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	09/04/2025

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 0600 Level of Harm - 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from mental abuse (intentional, willful, or reckless verbal or nonverbal action) and physical abuse (deliberate aggressive or violent behavior with the intention to cause harm) for two of four sampled residents (Residents 2 and 3) by failing to: 1. Ensure unidentified facility corporate staff (Person from the main company not a regular employee of the facility) did not forcefully pull and remove Residents 2 and 3 from motorized power wheelchairs (MPWC - a battery-operated device designed for individuals with mobility impairments, providing assisted motion with motorized base and a control system, typically a joystick) on 8/29/2025, and place Residents 2 and 3 into manual wheelchairs (MWC - mobility device on wheels that provides support for individuals with limited mobility propelled by the user or the care giver manually pushing the chair) against the residents wishes/will/consent. 2. Ensure Residents 2 and 3 were not confined in bed, and denied mobility from 8/29/2025 to 8/30/2025, when the facility deprived the residents of their preferred mobility device without clinical justification or consent. 3. Residents 2 and 3 were not subjected to intimidation (to make them feel frightened, afraid, or timid, often to force them to do something or to discourage them from acting) when the unidentified facility corporate staff forcefully pulled and removed Residents 2 and 3 from MPWC. These deficient practices resulted in Residents 2 and 3 being subjected to mental and physical abuse while under the care of the facility. Residents 2 and 3 experienced a loss of autonomy (the right and ability to govern or control oneself and make one's own choices), dignity, and independence, which caused psychosocial harm (is the negative mental or physical health impact resulting from psychosocial hazards, which are factors in the design or management of work that cause stress), including anxiety (nervousness), helplessness, and emotional distress. On 9/3/2025, Resident 2 was transferred to a general acute care hospital for further evaluation and management for left shoulder and arm pain.Findings: a. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including cellulitis (a skin infection that causes swelling and redness) of the buttock, seizures, obesity (excessively overweight), pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of left buttocks and sacral region unstageable, overactive bladder (OAB- problem with bladder causes sudden urge to urinate), acute kidney failure (rapid loss of kidney function), chronic pain syndrome, essential hypertension (high blood pressure), pain in both shoulders, weakness, gastro-esophageal reflux disease (GERD- heartburn and indigestion), dependence on wheelchair. A review of Resident 2's care plan titled With Motorized (Power) Wheelchair dated 5/17/2025 indicated no documented goals. The care plan intervention included, resident has been provided education of being aware of surroundings and being extra cautious to minimize risk of injury. A review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 8/14/2025, indicated Resident 2's cognition (the mental ability to make decisions of daily living) was intact. Resident 2 required set up or clean up assistance with eating. Resident 2 required moderate assistance with toileting, showering and transfers. The MDS indicated walking assessment was not completed due to medical condition or safety concerns. The same MDS indicated Resident 1 was independent with the use of MPWC. A review of Resident 2's GACH record titled Shoulder Pain dated 9/3/2025, indicated, Many things can cause shoulder pain including: An injury. Wear the sling Put ice and leave ice on for 20 minutes 2-3 times a day. A review of Resident 2's GACH Xray of the left shoulder dated 9/3/2025, indicated, Impression of no fracture (break in the bone) or dislocation. During an interview on 9/3/2025 at 1:46 p.m. the Assistant Director of Nursing (ADON) regarding the events surrounding Resident 2's transition from a motorized power wheelchair (MPWC) to a manual wheelchair (MWC). The ADON appeared hesitant to speak and expressed concern about potential retaliation. The ADON stated that unidentified corporate staff (Person from the main company not a regular employee of the facility) spoke with Resident 2 with the intent of minimizing the use of the MPWC and transition her to an MWC. According to the ADON, on 8/29/2025, Resident 2 initially agreed to the switch, with the understanding that her need for the MPWC would be evaluated. However, on 9/1/2025, ADON reported hearing that Resident 2 had changed her mind. Despite this, corporate staff allegedly proceeded with the plan and attempted to force Resident 2 out of the MPWC. ADON did not witness the incident directly but was informed of it afterward. The ADON stated that staff contacted the police, who arrived at the facility but only spoke with corporate representatives and not with Resident 2. The ADON then showed the surveyor a typed note on a laptop screen that read: