

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 02/25/2026
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure one of four residents (Resident 1) was free from any significant medication error by failing to notify a physician when a resident refused to take two antipsychotic medications (medications to treat mental illness) three consecutive times according to the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Preparation and General Guidelines with a revision date of 12/2019. This deficient practice had the potential for Resident 1 to experience worsening of bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs) symptoms such as extreme, episodic mood swings, deep depression and symptoms of schizophrenia such as hallucinations (often hearing voices), delusions (false, fixed beliefs) and disorganized thinking or behavior to return, reduce medication efficacy (effectiveness) and increased side effects such as anxiety, headache, tremble, muscle stiffness and uncontrollable movements, to return. Findings: During a review of Resident 1's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 1 was admitted to the facility on with the following diagnoses: schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), cognitive communication deficit (trouble participating in conversations), history of alcohol abuse, in remission, and noncompliance with medication administration. During a review of Resident 1's history and physical (H&P - a physician's complete patient examination) dated 9/25/2025, indicated Resident 1 had diagnoses of schizophrenia, bipolar disorder, history of alcohol abuse and medical noncompliance. The H&P also indicated Resident 1 did not have the mental capacity to understand and make medical decisions. During a review of Resident 1's physician progress notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 2/02/2026 indicated, Resident 1 had diagnoses of schizophrenia, bipolar disorder, history of alcohol abuse and medical noncompliance. H&P indicated Resident 1 refused medical care at times, refused conversation, was uncooperative and aggressive. The progress notes also indicated Resident 1 lacked the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/19/2026 indicated, Resident 1 had a severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). During a review of Resident 1's Psychiatry History and Physical (a standardized tool used by psychologists to record resident's mental and emotional state, behavior and any changes in their condition, to inform care planning and treatment) dated 10/19/2025 indicated, Resident 1 had medical diagnoses of bipolar disorder, schizophrenia and anxiety. The Psychiatry H&P indicated at the time of consultation, Resident 1 remained agitated and was stable on current dose of risperidone (Risperdal - used to treat symptoms of schizophrenia). During a review of Resident 1's Psychiatry H&P dated 11/22/2025, indicated that Resident 1's risperidone (Risperdal)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 555808	If continuation sheet Page 1 of 3

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was increased since last visit due to increased paranoia (one is overly suspicious and thinking others are out to harm you) and delusions (false beliefs). During a review of Resident 1's Physician Progress Record (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 2/06/2026, indicated that Resident 1's schizophrenia had mood lability (instability). During a review of Resident 1's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on impaired ambulation (act of walking) dated initiated on 1/09/2026, indicated, Resident 1 had a problem for altered behavior patterns related to diagnosis of schizophrenia, usage of psychotropic (medications that treat mental health disorders) medications. The CP goal indicated Resident 1 will have a minimal risk of decline daily. The CP intervention included notifying a physician of any risk/consequences as a result of non-compliance. During a review of Resident 1's Physician Order Summary Report (a condensed, organized document summarizing a patient's key medical information, including diagnoses, treatments, current medications, test results, and follow-up instructions) dated 1/15/2026, indicated, a physician ordered Resident 1 to have Depakote delayed release 500 mg to give 1000 mg by mouth at bedside for bipolar as manifested by erratic mood swing and risperidone 3 mg to give 1 tablet by mouth every 12 hours for paranoid schizophrenia as manifested by striking out at staff. During a review of Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated from 2/01/2026 through 2/25/2026, indicated there was no nursing documented or physician response evidence that indicated a physician was notified and responded about Resident 1's refusal to take risperidone and Depakote (treats various types of seizure and bipolar disorders) for at least three consecutive days. During a concurrent interview and record review on 2/25/2026 at 3:10 PM with Licensed Vocational Nurse (LVN) 1, Resident 's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 2/2026 was reviewed. The MAR indicated the following:a. Depakote 500 mg tablet to give 2 tablets by mouth at bedtime for bipolar disorder as manifested by erratic mood swings.b. Doses were missed on 2/01, 2/02, 2/03, 2/07, 2/09, 2/10, 2/12, 2/16 and 2/19 for a total of nine times out of 19 days.c. Risperidone 3 mg table to give 1 tablet by mouth every 12 hours for paranoid schizophrenia as manifested by striking out at staff.9 AM doses were missed on 2/01, 2/05, 2/06, 2/10, 2/17, 2/18 and 2/19 for a total of seven times out of 19 days.9 PM doses were missed on 2/01, 2/02, 2/03, 2/07, 2/09, 2/10, 2/12, and 2/16 for a total of eight times out of 18 days (resident was discharged at 4:30 PM). During the same concurrent interview and record review on 2/25/2026 at 3:10 PM, LVN 1 stated if Resident 1 refuses Depakote and risperidone at least three consecutive days, a physician should be notified then the nurse documents when physician was notified and the physician's response. LVN 1 further stated that when Resident 1 refused to take Depakote and risperidone for at least three consecutive days, everybody around [Resident 1] will be at risk for [Resident 1's] behavioral issues such as aggression, yelling, screaming, combativeness such as hitting other residents, pushing other residents, [Resident 1] can use other items such as a table or a chair to hurt other people. During a concurrent interview and record review on 2/25/2026 at 3:25 PM with the Director of Nursing (DON), Resident 1's MAR for 2/2026 was reviewed. The MAR indicated that Resident 1 refused Depakote nine times out of 19 days from 2/01 through 2/19/2026. The MAR also indicated that Resident 1 refused risperidone seven times out of 19 days for the 9 AM dose, and eight times out of 18 days for the 9 PM from 2/01 through 2/19/2026. DON stated when Resident 1 refused to take Depakote and Risperidone, then Resident 1's, behavior could lead to more erratic, escalate and be in trouble with other patients and altercations with other residents. The DON stated that Risperidone medication also</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stabilizes Resident 1's mood so that could be a high risk behaviors like mood swings and everything that would make her at risk for [Resident 1's] behavior. During the same concurrent interview and record review on 2/25/2026 at 3:25 PM with the DON, Resident 1's nursing progress notes from from 2/01/2026 through 2/19/2026 was reviewed. The DON stated, I can't find anything when asked to show a licensed nurse's documentation that a physician was notified about Resident 1's refusal to take Depakote and risperidone for at least three consecutive days in the month of 2/2026. The DON stated, the doctor will not know what to prescribe to the resident, what route to take, the doctor is thinking that the medications are being given. If the doctor does not know, then the doctor does not know what other interventions to give to the resident when asked the significance of notifying a physician regarding Resident 1's refusal to take vital medications such as Depakote and risperidone. During a review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Preparation and General Guidelines with a revision date of 12/2019, indicated if consecutive doses of a vital medication are refused, the physician is notified. Nursing documents the notification and physician response.</p>		