STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Monica Rehabilitation Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on observation, interview, and record review, the facility failed to ensure the resident, who was assessed as risk for falls, did not fall and sustained injury for one of four residents (Resident 1). The facility failed to: 1. Ensure Resident 1 was supervised and monitored to prevent repeated falls and injuries from 9/13/2024 to 3/15/202 per care plan titled; Falling Star dated 9/13/24. 2. Revise and evaluate the effectiveness of interventions of Resident 1's care plan titled, Falling Star Program, dated 9/13/24 after Resident 1 was found on floor11/14/2024, to prevent Resident 1 from future falling. 3. Ensure there was no urine on the floor by the Resident 1's bedside that led Resident 1 to slip on the paddle of urine and fall. 4. Ensure Resident 1 was place on one to one (1:1-staff that are immediately at hand can help prevent a fall or redirect a patient from engaging in a harmful act) care with a sitter per Falling Star Program, dated 9/13/2024. 5. Ensure staff followed the facility's policy and procedures (P&P) titled, Falls and Fall Risk, managing dated 11/21/2024, which indicated, staff will identify interventions related to the resident's specific risk and causes to prevent the resident from falling and to minimize complications from falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As a result, Resident 1 had three falls on 9/13/2024, 11/14/2024, and 3/15/2025 where Resident 1 suffered severe pain and left sub-capital (below) left femoral (thigh bone) neck fracture requiring hospitalization to undergo hemiarthroplasty (a surgical procedure where half of a joint is replaced with an artificial implant) of the left hip. Findings: (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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's admission record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included Osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time), repeated falls, protein malnutrition (deficiency or imbalance of protein and energy), atherosclerosis (disease characterized by the buildup of plaque in the inner walls of the arteries), major depressive disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, significantly impacting daily functioning) and epilepsy (disorder of the brain characterized by sudden alteration of behavior due to a temporary change in the electrical functioning of the brain) A review of Resident 1s Minimum Data Set (MDS - a standardized resident assessment tool) dated 1/13/2025, indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 1 required supervision or touching assistance with personal hygiene, upper body dressing and ambulating up to 10 feet, Resident 1 required partial moderate assistance with personal hygiene and lower body dressing. The MDS indicated Resident 1 is continent (ability to voluntary release of urine or feces). A review of Resident 1's Fall Risk assessment dated [DATE], indicated Resident 1 had decreased muscular coordination, and an unsteady gait/balance while standing and walking, placing the resident at a moderate risk for falls. A review of Resident 1's Rehab Admission Rehabilitation Screening notes dated 9/18/2024, indicated Resident 1 was totally dependent on staff and required two persons assistance for bed mobility and transfer. The Rehab Admission Rehabilitation Screening notes indicated Resident 1 was not evaluated for ambulation. The Rehab Admission Rehabilitation Screening notes indicated Resident 1 used a wheelchair for locomotion (movement), and that the resident was totally dependent and required two persons assistance with sitting balance. The Rehab Admission Rehabilitation Screening notes indicated Resident 1 was unsteady, and had mild difficulty with cognition, decision making due to a memory problem. A review of Resident 1's Change of Condition (COC - a deviation from a patient's baseline state of health, often involving a sudden or clinically significant worsening) Situation-Background-Assessment-Recommendation (SBAR- is a technique used to provide a framework for communication between members of the health care team) form and progress notes dated 9/13/2024, at 6:45 AM indicated a certified nurse assistant (CNA) found Resident 1 sitting on the floor at foot of her bed and had blood on the hair and on the left hand. The COC-SBAR indicated that upon assessment, Resident 1 sustained a cut to the left side of the head and a cut underneath the left eye. The COC-SBAR indicated Resident 1 did not respond to verbal stimuli, blood pressure, heart rate, respirations, temperature and oxygen saturation were taken and 911 (emergency response telephone number) was called. Resident 1 was transferred to an acute care hospital for a higher level of care. A review of Resident 1's care plan titled, Falling Star Program, dated 9/13/2024, indicated Resident 1 was at risk for falls related to history of falls, dementia, muscle wasting. The care plan goal indicated to reduce risk of falls and/or injury through appropriate intervention(s) daily until the next assessment. The care plan interventions include bed in lowest position, wheelchair's wheels locked, call light within reach, environment-maintained clutter free, non-skid shoes/slipper when out of bed, room organization, safety round checks, and may apply pad alarm on the bed to alert staff to assist resident to prevent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's care plan titled, Resident has had an actual fall created on 9/13/2024, indicated that: -On 9/13/2024, Resident 1 with cut of left side of the head and underneath left eye. Resident 1 was found sitting on the foot of her bed. Resident 1 was transferred to GACH via 911. - On 11/14/2024, Resident 1 was found on floor sitting on buttocks against bed sitting in upright position. -On 3/15/2025, Resident 1 had an actual fall. Resident 1 was found lying at the foot of her bed, positioned on the left side. Patient's muscles are tensed and shaking continuously. Risk factors include poor balance, poor communication, unsteady gait and dementia. The interventions indicated Resident 1 to have resident's bed at lowest position when in bed three times a day for fall precaution, floor pads for safety precaution. A review of Resident 1's Fall Risk assessment dated [DATE] at 9:25 AM, indicated Resident 1 had unwitnessed fall inside her room obtained left forehead skin tear s/p (status post-after) seizure. The Fall Risk Assessment - fall interventions included skilled rehab (rehabilitation) services for Physical Therapy (PT - is a healthcare specialty that focuses on improving physical function and movement using exercises, manual therapy, and other modalities), Occupational Therapy (OT - The practice of helping individuals with disabilities or health conditions improve their ability to participate in daily activities and maintain independence), and Safety awareness. A review of Resident 1's GACH Vascular Neurology (a specialized field within neurology that focuses on diagnosing, treating, and managing diseases and conditions related to the blood vessels of the brain and spinal cord) Progress Note dated 9/15/2024, indicated Resident 1 was brought to the emergency roiagnom on [DATE] after unwitnessed fall. A review of Resident 1's Computerized Tomography (CT - is a medical imaging technique that uses x-rays to create detailed, cross-sectional images of the body's internal structures, such as bones, organs, and blood vessels) from the GACH indicated the CT scan was unremarkable, and Resident 1 was discharged from ED. A review of Resident 1's GACH Hospitalist (a Physician whose primary focus is caring for hospitalized patients only) Progress Notes signed by GACH medical doctor (MD) dated 9/15/2024 at 1:05 PM, indicated that on 9/13/2024 at 1:05 PM, Resident 1 presented to the GACH from the skilled nursing facility (SNF) due to unwitnessed fall. The GACH hospitalist progress notes assessment and plan included . Staples (fasteners used to close wounds or surgical incisions) to be removed in 7-10 days from head laceration after fall at SNF. A review of Resident 1 Interdisciplinary Team (IDT- group of healthcare professionals from various disciplines who work together to provide comprehensive and coordinated care for patients) Review-Fall dated 9/16/2024 at 11:40 AM, indicated Resident 1 had unwitnessed fall inside her room obtained left forehead skin tear s/p seizure . was transferred to hospital via 911. The IDT Review- Fall interventions include skilled rehab services for PT and OT, and safety awareness. The IDT Review-Fall did not address interventions to prevent future falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's COC-SBAR dated 11/14/2024 at 11:50 AM, indicated Resident 1 was found on floor sitting on buttocks back against bed sitting in upright position, increased confusion noted, complaining of dizziness and unsteady gait. The COC-SBAR indicated Resident 1 was not sent to GACH after the fall. A review of Resident 1 IDT Review-Fall dated 11/24/2024 at 12:00 AM, indicated [Resident 1] found on floor sitting on buttocks back against bed sitting in upright position. Bed in lowest level, call light within reach. The IDT Review- Fall assessment/root cause analysis indicated (Resident 1) was demented, periods of not calling for assistance due to forgetfulness. Intervention was to leave the bed to lowest level for prevention of injury. The IDT Review- Fall interventions include bilateral (both) upper rails for enabler and mobility use due to generalized muscle weakness. Monitor side effects from antidepressant medication, Zoloft. On skilled PT to promote gait and safe functional transfer and mobility. The IDT Review-Fall did not address interventions to prevent future falls. A review of Resident 1's COC-SBAR dated 3/15/2025 at 1:15 AM, indicated that on 3/15/2025 at 1:15 AM, the charge nurse (unidentified) notified the writer (a registered Nurse -RN) that Residen1 was found lying on the left side on the floor at the foot of the bed. The COC-SBAR indicated Resident 1 was experiencing significant discomfort and pain evidenced by the resident guarding of the left hip. The COC-SBAR indicated Resident 1's left hip muscle was tensed, and the muscle was shaking continuously. The COC-SBAR indicated Resident 1 refused the charge nurse to take the vital signs (measurable physiological indicators that reflect a person's overall health and well-being including blood pressure - BP 129/68 millimeters of mercury [mmHg- unit of measurement -normal is less than 120/80 mmHg], temperature [Temp] 97.5 degrees Fahrenheit [F - normal range 97-99], Pulse [heart rate-HR] 72 beats per minute [normal 60-100], respirations [RR] 18 breaths per minute [normal 12-18], and Oxygen saturation [O2 Sat - percentage of oxygen present in the blood] . The COC-SBAR indicated Resident 1 stated that she was trying to go the bathroom. The COC-SBAR indicated Paramedics (healthcare professionals, who provides advanced emergency medical care and transportation) were contacted immediately, came to the facility, assessed Resident 1 and determined that Resident 1 needed to be transferred to the emergency room (ER-a specialized hospital area equipped to handle and treat patients with sudden, serious illnesses or injuries requiring immediate medical attention). A review of Resident 1's x-ray dated 3/15/2025 at 10:42 AM, indicated an impression of Redemonstrated (a finding or condition has been observed again on a follow-up examination) sub-capital left femoral neck fracture (a fracture of the neck of the femur specifically in the sub-capital region (the area just below the head of the femur) on the left side. A review of Resident 1's GACH History and Physical dated 3/15/2025 at 11:34 AM, indicated Resident 1 presenting from Skilled Nursing facility (SNF) with unwitnessed fall with left hip pain (pain level not indicated). A review of Resident 1's GACH Operative Report dated 3/16/2025 at 3.11 PM, indicated Resident 1 had a pre-operative (before surgery) diagnosis of displaced left femoral neck fracture and that on 3/16/2025 at 3:11 PM Resident 1 had left hip hemiarthroplasty. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's GACH Orthopedic (medical specialty focused on the diagnosis, treatment, and prevention of conditions related to the musculoskeletal system (bones, joints, muscles, tendons, ligaments, and nerves) Consult Notes dated 3/15/2025 at 1:21 PM indicated Resident 1, with a history of dementia, who presented with severe pain in the left hip which began after an unwitnessed fall yesterday (3/14/2025) at the skilled nursing facility (SNF) where she was found in a puddle of urine. has continued severe pain in the left hip that is worse with movement and improved with rest . A review of Resident 1's COC-SBAR dated 3/18/2025 at 4:53 PM and documented by RN Consultant, indicated that on 3/15/2025 at 1:15 AM, indicated that Resident 1 was transferred to hospital via 911 due to unwitnessed fall . 2 CNAs heard the loud noise from Resident 1's room then rushed to the resident. The 2 CNAs called the Charge Nurse (unidentified), and RN (unidentified) assessed Resident 1. The COC-SBAR indicated that 1 (one) transferred the resident back to bed and paramedics called because Resident 1 was in pain. During a concurrent observation and interview on 4/1/2025 at 12:37 PM, in Resident 1's room, with licensed vocational nurse (LVN) 1, Resident 1's call light was observed on the resident's dresser drawer and not within reach. LVN 1 stated Resident 1's call light was probably moved away from the resident by a Certified Nurse Assistant (CNA) 1, who cleaned Resident 1 in the morning (4/1/2025). LVN 1 stated the CNA1 must have forgotten to put the call light back to be within Resident 1's reach. LVN 1 stated Resident 1, is forgetful, sometimes she (Resident 1) stands on her own and is a fall risk. LVN 1 stated Resident 1 fell and sustained an injury last month (unable to recall the exact date). LVN 1 stated residents call light is supposed to be within the residents reach so that it is easier for the residents to call for assistance. During an interview on 4/1/2025 at 12:41pm, CNA 1 stated Resident 1 is confused, pleasant, and can communicate some needs. CNA 1 stated Resident 1 is incontinent bowel and bladder (inability to prevent the involuntary release of urine or feces). CNA 1 stated Resident 1 used to ambulate (walk) but does not walk since the resident was readmitted on [DATE]. CNA1 stated Resident 1 does not have situational awareness (conscious knowledge of the immediate environment and the events that are occurring in it) and is unable to recognize that she (Resident 1) is a risk for falls. During an observation in Resident 1's room on 4/1/2025 at 1:30 pm, Resident 1 was observed getting out of bed unsupervised, and stepped on a wet floor mat with water. Resident 1 unsteadily bent forward and down and picked up a water pitcher that was on the floor. Resident 1 then placed the water pitcher on top of her bedside table. During an observation on 4/1/2025 at 1:34 pm, CNA 1 was observed enter Resident 1's room as Resident 1 was trying to get back in bed. CNA 1 then assisted Resident 1 back to bed. During an interview with director of nursing (DON) on 4/1/2025 at 5:18 pm, DON stated Resident 1 fell in the facility on 3/15/2025, because Resident 1 is confused more than usual, there was urine was on the floor by the Resident 1's bedside, and that Resident 1 slipped on the paddle of urine and fell . DON stated Resident 1 should have been place on one to one (1:1-staff that are immediately at hand can help prevent a fall or redirect a patient from engaging in a harmful act.) care with a sitter. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of facility policy and procedures (P&P) titled Falls and Fall Risk, Managing, dated 11/21/2024, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to prevent the resident from falling and to minimize complications from falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. A review of facility P&P titled, Falls - Clinical Protocol dated 11/21/2024 indicated, Based on preceding assessment, the staff and physician will identify pertinent interventions to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The staff with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and complications have been resolved. A review of facility Mandatory facility in-service (training programs designed for healthcare professionals to update their knowledge and skills and improve their professional development) and lesson plan dated 3/18/2025 titled Clinical Protocol for falls and fall prevention, assessments dated 3/18/2025, indicated, Upon completion of this activity, participant/s will be able to: Understand the risk factors associated with falls Identify strategies to prevent falls.