

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 12/11/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to report an allegation of verbal abuse (any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability), for one out of two sampled residents (Resident 1) to the Department of Public Health and Ombudsman (an official appointed to investigate individuals' complaints against maladministration) in accordance with the facility's policy and procedures (P&P) titled, Abuse Investigation and Reporting, reviewed 1/21/2025, within 2 hours after the facility became aware of the abuse allegation on 11/27/2025. This deficient practice had the potential to delay of an onsite inspection by the California Department of Public Health (CDPH) and the Ombudsman to ensure Resident 1's circumstance were investigated. This deficient practice also had the potential to place Resident 1 at further risk for abuse. A review of Resident 1's admission Record indicated the facility originally admitted the resident on 5/23/2025 and readmitted the resident on 6/20/2025 with diagnoses including heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and cystitis (inflammation of the bladder, often causing pain, pressure, and a frequent, urgent need to urinate). A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2025, indicated the resident's cognitive (ability to acquire and understand knowledge) ability was intact. The MDS also indicated Resident 1 was dependent upon staff with personal hygiene, dressing, bathing, oral hygiene and toileting hygiene. A review of Resident 1's Behavior Related Incidents form, dated 11/27/2025 Resident 1 alleged Resident 2 hit Resident 1 on the leg. A review of Resident 2's admission record indicated the facility originally admitted the resident on 5/19/2025 and readmitted the resident on 7/1/2025 with diagnoses that included left thigh fracture, heart failure and diabetes mellitus. A review of Resident 2's Behavior Related Incidents form, dated 11/27/2025, indicated at 5:21 AM on 11/27/2025 law enforcement walked in and approached Resident 2's room and Resident 1 claimed Resident 2 hit him on the leg. The form further indicated law enforcement left the facility at 5:30 AM. During an interview on 12/10/2025 at 10:47 AM Resident 2 stated Resident 1 used an expletive while telling Resident 2 to shut up. Resident 2 stated he then went to Resident 1's room and used the same expletive while telling Resident 1 to shut up. Resident 2 denied hitting Resident 1. Resident 2 further stated he woke up the next morning on Thanksgiving day (11/27/2025) to the police at his door. During the investigation Resident 1 refused to be interviewed. During a concurrent interview and record review on 12/11/2025 at 11:45 AM, Resident 2's Behavior Related Incidents form, dated 11/27/2025 was reviewed with MDS Coordinator (MDSC) 1. MDSC 1 stated on 11/27/2025 police officers came to the facility after Resident 1 reported an allegation of physical abuse to law enforcement. MDSC 1 stated the facility became aware of Resident 1's abuse allegation on 11/27/2025 around 5:30 AM. MDSC 1 stated the facility is mandated to report allegations of abuse to the state survey agency within 2 hours. MDSC 1 also stated Resident 1's allegation of abuse should have been reported to the state survey agency by 7:30 AM on 11/27/2025. MDSC 1 further stated it is important to report allegations of abuse within two hours in order to investigate the abuse allegation right away. During an interview and record review on 12/11/2025 at 2:52 PM, Resident 2's Behavior Incident Form, dated 11/27/2025 and the fax confirmation of reporting for Resident 1's abuse allegation were reviewed with the Nurse Consultant (NC). NC stated the fax confirmation indicates the abuse allegation was reported to the state survey agency on 11/27/2025 at 9:09 AM. NC stated that is beyond the two hour timeframe. A review of the facility's policy and procedures (P&P) titled, Abuse Investigation and Reporting, reviewed 1/21/2025, indicated: 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. 4. Notices will include, as appropriate: b. The number of the room in which the resident resides; c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.); d. The date and time the alleged incident occurred; e. The name(s) of all persons involved in the alleged incident; and f. What immediate action was taken by the facility.