no episodes of continent voiding or bowel movements) and required maximum assistance (helper does more than half the effort) for rolling left and right, sit to lying and lying to sitting on the side of the bed. During a review of Resident 390's Care Plan for At Risk for Falls, dated 12/5/2024, the Care Plan indicated to place the resident's call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 10/21/2024, indicated staff will ensure the call light is within reach of resident and secured, as needed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49390 Based on observation, interview and record review, the facility failed to ensure to protect one of two sampled residents' (Resident 390) rights to be free from neglect (the failure of the facility, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress) when Certified Nurse Assistant (CNA) 3 and CNA 4 did not clean Resident 390 after she had bowel movement and did not turn and reposition Resident 390 when she requested to be repositioned. This failure resulted in Resident 390 had to eat with soiled incontinence (inability to control the release of urine or stool) brief, was left uncomfortable, felt upset, frustrated, helpless and neglected. Findings: a. During a concurrent observation, interview on 1/21/2025 at 4:22 p.m., in Resident 390's room, Resident 390 appeared upset and stated CNA 3 and CNA 4 (unable to recall exact day) would speak to her in a harsh and elevated tone of voice when she requested for assistance. Resident 390 stated on 1/19/2025 morning, she requested to be cleaned because she had a bowel movement, but CNA 3 told her she needed to wait for CNA 3 to finish passing meal trays before CNA 3 would clean her. Resident 390 stated this happened several times in December to January 2025. Resident 390 stated the longest time she had to wait to be cleaned was 40 minutes. Resident 390 questioned if passing meal trays was more important than cleaning her. Resident 390 stated the delayed in care made her feel uncomfortable, upset, frustrated, and neglected. Resident 390 stated she felt helpless when CNA 3 and CNA 4 ignored her request for assistance, and she have no choice but tolerate how they treat her because she was sick, unable to walk and care for herself. During an interview on 1/22/2025 at 2:39 p.m., CNA 1 stated on 1/19/2025 at 8:30 a.m., Licensed Vocational Nurse (LVN) 5, CNA 3 and another CNA (unidentified) were talking about how Resident 390 refused CNA 3 to clean her. CNA 1 stated she did not know why Resident 390 refused CNA 3, but she (CNA 1) volunteered to take care of Resident 390. CNA 1 confirmed Resident 390 was incontinent and had a large bowel movement when she cleaned Resident 390. During a telephone interview on 1/22/2025 at 2:52 p.m., LVN 5 stated on 1/19/2025 at 8 a.m., CNA 3 was busy passing meal trays, had to feed another resident (unidentified), and was not able to change Resident 390 incontinence brief right away. LVN 5 stated CNA 3 informed her when CNA 3 returned to Resident 390's room to clean the resident, Resident 390 refused to be cleaned. LVN 5 stated she talked to Resident 390 and the resident was upset because she waited too long for CNA 3 to clean her. LVN 5 stated Resident 390 refused CNA 3 to clean her and preferred to be cleaned by the next shift 3-11 p.m., or someone else. LVN 5 stated she had to reassigned Resident 390 to CNA 1. LVN 5 stated CNA 3 should have asked another CNA to helped pass the meal trays. LVN 5 stated asking for assistance to pass the meal trays was doable because they have enough staff to assist and were not short staffed. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/23/2025 at 8:30 a.m., CNA 3 stated in an elevated tone of voice, Resident 390 was very demanding, frequently used her call light to request to be cleaned, repositioned, fed, and showered. CNA 3 stated on 1/19/2025 at 7:30 a.m., while CNA 3 was passing meal trays, Resident 390 pressed the call light and requesting to change her soiled incontinence brief. CNA 3 stated she asked Resident 390 if she could wait until she (CNA 3) finished passing the meal trays and she would return back to clean Resident 390. CNA 3 stated she did not know who passed Resident 390's meal tray but told Resident 390 after she clean Resident 390 then she (Resident 390) could eat. CNA 3 stated after passing meal trays to other residents, she went back into Resident 390's room and Resident 390 was already eating and refusing to be cleaned. CNA 3 stated she called LVN 5 (charge nurse) because Resident 390 was refusing to be cleaned and LVN 5 told her the assignment would be changed. CNA 3 stated when they were passing meal tray, they cannot do fecal or urinary incontinence care because of an infection control rule which was no cleaning resident to prevent contamination of food and prevent foul odor during mealtime. CNA 3 stated the food would get cold if there was a delay in passing the meal trays. CNA 3 stated she did not ask help to pass the meal trays or clean Resident 390 because she was assigned to the resident and no one else was going to clean her. During an interview on 1/23/2025 at 9:42 a.m., the Director of Staff