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	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Monica Rehabilitation Center	1338 20th Street Santa Monica, CA 90404

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review the facility failed to ensure facility staff implemented the facility's policy and procedures (P&P) titled, Assisting the Resident with in-room meals reviewed 6/2/2025, for three of three residents (Residents 1, 3, and 4) by failing to:Assist Residents 1, 3, and 4 with feedingDocument meal intake percentages according t, Residents 1, 3 and 4.Ensure Certified Nursing Assistant (CNA) 1 reported/notified to a licensed nurse (Licensed Vocational Nurse [LVN] and or Registered Nurse [RN] when Resident 1 had decreased meal intake.These deficient practices had the potential to cause inadequate nutrition, choking and or weight loss for Residents 1, 3, and 4. Findings: On 2/24/2026 The California Department of Public Health (CDPH) received an anonymous complaint alleging the facility Licensed staff does not walk around and ensure the CNA's are working. On 2/27/2026 CDPH received a complaint alleging the facility staff was observed ignoring residents and the care was unsuitable for a resident with Dementia. A review of Resident 1's admission Record indicated the facility admitted Resident 1 on 2/24/2026 with diagnoses including metabolic encephalopathy (broad term for brain dysfunction caused by systemic illness, chemical imbalances or toxins), Urinary tract infection (UTI- an infection in the bladder/urinary tract), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, hyperlipidemia (high fat in the blood), anemia (a condition where the body does not have enough healthy red blood cells), dementia (a progressive state of decline in mental abilities), hypertension (high blood pressure), pressure ulcer of the right buttock (Full-thickness loss of skin. Dead and black tissue may be visible), gastroesophageal reflux disease (GERD-heartburn). A review of resident 1's Minimum Data Set (MDS-a resident assessment), dated 2/28/2026 Indicated Resident 1's cognition (mental ability to make decisions for daily living) was not intact. Resident 1 required maximal assistance with eating. (Helper does more Than half the effort). The MDS further indicated resident 1 was dependent (helper does all the effort), with toileting, showering and transferring in between surfaces. A review of Resident 1's nutrition assessment dated [DATE] indicated Resident 1 required total assistance for eating. A review of Resident 1's care plan titled, initiated 3/6/2026 indicated decreased self-feeding abilities (dependent diner) related to metabolic encephalopathy and dementia. No interventions noted. A review of Resident 1's care plan titled, Resident 1 is at nutritional risk related to limited mobility, indicated a goal of no significant weight loss and interventions included to document po intake at every meal. A review of resident 1's meal intake documentation dated 3/9/20206 timed at 2:46p.m. indicated resident not available. A review of Resident 3's admission record indicated the facility originally admitted Resident 3 on 2/27/2025 and most recently on 1/24/2026 with diagnosis including; hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) on the right side, encephalopathy, UTI, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), DM, muscle weakness, aphasia (difficulty talking), dysphasia (difficulty swallowing), hyperlipidemia, anxiety disorder (A group of mental health conditions characterized by persistent, excessive and uncontrollable fear, dread or worry that interferes with daily functioning) and hypothyroidism (low (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 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thyroid function). A review of Resident 3's MDS dated [DATE] indicated Resident 3's cognition was not intact. Resident 3 required Supervision or touch assistance (helper provides verbal cues and or touching/steadying/ and or contact guard assistance as resident completes activity), with eating. A review of resident 3's care plan titled, Resident 3 was at nutritional risk of weight loss related to limited mobility initiated 2/6/2026 indicated a goal for resident 3 was to maintain adequate nutritional status evidenced by no weight loss. An intervention included to document PO intake at every meal. A review of Resident 3's physician order dated 2/21/2026 indicated fortified regular diet puree (a smooth creamy paste or thick liquid produced by blending, mashing or straining cooked food), level 4 texture, thin consistency, patient is a feeder. A review of Resident 3's meal intake documentation dated 3/9/20206 timed at 2:44p.m. indicated resident not available. A review of Resident 4's admission Record indicated the facility admitted Resident 4 on 6/6/2025 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left side, asthma (A chronic often lifelong respiratory disease characterized