| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555808 | A. Building<br>B. Wing | 07/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Santa Monica Rehabilitation Center | 1338 20th Street<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for one of four residents (Resident 1) by Resident 2. Resident 1 had a behavior of wandering behavior into other residents' rooms. The facility failed to:- Develop a comprehensive care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to address Resident 1's wandering, per the facility's policy and procedure (P&P) titled, Wandering and Elopements. - Accurately assess Resident 1's risk for wandering upon admission- Adequately monitor Resident 1's location to ensure the resident's safety and prevent the resident from wandering into other resident rooms. - Provide a safe environment for Resident 1 As a result, On 7/6/2025, Resident 1 wandered into Resident 2's room and ate Resident 2's sandwich.On 7/20/2025, Resident 1 again wandered into Resident 2's room and drank Resident 2's sports drink causing Resident 2 to become angry and throw a bottle at Resident 1's head. Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted the resident on 6/26/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and history of falling. During a review of Resident 1's Wandering Risk Assessment, dated 6/26/2025 [upon admission], the wandering risk assessment form indicated the form consisted of seven sections that addressed the resident's orientation, behavior/mood, recent experiences, mobility, diagnosis, medications and history of wandering. A further review of the wandering risk assessment form indicated the facility did not assess Resident 1's orientation, behavior/mood and recent experiences. The Wandering Risk Assessment form also indicated the Resident 1 scored number four (4 - the resident is a low risk for wandering). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 7/3/2025, the MDS indicated Resident 1 had severe cognitive impairment (problems with a person's ability to think, remember, and make decisions). The MDS also indicated the resident had no episodes of wandering in the previous one to three days. The MDS indicated Resident 1 required substantial to maximal assistance from facility staff with eating, oral hygiene and dressing and was dependent upon staff for toileting hygiene, showering and personal hygiene. During a review of Resident 1's Wandering Risk Assessment form, dated 7/9/2025, the wandering risk assessment form indicated Resident 1 risk wandering score was 11 (the resident is at high risk for wandering). During a review of Resident 1's Change of Condition (COC-technique provides a framework for communication between members of the health care team and used as a tool to foster patient safety), dated 7/20/2025, indicated Resident 1 was found in Resident 2's room. The COC indicated that Resident 2 became upset and hit Resident 1 in the back of the head. The COC further indicated Resident 1's physician was notified and then ordered for Resident 1 to be transferred to a general acute care hospital (GACH). During a review of Resident 1's care pan (CP) on resident demonstrated wandering behaviors, initiated 7/21/2025 (the day after the altercation between Resident 1 and Resident 2), the CP indicated the goal was for the resident to remain safe in the environment into other resident's spaces and to prevent recurrence of altercation (a loud argument or disagreement) or conflict with other residents. The CP interventions included to monitor Resident 1's whereabout frequently, assess the resident for underlying causes of wandering, and to educate staff on resident's wandering pattern and preferred redirection techniques. During a review of Resident 1's care plans, indicated there were no care plans developed that addressed Resident 1's wandering behavior prior to 7/21/2025 (after the altercation involving Resident 1 and Resident 2) and there was no documented evidence regarding monitoring Resident 1's whereabouts prior to 7/21/2025. During a review of Resident 2's admission record, the admission record indicated the facility admitted the resident originally on 3/31/2021 and re-admitted the resident on 12/26/2024 with diagnoses that included right sided hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body) , seizures (a sudden burst of electrical activity in the brain) and a history of falling. During a review of Resident 2's COC form, dated 7/20/2025, the COC indicated Resident 2 became angry that another resident [Resident 1] came into Resident 2's room and drank his (Resident 2's) juice. The COC also indicated Resident 2 hit Resident 1 in the back of the head. During an interview on 7/30/2025 at 11:46 AM, Resident 2 stated that on 7/6/2025, Resident 1 entered Resident 2's room and ate Resident 2's sandwich. Resident 2 stated a facility staff member (unknown to Resident 2 and FM 1) removed Resident 1 from the room. Resident 2 further stated that two weeks later on 7/20/2025, Resident 2 arrived at his room and again found Resident 1 drinking a sports drink from Resident 2's bedside. Resident 2 stated he (Resident 2) became very upset and acted |