

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 04/08/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review for one of three sampled Residents, Resident 1. The facility failed to develop interventions to stop resident 2 from allegedly verbally abusing Resident 1.</p> <p>This deficient practice places Resident 1 at risk for continued verbal abuse from Resident 2.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated the facility admitted this [AGE] year-old female on 12/19/2022 with diagnoses including bilateral osteoarthritis of knee (a progressive disorder of the joints, caused by a gradual loss of cartilage), anemia (a condition where the body does not have enough healthy red blood cells), myalgia (generalized muscle pain), hyperlipidemia (high fat in the blood), anxiety (intense, excessive worrying over everyday situations), essential hypertension (HTN-high blood pressure), chronic peripheral venous insufficiency (improper functioning veins in legs), chronic sinusitis (long term infection of sinuses), cardiac murmur(sound of blood flowing through a diseased heart valve), gastro esophageal reflux (GERD- indigestion and heart burn).</p> <p>A review of Resident 1 ' s history and physical (H&P- physician physical assessment and plan of care) dated 9/4/2024 indicated Resident 1 ' s cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS-a resident assessment) dated 3/12/2025 indicated Resident 1 was dependent (helper does all the effort and resident does none of the effort to complete the task) with toileting, showering and transfer (how resident moves between surfaces including to and from: bed, chair, wheelchair and standing position) with one-person physical assist. It further indicated Resident 1 did not walk at the time of this assessment.</p> <p>A review of Resident 2 ' s admission record indicated the facility admitted this [AGE] year-old female on 1/29/2024 with diagnoses including atrial fibrillation (irregular heartbeat), acute kidney failure (sudden loss of kidney function), overactive bladder (a problem with bladder function that causes sudden need to urinate), unsteadiness on feet, essential hypertension, dizziness and giddiness and dyspnea (difficulty breathing).</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment) dated 1/27/2025 indicated Resident 2 ' s cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. Resident 2 required set up assistance (helper sets up or cleans up; resident completes activity) with toileting and showering. Resident 2 was independent with transfers (how resident moves between surfaces including to and from: bed, chair, wheelchair and standing position) and required supervision or touch assistance with ambulating 10-50 feet with a walker.</p> <p>A review of Resident 1 ' s grievance/complaint form dated 3/12/2025 indicated on 3/11/2025 at 7:00 p.m. Resident 2 left the light on and exited the room refusing to turn the light off. The Resident 2 opened the window while it was cold outside. Recommended actions include offered both residents room change, and both refused.</p> <p>On 4/7/2025 The California Department of Public Health (CDPH) received an anonymous complaint alleging Resident 1 was crying stating Resident 2 would not allow Resident 1 to leave the room stating Resident 2 closes the door and physically barricades Resident 1 inside of the room. Resident 1 further alleged that Resident 1 had CNA push her bed so Resident 1 can ' t do anything. Also, Resident 1 alleged Resident 2 makes Resident 1 turn personal light and tv off at a certain time and Resident 2 makes Resident 1 feel like not getting out of bed. Lastly, Resident 1 stated this was reported to facility staff and has not been addressed.</p> <p>During an interview on 4/8/2025 at 9:00 am with the Ombudsman (OMBUDS-an advocate for residents of nursing homes, board and care centers, and assisted living facilities). The OMBUDS stated, I visited the facility back in November 2024 and spoke with both residents. The OMBUDS stated Resident 2 complained the Resident 1 gets more consideration when it comes to preferences in the room. Resident 2 wanted the door closed and the light off at night. The OMBUDS asked for a night light for Resident 1and Resident 2 was okay with the compromise.</p> <p>During an interview on 4/8/2025 at 10:15 a.m. with Resident 1 inside of Resident 1 ' s room and certified nursing assistant (CNA) translating in Spanish. Resident 1 stated, I have a lot of trouble with Resident 2, Resident 2 pushes my bed with the wheelchair, and we fight all of the time over the bed. Last week Resident 2 closed the door, and I asked Resident 2 to open the door and Resident 2 would not open the door. At 7:00 p.m. Resident 2 likes the door to be closed and the light and tv to be off and I want to keep watching tv with the light on. Last year I asked someone to move my bed a little away from Resident 2 ' s side and Resident 2 came in the room and said to me you happy now b-word. When I try talk to Resident 2 about the door and the light Resident 2 tells me to shut up. I have reported this, and they say they are working on it but nothing changes. Sometimes I am scared because Resident 2 says too many mean things.</p> <p>During a concurrent observation and interview on 4/8/2025 at 10:21 a.m. with Resident 2 in the doorway of Resident 1 and 2 ' s room. Resident 2 was sitting in the w/c and parked chair in the doorway as this surveyor, Resident 1 and the CNA were trying to exit the room blocking us from exiting the room. Resident 2 stated, Aren ' t you from the state, don ' t you want to talk to me, aren ' t you (called this surveyor by the name of another surveyor). This surveyor had to ask Resident 2 to back away from the door to let us out of the room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/8/2025 at 10:20 a.m. with the CNA. The CNA stated, I have seen Resident 2 block the door before. When I go into the room to give care to Resident 1, Resident 2 will put her walker and wheelchair in between Resident 1 ' s bed and the door so we can ' t get out of the room; then Resident 2 will get mad if I try to move or touch the items. Then Resident 2 will say, I don ' t care if you have to wait 2 hours for my CNA to move my things don ' t touch them. Then Resident 2 always changes the story and blames others. There was a time when I changed Resident 1 ' s brief while Resident 2 was in the room and Resident 2 said, this room stinks, this b-word. When that happened, I reported it to the director of staff development (DSD) and was told to write a letter, but I don ' t know what happened after that. Resident 2 always threatens to call the state and threatened my job, she calls me fatty even though I don ' t do anything wrong, Resident 2 is a bully.</p> <p>During an interview on 4/8/2025 at 10:51 a.m., the DSD stated Resident 1 has mentioned incidents when Resident 2 pushed Resident 1 ' s bed and opened the window on Resident 1 ' s side of the room knowing Resident 1 can ' t get up. We offered room changes to both residents but neither of them wants to move. I am not aware of any verbal abuse between the two residents. Lastly, Since October 2024 Resident 2 has requested that I not talk to Resident 2 as Resident 2 has filed several alleged abuse cases against myself, so I am not allowed to have any interactions with Resident 2.</p> <p>During an interview on 4/8/2025 at 10:52 a.m. with the regional director (RD). The RD stated, I was not aware of any verbal abuse between Resident 1 and Resident 2.</p> <p>During an interview on 4/8/2025 at 12:15 p.m. with Resident 2. Resident 2 stated, you know Resident 1 slapped and kicked me and that ' s why I can ' t take care of Resident 1 anymore. Resident 2 then stated, but I love Resident 1.</p> <p>During an interview on 4/8/2025 at 1:02 p.m. with the Administrator (Adm). The Adm stated, I have been here for about 2 weeks now. I was aware of Resident 2 ' s multiple allegations alleged abuse against the DSD, but I was not aware of any alleged abuse between Resident 1 and Resident 2. I was aware a room change was offered, and they both refused, I will be monitoring the situation closely.</p> <p>During a concurrent interview and record review on 4/9/2025 at 2:58 p.m. with the social service assistant (SSA). Resident 1 ' s nursing progress note dated 3/12/2025 was reviewed. Resident 1 ' s progress note indicated Resident 1 informed the SSA the night before at 7:00 p.m. Resident 2 left the light on and exited the room, refusing to turn off the light. Additionally, Resident 1 reported that Resident 2 opened the window despite Resident 1 ' s discomfort and inability to get out of bed to close the window. Lastly the note indicated the SSA would complete a grievance form. The SSA stated a grievance form was completed and given to the unnamed administrator at the time. The SSA stated, I offered them both a room change and neither wanted to change rooms. The SSA stated, I did not follow up with them after the grievance was filed because I was not a work to perform the three day follow up.</p> <p>(continued on next page)</p>		

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<p>F 0600</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 on 4/9/2025 at 4:00 p.m. with the registered nurse (RN). Resident 2 ' s nursing progress noted dated 1/12/2025 timed at 4:33 a.m. was reviewed. Resident 2 ' s progress note indicated while the RN was rounding (walking around checking on residents) at 3:20 a.m. Resident 1 and Resident 2 were found having a verbal altercation. Resident 2 wanted the door closed and the light off and Resident 2 wanted to keep the light on and the door open. Resident 2 alleged the OMBUDS said Resident 2 could keep the door closed and stated the Adm had promised to move Resident 2 to another room. After 45 minutes the RN convinced Resident to turn off the light and left the resident in the room. Lastly, the note indicated social services would be notified to follow up because a lasting solution is needed for the situation. The RN stated, When I was rounding, I heard them yelling at each other back and forth about the door and the light. I wanted to separate them, and I asked both of them individually if they wanted to switch rooms and they both said no. That is when Resident 2 told me the Adm had promised to move Resident 2 to another room. I convinced Resident 1 to turn off the light over the bed and told Resident 2 I would leave a note for social services to follow up with them the next day. I did not hear any derogatory remarks made by either resident but something more permanent needed to be done or they will just continue to fight.</p> <p>A review of the facility's policy and procedures (P&P) titled, Abuse Investigation and Reporting, reviewed 11/2024, the P&P indicated:</p> <p>All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.</p> <p>Role of the Administrator</p> <ol style="list-style-type: none"> 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. <p>Role of the Investigator</p> <ol style="list-style-type: none"> 1. The individual conducting the investigation will, as a minimum: <p>(continued on next page)</p>		

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