Development (DSD) stated, CNA 3 told him on 1/22/2025, CNA 3 was going to distribute the meal trays first on 1/19/2025 before cleaning and changing Resident 390's incontinence brief because of infection control concern and cleaning Resident 390 was dirty and she does not want to contaminate the food. The DSD stated when staff were passing meal trays, they can stop passing meal trays and provide incontinence care to residents. The DSD stated the infection control rule that applies after you perform incontinence care was to ensure to do proper hand washing. The DSD stated resident requests needed to be addressed right away because staff not providing care right away was neglecting to provide care and services to the resident. During an interview on 1/23/2025 at 10:50 a.m., the Director of Nursing (DON) stated she spoke to Resident 390, CNA 1, CNA 3 and LVN 5. The DON stated Resident 390 informed her that on 1/19/2025 at 7:30 a.m., CNA 3 brought the breakfast tray to Resident 390 room but Resident 390 said she needed to be cleaned because she had a bowel movement. The DON stated CNA 3 said she told Resident 390 that she would have to wait to be cleaned after CNA 3 passed the meal trays. CNA 3 said she came back at 8 a.m., saw Resident 390 eating her breakfast and Resident 390 refused CNA 3 to clean the resident. The DON stated they teach the staff if the resident needed to be cleaned, the resident should be cleaned. The DON stated the food temperature was important, but the resident should have been cleaned. The DON stated CNA 3 should have asked for assistance to replace her to pass the meal trays. The DON stated they were not short staffed and have enough staff to assist with meal trays. The DON stated denying Resident 390's request to be changed and telling her to eat later after being changed but not cleaning and changing incontinence brief right away was neglecting to provide care and services to resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/23/2025 at 11:14 a.m., the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 11/4/2024, was reviewed with the Administrator (ADM), the ADM stated the P&P indicated the definition of Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. The ADM stated it was a neglect to care for resident when the employees did not provide incontinence care to Resident 390 when she requested to be cleaned. The ADM stated Resident 390 should have not been left soiled to pass meal trays. The ADM stated the facility has no infection control rule that prohibit the staff from cleaning the resident during mealtime. The ADM stated an infection control was a concern if the staff did not perform handwashing after doing incontinence care. The ADM stated the facility was not short staffed and CNA3 should have called for help. The ADM stated not changing a resident, not answering call light, telling residents we would be doing something and not doing it was neglecting to care for resident. b. During an interview on 1/21/2025 at 4:36 p.m., CNA 4 stated Resident 390 was very demanding, used the call light a lot and wanted everything to be done promptly. CNA 4 stated Resident 390 was upset when CNA 4 would ask Resident 390 to wait but Resident 390 has to wait when she was busy with other residents. CNA 4 stated the call lights were answered in the order of who pressed the call light first. CNA 4 stated Resident 390 wanted to be repositioned every 30 minutes, was very demanding and would use the call light just to ask what was going on in the activity room (located in front of Resident 390's room) and stated in elevated tone of voice emphasizing That was not an emergency. During an interview on 1/21/2025 at 4:40 p.m., CNA 4 stated she provided incontinence care to Resident 390 before going on break at 7 p.m. (unable to recall date) then after her 30 minutes break, one of the residents (did not specify) requested to be cleaned but at the same time Resident 390 had her call light on. CNA 4 stated she asked what Resident 390 needed, and Resident 390 said she wanted to be repositioned. CNA 4 stated she cancelled Resident 390's call light and told her she would return after answering another resident's call light. CNA 4 stated in her mind Resident 390 was just changed and could wait. CNA 4 stated she did not ask anyone to assist Resident 390 because the other CNAs were busy with their residents. CNA 4 stated it took 10 minutes to do incontinent care for the other resident and then CNA 4 returned to repositioned Resident 390. CNA 4 stated they were not short staff but did not ask anyone for assistance and assumed everybody was busy with their own residents. CNA 4 stated they do not ask for help as they have their own assignment, and the resident would have to wait. During an interview on 1/23/2025 at 9:42 a.m., the DSD stated the CNA's can call for assistance if there were multiple call lights activated at the same time. The DSD stated it could take 10-20 minutes to change a resident, so it would be faster for the CNA to turn and reposition Resident 390 first or the CNA can ask for assistance from any staff, so the resident does not need to wait too long. The DSD stated anyone can turn and reposition the resident. The DSD stated they were not short staff and there should be available help. The DSD stated resident requests should be addressed right away because not answering the call light, repositioning resident when the resident request for assistance was neglecting to provide or attend to resident needs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Post Acute	1323 17th Street Santa Monica, CA 90404