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to provide social services to four out of six sampled residents (Resident 1, Resident 3, Resident 4, and Resident 5) by failing to have the Social Services Director (SSD) assess the residents' psycho-social well-being after the residents' were involved in physical and/or abuse allegations. On 11/27/2025, Resident 1 alleged Resident 2 hit him on the leg the previous day and Resident 1 called law enforcement to investigate. On 11/29/2025, the Activity Assistant (AA) witnessed an episode of verbal abuse when Resident 4 called Resident 3 an invective while passing Resident 4 and Resident 4 addressed Resident 3 as a curse word in return. On 12/5/2025, Resident 5 alleged Resident 6 hit Resident 5 on the wrist. This deficient practice had the potential for the residents' psychosocial needs to go unaddressed. a. A review of Resident 1's admission Record indicated the facility originally admitted the resident on 5/23/2025 and readmitted the resident on 6/20/2025 with diagnoses that included heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and cystitis (inflammation of the bladder, often causing pain, pressure, and a frequent, urgent need to urinate). A review of Resident 2's admission record indicated the facility admitted the resident on 5/19/2025 and readmitted the resident on 7/1/2025 with diagnoses that included heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 1's Behavior Related Incidents form, dated 11/27/2025 Resident 1 alleged Resident 2 hit Resident 1 on the leg. A review of Resident 2's Behavior Related Incidents form, dated 11/27/2025, indicated that on 11/27/2025 at 5:21 AM law enforcement walked in and approached Resident 2's room and Resident 1 claimed Resident 2 hit him on the leg. The form further indicated law enforcement left the facility at 5:30 AM. During an interview on 12/10/2025 at 10:47 AM Resident 2 stated Resident 1 told used an expletive while telling Resident 2 to shut up. Resident 2 stated he then went to Resident 1's room and used the same expletive while telling Resident 1 to shut up. Resident 2 denied hitting Resident 1. Resident 2 further stated he woke up the next morning on Thanksgiving day (11/27/2025) to the police at his door. During the investigation Resident 1 refused to be interviewed. b. A review of Resident 3's admission record indicated the facility re-admitted the resident on 3/21/2024 with diagnoses that included atrial fibrillation, mood disorder and depression. A review of Resident 4's admission record indicated the facility readmitted the resident on 10/28/2017 with diagnoses of hydrocephalus, depression and gait and mobility abnormalities. A review of Resident 4's Behavior Related Incidents form, dated 11/29/2025, indicated Resident 4 used abusive speech towards Resident 3 while passing Resident 3 in the activity room. During an interview on 12/10/2025 at 10:39 AM, Resident 3 stated while in the activity room, Resident 4 was going past Resident 4. Resident 3 also stated while going by Resident 3 thought Resident 4 was in the way and called Resident 3 a curse word. Resident 4 denied calling Resident 4 an expletive. During an interview on 12/10/2025 at 1:24 PM, AA stated they witnessed Resident 4 call Resident 3 a curse word when Resident 3 passed by Resident 4 in the activity room/dining room. AA stated Resident 4 then called Resident 3 the word for a female dog. A review of Resident 5's admission record indicated the facility re-admitted the resident on 9/17/2025 with diagnoses including but not limited to epilepsy (a seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] disorder), autistic disorder (developmental difference in how the brain works, leading to unique ways of communicating, socializing, learning and experiencing the world) and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 5's Behavior Related Incidents form, dated 12/5/2025 indicated Resident 5 claimed Resident 6 (Resident 5's roommate at the time) hit Resident 1 on the wrist. During an interview on 12/10/2025 at 9:30 Resident 5 stated Resident 6 hit him on the wrist. Resident 5 stated he was not aware of why Resident 6 hit him. Resident 5 also stated the social services director did not come and speak with him about his feelings and he would have liked to speak with her. During an interview on 12/11/2025 at 11:26 AM, the SSD stated they had been employed with the facility since 11/26/2025. The SSD stated they did not follow up with Residents 1, 2, 4, and 5 following the abuse allegations made. The SSD further stated they followed up with Resident 3 twice on 12/1/2025 and 12/10/2025 however she did not document these interactions. The SSD further stated she is to follow up</p>		