

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555808	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/01/2025
NAME OF PROVIDER OR SUPPLIER  Santa Monica Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1338 20th Street Santa Monica, CA 90404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43261</p> <p>Based on interview and record review, the facility staff failed to:</p> <ol style="list-style-type: none"> <li>1. Notify the physician (MD) when one of three sampled residents (Resident 2) had change of condition (COC/CIC)</li> <li>2. Documented that Resident 2 had complained of a sore throat, swallowing issues, and body itching.</li> </ol> <p>These deficient practices had the potential to result in possible delayed provision of necessary care and services to Resident 2.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record indicated the facility admitted Resident 2 on 3/4/2025 with diagnoses including congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning).</p> <p>A review of Resident 2 's Minimum Data Set (MDS-a resident assessment tool), dated 3/11/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and required moderate assistance from staff for activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene).</p> <p>A review of Resident 2 's laboratory (lab) results, indicated Resident 2 tested positive for Pertussis (whooping cough-a highly contagious respiratory tract infection) collected on 3/12/2025 and reported on 3/14/2025.</p> <p>During an interview with Resident 2 's family member (R2FM) on 3/28/2025 at 10:48 a.m., R2FM stated Resident 2 complained of sore throat and was having issues swallowing. R2FM stated R2FM requested the facility to perform some lab test. R2FM stated Resident 2 tested positive for Pertussis two days after Resident 2 complained of a sore throat and swallowing issues.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with Registered Nurse 1 (RN) 1, on 3/28/2025 at 3:45 p.m., Resident 2 ' s medical record (MR) was reviewed. The MR indicated there was no documented evidence (COC/CIC) that Resident 2 had complained of a sore throat, was having swallowing issues, and body itching. RN2 stated and validated that a COC/CIC was not done when Resident 2 was complaining of sore throat and body itching. RN1 stated the facility should have done a COC/CIC and was supposed to do a COC/CIC for Resident 2.</p> <p>During an interview with Infection Preventionist Nurse (IPN) on 3/31/2025 at 8:20 a.m., IPN stated and validated there was missing documentation of the sore throat and body itching for Resident 2. IPN stated that when a resident complains of a sore throat and body itching, staff needs to notify the MD and document same as a COC/CIC.</p> <p>A review of the facility policy and procedures (P&amp;P), titled, Change in a Resident ' s Condition or Status, reviewed on 11/21/2024, indicated, facility will promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/[NAME] condition and/or status. P&amp;P also indicated, prior to notifying the MD, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR (situation, background, appearance and review/notify- structured tool for healthcare provider that provides communication between members. Also, being used as documentation for any changes of condition) Communication Form.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>43261</p> <p>Based on interview and record review, the facility failed to ensure document grievances per facility policy for one of three sampled resident (Resident 2).</p> <p>This deficient practice violated Resident 2 and Resident 2 ' s family member (R2FM) right to have grievance addressed and had a potential to delay any necessary care and services for Resident 2.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record indicated the facility admitted Resident 2 on 3/4/2025 with diagnoses including congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning).</p> <p>A review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool), dated 3/11/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and requiring moderate assistance from staff for activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene).</p> <p>A review of Resident 2 ' s Progress Notes (PN) dated 3/14/2025, PN indicated the Social Service Director (SSD) documented that R2FM was displeased with lack of activities, trying to reach various department heads via phone and issues with response time from nursing staff.</p> <p>During an interview with R2FM on 3/28/2025 at 10:48 a.m., R2FM stated that ever since Resident 2 was admitted to the facility, there was no activity staff that assisted Resident 2. R2FM also stated that when R2FM tries to reach either a department heads (HO or nursing by phone, the OOD nor nursing ever calls R2FM back which made it hard to ask about Resident 2 ' s care.</p> <p>During a concurrent interview and record review with the Director of Nursing (DON) on 4/1/2025 at 4:01 p.m., the facility residents Grievances from 3/1/2025 to 3/31/2025 were reviewed. There was documented grievances completed for Resident 2. The DON stated and validated missing documented grievances for Resident 2. The DON stated that SSD is supposed to ask R2FM if R2FM wants to put all of the issues in writing via grievances form or SSD can assist with filling up the grievance form.</p> <p>A review of the facility policy and procedures (P&amp;P), titled, Grievances/Complaints, Recording and Investigating, reviewed on 11/21/2024, indicated, upon receiving a grievance and complaint report, facility will begin an investigation into the allegation and the Resident Grievance/Complaint Investigation Report Form will be filed within five working days of the incident.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261</b></p> <p>Based on interview and record review the facility failed to protect two of three sampled residents (Residents 2 and 3) from misappropriation (the unauthorized, improper, or unlawful use of funds or other property for purposes other than that for which intended) of property and personal belongings by failing to:</p> <ol style="list-style-type: none"> <li>1. Inventory and document belongings upon admission and discharge for Resident 2.</li> <li>2. Release Resident 3's belongings to Resident 3 or the Resident 3 ' s representatives when Resident 3 was transferred to general acute care hospital (GACH).</li> </ol> <p>These deficient practices:</p> <ol style="list-style-type: none"> <li>1. Resulted in Resident 3 not receiving all belongings.</li> <li>2. Had the potential to loose Residents 2 and 3 belongings.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. A review of Resident 2's Admission Record indicated the facility admitted Resident 2 on 3/4/2025 with diagnoses including congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning).</li> </ol> <p>A review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool), dated 3/11/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and requiring moderate assistance from staff for activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene).</p> <p>During a concurrent interview and record review with the Director of Nursing (DON) on 4/1/2025 at 10:41 a.m. , Resident 2 ' s Medical Record (MR) was reviewed. The MR indicated the inventory of personal belongings list for Resident 2 upon admission and discharge was missing. The DON stated and validated Resident 2 was missing inventory of personal belongings list. The DON stated that upon a resident's admission, staff must do an inventory of resident ' s personal belongings and document in the resident's medical record. The DON also stated during a resident's discharge, the facility must check the inventory of personal belongings and have the resident or resident representatives sign the list indicating all belongings were returned back to the residents.</p> <ol style="list-style-type: none"> <li>2. A review of Resident 3's Admission Record indicated the facility admitted Resident 3 on 11/9/2024 with diagnoses including metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), malnutrition (lack of sufficient nutrients in the body) and atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow).</li> </ol> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 3's cognitive (skills for daily decision-making was severely impaired and was dependent from staff for ADLs.</p> <p>During a concurrent interview and record review with the DON on 4/1/2025 at 10:41 a.m., Resident 3 ' s MR was reviewed. The MR indicated the inventory of personal belongings list for Resident 3 dated 11/9/2024 upon admission, indicated that Resident 3 had one jacket, four shirts, one shoes and three pants with no discharge signature by the resident or resident representative. The inventory of personal belongings list indicated that on 12/28/2024, Resident 3 had two sweat pants and a blanket delivered by a family. However, the inventory of personal belongings list, indicated there was no discharge signature by the resident or resident representative. The DON stated and validated there was no documentation that Resident 3 ' s belongings were returned to the resident or the resident's representative(s). The DON stated that when a resident is transferred to GACH, the facility staff should follow up with the resident and or resident ' s representative tand return the resident's belongings.</p> <p>A review of the facility policy and procedures (P&amp;P), titled, Personal Property, reviewed on 11/21/2024, indicated, the resident ' s personal belongings and clothing are inventoried and documented upon admission and updated as necessary.</p> <p>A review of the facility P&amp;P, titled, Release of a Resident ' s Personal Belongings reviewed on 11/21/2024, indicated, facility protects the personal belongings of a resident who has been transferred or discharged from the facility. Individuals receiving the resident ' s personal belongings will be required to sign a release for such items.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>43261</p> <p>Based on interview and record review, the facility failed to ensure baseline care plan was developed and implemented within 48 hours of admission for one of six sampled residents (Resident 2).</p> <p>This deficient practice had the potential to negatively affect the provision of care and services for Resident 2.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record indicated the facility admitted Resident 2 on 3/4/2025 with diagnoses including congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning).</p> <p>A review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool), dated 3/11/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and requiring moderate assistance from staff for activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene).</p> <p>A review of Resident 2 ' s Care Plan initiated on 3/14/2025, care plan indicated Resident 2 was at risk for falls.</p> <p>A review of Resident 2 ' s Care Plan initiated on 3/14/2025, care plan indicated Resident 2 was allergic to ferrous sulfate (iron-supplement), Penicillin (antibiotic - medication used to treat infection) and sulfa (medication to treat infection).</p> <p>A review of Resident 2 ' s Care Plan initiated on 3/14/2025, care plan indicated Resident 2 was at risk for discomfort and pain.</p> <p>A review of Resident 2 ' s Care Plan initiated on 3/14/2025, care plan indicated Resident 2 has potential impairment to skin integrity.</p> <p>During an interview with the Director of Nursing (DON) on 4/1/2025 at 10:41 a.m., the DON stated and verified that Resident 2 ' s initial care plans for falls, allergies, pain/discomfort and skin integrity were not initiated within 48 hours of admission and must be done within 48 hours upon admission.</p> <p>A review of the facility policy and procedures (P&amp;P), titled, Care Plans-Baseline, reviewed on 11/21/2024, indicated, a baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within 48 hours of admission.</p>		