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2025 at 3:18 p.m., the DON stated if the resident voiced being uncomfortable and wanted to be repositioned the nurses should check the resident even if they were cleaned 30 minutes ago. The DON stated it would only take few minutes to reposition the resident and CNA 4 should have repositioned Resident 390 as she was probably uncomfortable. The DON stated CNA 4 could have asked for assistance if she cannot reposition Resident 390. The DON stated anybody can assist to help reposition residents and there was no reason for Resident 390 to wait. The DON stated they were not short staff and there should be enough help to assist Resident 390. The DON stated not answering the call light, not turning and repositioning resident in a timely manner was neglecting to provide care and services to resident that could lead to skin breakdown. During a review of Resident 390's Admission Record (Face Sheet), dated 12/3/2024, the Face Sheet indicated the facility admitted Resident 390 on 12/3/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), protein-calorie malnutrition (PCM- a condition that occurs when the body does not get enough protein or calories), muscle weakness (a lack of strength in muscles, making it difficult to move or contract them normally) other abnormalities of gait and mobility. During a review of Resident 390's Care Plan for Bowel Incontinence, dated 12/5/2024, the Care Plan indicated an intervention to check the resident every two hours and assist with toileting as needed. During a review of Resident 390's Minimum Data Set (MDS- a resident assessment tool), dated 12/6/2024, the MDS indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired and dependent (helper does all the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The MDS indicated Resident 390's bowel and bladder and were always incontinent (no episodes of continent voiding or bowel movements) and required maximum assistance (helper does more than half the effort) for rolling left and right, sit to lying and lying to sitting on the side of the bed. During a review of Resident 390's Documentation Survey Report (document used by CNA to chart activities of daily living), dated January 2025, the Documentation Survey Report indicated CNA 1 documented on 1/19/2025 that Resident 390 had an incontinent, large bowel movement. During a review of the facility's P&P titled, Call Lights: Accessibility and Timely Response, dated 10/21/2024, indicated staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the personnel should be notified. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 11/4/2024, the P&P indicated Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The P/P indicated indicators of abuse and neglect includes failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49390 Based on observation, interview and record review, the facility failed to ensure two of five Certified Nurse Assistants (CNAs) have the competency to provide care in a respectful and timely manner. This failure resulted in Resident 390's needs not being provided care and services in a timely manner that led to feelings of frustration and disappointment. Findings: a. During a concurrent observation, interview on 1/21/2025 at 4:22 p.m., in Resident 390's room, Resident 390 appeared sad and upset. Resident 390 stated she was told by CNA 3 and CNA 4 (unable to recall exact day) in a harsh and elevated tone of voice that she would need to wait for the CNA to finish taking care of another resident before assisting her with incontinence care. Resident 390 stated that on 1/19/2025 morning, she requested to change her incontinence brief because she had a bowel movement, but CNA 3 told her she needed to wait for CNA 3 to finish passing meal trays before CNA 3 would clean her. Resident 390 stated the CNAs were probably busy but asked if passing meal trays was more important than cleaning her. Resident 390 stated the delayed in providing her incontinence care made her feel uncomfortable, upset, frustrated, and neglected. Resident 390 stated she felt helpless when CNA 3 and CNA 4 would just ignore her request for assistance, and she have no choice but tolerate how they treat her because she was sick, unable to walk and felt sad that they have to treat her like a child. During an interview on 1/21/2025 at 4:36 p.m., CNA 4 stated Resident 390 was very demanding, used the call light a lot and wanted everything to be done promptly. CNA 4 stated sometimes Resident 390 would be upset when Resident 390 was told to wait when CNA 4 was busy with other residents but Resident 390 has to wait. CNA 4 stated the call lights were answered in the order of who pressed the call light first and residents have never complained. CNA 4 stated in her mind Resident 390 was just changed and could wait. CNA 4 stated Resident 390 wanted to be repositioned every 30 minutes, was very demanding and would use the call light just to ask what was going on in the activity room (located in front of Resident 390's room) and stated in elevated tone of voice emphasizing That was not an emergency. CNA 4 stated they were not short staff but did not ask anyone for assistance and assumed everybody was busy with their own patient. CNA 4 stated they do not ask for help as they have their own resident, and the resident would have to wait. During an interview on 1/23/2025 at 9:42 a.m., the Director of Staff Development (DSD) stated, CNA 3 told him on 1/19/2025 CNA 3 was going to distribute the meal trays first before cleaning and changing Resident 390's incontinence brief because of infection control issue and that cleaning Resident 390 was dirty and does not want to contaminate the food. The DSD stated that when staff were passing meal trays, they can stop passing meal trays and provide incontinence care to residents. The DSD stated the infection control rule that applies after you perform incontinence care was to ensure to do proper hand washing. The DSD stated he would need to remind the staff to ensure to clean the residents when the residents requested to be clean even during mealtime. The DSD stated there was no infection control rule that prohibits the staff from cleaning the residents during mealtime. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Competency Evaluation, dated 10/21/2024, indicated, Definitions: Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual need to perform work roles or occupational functions successfully. Policy Explanation and Compliance Guidelines: 1. The knowledge and skills required among staff to meet residents' needs are determined through the facility assessment process. During a review of the facility's job description titled, Certified Nurse Assistant, dated 2023, indicated the Major Duties and Responsibilities: Assist resident with or perform activities of daily living for resident in accordance with care plans and establish policies and procedures. Additional Assigned Tasks: Treat all residents with dignity and respect. Promotes and protects all residents' rights. Accept certified nursing assistant assignments as staffing needs require. Perform certified nursing assistant duties as assigned, in accordance with facility policies and procedures. Personal Skills and Traits Desired/Physical Requirements/Working Conditions: Ability to make independent decisions when circumstances warrant such action. Ability to deal tactfully with personnel, residents, family members, visitors, government agencies/personnel and the general public. Must have patience, tact, and willingness to deal with difficult residents, family and staff. 50961

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review the facility failed to dispose of medications in a manner that was not retrievable (able to get back,) in one of one inspected medication room (Medication room [ROOM NUMBER].) This failure had the potential to increase the opportunity for medication diversion (the transfer of a medication from a lawful to an unlawful channel of distribution or use,) and increase the risk that residents in the facility could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm, and hospitalization . Findings: During a concurrent observation and interview on [DATE] at 11:21 a.m. with Licensed Vocational Nurse (LVN) 3 in Medication room [ROOM NUMBER], the pharmaceutical waste bin was open and contained a mixture of intact (unchanged from original form) loose medication tablets and capsules out of their manufacturer packaging, medications in manufacturer bottles, creams/ointments and unopened and unused suppositories and patches in their original manufacturer packaging. LVN 3 stated the pharmaceutical waste bin was open and contained medications that were disposed in original manufacturer packaging and as loose tablets and capsules. During an interview on [DATE] at 11:39 a.m. with Registered Nurse (RN) 1 in Medication room [ROOM NUMBER], pharmaceutical waste bin was open and contained intact lose medication tablets and capsules, medications in bottles, creams/ointments and unopened and unused suppositories and patches. RN 1 stated per the facility policy and procedures (P&P) medications needed to be disposed of in a manner that the medications could not be retrieved by pouring liquid over them to disintegrate (break apart) the medications. RN 1 stated the pharmaceutical bin did not contain liquid poured over the medications, and the medications remained in a form that could be easily retrieved and re-used. RN 1 stated when medications are not disposed properly there could be the potential for accidental misuse and diversion. During an interview on [DATE] at 1:07 p.m., with the Director of Nursing (DON) and in the presence of the Administrator (ADM,) the DON stated the pharmaceutical waste bin contained medications that were disposed in their original manufacturer packaging and as lose tablets and capsules and medications in original manufacturer packaging. The DON stated the pharmaceutical bin did not contain liquid that disintegrated the medications, and the medications remained in their original form, allowing for easy access, retrieval, and potential re-use. DON stated the facility failed to dispose of medications in Medication room [ROOM NUMBER] in a manner to prevent retrieval. The DON stated without proper disposal of medications there was increased potential of accidental misuse and diversion of medication, and exposure of harmful substances affecting the safety of all residents and staff. During a review of the facility's P&P, titled Storage of Medications, last reviewed [DATE], the P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Medication Destruction, last reviewed [DATE], the P&P indicated, Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed. During a review of the facility's P&P titled Destruction of Unused drugs, last reviewed [DATE], the P&P indicated: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49390 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage preparation practices in the kitchen when: 1. The peas and carrots were not dated, labeled in the walk-in freezer. 2. The waffles and cheese were not correctly labeled, dated and stored in the freezer. These failures 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 illness in 42 of 42 medically compromised residents who received food from the kitchen. Findings: During a concurrent observation and interview, on [DATE] at 8:11 a.m., in the kitchen, with the Dietary Manager (DM), Freezer 1 had two bags of peas and one bag of carrots that were not dated and labeled. The DM stated the bags of peas and carrots had just been opened by the cook but must have forgotten to label them with the date it was opened and used by date. The DM stated it was important to label food with the date it was opened and the used by date to know when to dispose of expired food and to prevent cooking and serving food that can cause illness to the residents. During a concurrent observation and interview, on [DATE] at 8:19 a.m., in the kitchen with the DM, the overflow freezer had cheese with a use by date of [DATE]. The DM stated the date on the cheese label should have been updated from when it was moved to the freezer which would have extended the use by date. The overflow freezer also had waffles with an open date of [DATE] and used by date of [DATE]. The DM stated the dates were labeled incorrectly since the open date and used by date do not make any sense being opened in November prior to the open date. The DM stated they should label the used by dates correctly. During a review of the facility's Policy and Procedure (P&P) titled, Food Safety and Food Storage, dated [DATE], the P&P indicated labeling, dating, and monitoring refrigerated food, so it is used by its use-by-date, or frozen/discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50958 Based on observation, interview, and record review, the facility failed to ensure the staff followed the facility's infection control policy and procedure (P&P) by not labeling the personal hygiene belongings (two emesis basins, two toothbrushes, one toothpaste and two bottles of bath soap) in the shared bathroom for four of 14 sampled residents (Resident 25, Resident 27, Resident 28, and Resident 31). This deficient practice had the potential to result in Resident 25, Resident 27, Resident 28, and Resident 31 getting and spreading infection (the establishment of an infective agent in or on a suitable host, producing clinical signs and symptoms such as fever, redness, heat, etc.). Findings: During an observation on 1/21/2025 at 9:24 a.m. in a shared bathroom (shared by Resident 25, 27, 28, and 31), there were two toothbrushes (inside a wall cabinet on top of the sink) , two emesis basins (one was on top of the paper roll machine, the other was on top of the cabinet), two bottles of body soap (one was in the cabinet, another was on top of the sink), and one toothpaste (inside the cabinet) without resident identification labels. During an interview on 1/21/2025 at 9:26 a.m. with Certified Nurse Assistant (CNA)/Restorative Nurse Assistant (RNA) 1, CNA/RNA 1 stated the facility should not leave residents' personal hygiene belongings unlabeled inside the shared bathroom. CNA/RNA 1 stated the unlabeled used items in the bathroom could cause and spread infection between residents and should be thrown away. During an interview on 1/23/2025 at 9:53 a.m. with the Infection Preventionist (IP), IP stated the facility should follow the infection control policy and procedure and throw away any resident's personal hygiene belongings without labeling in the shared bathroom to prevent resident getting and spreading infection. During a review of Resident 25's Admission Record, the Admission Record indicated the facility admitted Resident 25 on 5/23/2024 with diagnoses including major depression disorders, protein-calorie malnutrition (reduced nutrients leading to changes in body composition and function), gastro-esophageal reflux disease (GERD- a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), abnormalities a of gait and mobility, and schizophreniform disorder (a mental illness characterized by disturbances in thought). During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool) dated 12/16/2024, the MDS indicated the resident had intact cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. The MDS indicated the resident required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance) to complete personal hygiene activities (including combing hair, shaving, applying makeup, washing/drying face and hands). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 1/2/2025 with diagnoses including acute respiratory failure with hypoxia (a condition in which the body is unable to adequately oxygenate the blood due to a decline in lung function), chronic pancreatitis (a progressive inflammatory disease characterized by irreversible damage to the pancreas), immunodeficiency (a condition in which the body's immune response was reduced or absent), fracture (broken bone) of one right side rib, end stage renal disease (ESRD- irreversible kidney failure). During a review of Resident 27's MDS dated [DATE], the MDS indicated the resident had intact cognitive skills for daily decision making. The MDS indicated the resident required partial assistance (staff did less than half the effort) from staff to complete self-care including bathing, dressing, using the toilet, or eating. The MDS indicated the resident required supervision or touching assistance to complete oral hygiene. During a review of Resident 28's Admission Record, the Admission Record indicated the facility admitted Resident 28 on 11/2/2024 with diagnoses including immunodeficiency, type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control), and anxiety disorder (a mental illness caused excessive and uncontrollable feelings of fear and anxiety). During a review of Resident 28's MDS dated [DATE], the MDS indicated the resident had intact cognitive skills for daily decision making. The MDS indicated the resident required supervision or touching assistance to complete oral hygiene. The MDS indicated the resident required partial assistance from staff to complete personal hygiene. During a review of Resident 31's Admission Record, the Admission Record indicated the facility admitted Resident 31 on 7/30/2024 with diagnoses including transient cerebral ischemic attack (a short period of reduced blood flow to the brain), major depressive disorder, hypertension (high blood pressure), and dementia (a progressive state of decline in mental abilities) with anxiety. During a review of Resident 31's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS indicated the resident required partial assistance from staff to complete oral hygiene and personal hygiene. During a review of the facility's policy and procedure titled, Infection Prevention and Control Program, revised 12/9/2024, the P&P indicated the facility should follow guidelines for general infection prevention and control while providing resident care services. The P&P indicated all staff should follow the standard precaution (based on the principle all blood, body fluids, secretions, regardless of whether contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents) for all residents all the time.

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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 0912 Level of Harm - Potential for minimal 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** 50961 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq ft-unit of measurement) per resident in three of 28 rooms (Rooms # 9, 16, and 28). This failure had the potential for residents to have inadequate space for care, privacy, and mobility. Findings: During an observation on 1/23/25 at 11:40 a.m. in rooms [ROOM NUMBER], the residents were moving freely inside their room. There was adequate space for the operation and use of wheelchairs, walkers, or canes. During a review of the Room Waiver Request Letter, dated 1/23/25, the letter indicated Rooms # 9, 16, and 28 did not meet the 80 sq ft per resident requirement per federal regulations. The letter also indicated, the rooms are in accordance with any special needs of each resident and enough space is provided for resident's dignity and privacy. The room waiver request indicated the following: Room # Square Footage (sq ft) Bed Capacity Sq Ft per Resident 9 148.96 2 74.48 16 143.82 2 71.91 28 156.5 2 78.79 During an interview on 1/23/25 at 12:36 p.m., with Resident 14 in resident's room measuring 78.79 sq ft per person, the resident stated there was enough space to maintain privacy and for facility staff to provide care. Resident 14 also stated there was enough space for their personal belongings and equipment such as wheelchairs and walkers. During an interview on 1/23/25 at 1:10 p.m. with Licensed Vocational Nurse (LVN), LVN 4 stated there was enough space in room [ROOM NUMBER] to provide care to residents. During an interview on 1/23/25 at 3:42 p.m. with the Director of Nursing (DON), DON stated the facility does have a room waiver, but measures have been taken for the room variance to not adversely affect the resident's care.