by inflammation, swelling and narrowing of airways), epilepsy (A chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden abnormal electrical discharges in the brain), unspecified protein calorie malnutrition, muscle weakness, dysphagia, UTI, aphasia, hyperlipidemia, and HTN. A review of Resident 4's MDS dated [DATE] indicated Resident 4's cognition (mental ability to make decisions for daily living) was not intact. Resident 4 required moderate assistance (helper does less than half the effort) with eating. A review of Resident 4's care plan titled, Resident 4 was at nutritional risk related to limited mobility, revised 3/4/2026 indicated the goal to have no significant weight changes. Interventions included to document po intake at every meal. A review of resident 4's meal intake documentation dated 3/9/2026 timed at 2:45p.m. indicated resident not available. During an observation on 3/9/2026 at 12:37 p.m. in Resident 1's room. Resident 1 was lying flat in bed wearing eyeglasses with eyes closed and appeared to be chewing with a piece of orange material noted in Resident 1's mouth and on Resident 1's lips and a half-eaten piece of potato was noted on the sheet next to Resident 1's face. Resident 1's meal tray was noted on bedside table next to bed with cover on top and fork on plate. The food cover was removed and the food plate contained a piece of carrot that was noted on the fork, a full serving of carrots with a few bitten pieces, a full serving of potatoes with a few bitten pieces and a piece of meat broken into two pieces. A whole piece of cake and an unopened juice. During an observation on 3/9/2026 at 12:56 p.m. in Resident 1's room, CNA 1 entered room and sat down next to Resident 1 and proceeded to feed Resident. During an observation on 3/9/2026 at 1:08 p.m. CNA 1 concluded feeding Resident 1, placed the top on the tray and removed the tray from the room. A record review of the Nursing Assignment dated 3/9/2026 indicated CNA 1 was assigned to Resident 1, 3 and 4. During an interview on 3/9/2026 at 1:17 p.m. with CNA 1. CNA 1 stated this was the first time caring for Resident 1. CNA 1 stated Resident 1 did need assistance to be fed. CNA 1 stated, I I started to feed Resident 1 then I was told to go to the dinning room because Resident's 3 and 4 were there and they needed assistance as well. CNA 1 stated, Usually there is a staff person in the dinning room to assist them, but I don't know what happened today. After I finished with them, I came back down to finish feeding Resident 1. During an observation on 3/9/2026 at 1:45 p.m. at the nursing station the Licensed Vocational Nurse (LVN) 1 was sitting and approached by the assistant Director of Nursing (ADON). The ADON stated to LVN 1, monitor your staff. During an interview on 3/9/2026 at 1:47 p.m. with LVN 1. LVN 1 stated, The ADON (Assistant Director of Nursing) told me the CNA's needed to go upstairs to the dinning room and monitor if their residents were being fed, and if they weren't then they needed to stay there and feed them and if they are unable, they needed to call licensed nursing for help, it was an in service. LVN 1 stated, The restorative nursing assistant (RNA) is usually responsible for feeding residents in the dinning room however I was told at 12:25 p.m. there were no RNA's in the dining room. I saw CNA 1 in the dining room passing trays and setting up for [Resident's 3 and 4] at that time because I paged CNA 1 to go up there when I was told there were no RNA's there. LVN 1 stated, Resident 1 does require assistance with feeding and CNA 1 did (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not ask for any assistance to feed Resident 1; nor did CNA 1 report any decreased intake for Resident 1. Lastly, LVN 1 stated, if a resident consumes less than 50% of their meal the CNA are supposed to report that to me and complete a stop and watch form. During an interview on 3/9/2026 at 3:14 p.m. with the RNA. The RNA stated there are usually three RNA's assigned to the dining area to assist with passing meal trays and feeding residents. The RNA stated in the morning at around 9:30a.m. she was asked by a charge nurse to accompany a blind resident to an appointment. The RNA then notified ADON of the request as well. The RNA went with the unnamed resident to the appointment between 9:30 a.m. and 10:00 a.m. and did not return to the facility until 3:00 p.m. The RNA stated Resident 3 requires set up and full assistance with feeding with encouragement to continue eating. The RNA stated Resident 4 usually required set up meaning opening all liquids for consumption, and supervision while eating because Resident 3 has some swallowing problems and eats very slowly. During an interview on 3/9/2026 at 2:28 p.m. with LVN 2. LVN 2 stated, I was rounding and noticed there were no RNA's in the dinning room at around 12:15 p.m. and the CNA's were taking their residents back to their rooms, so I notified the ADON. LVN 2 stated, there was one RNA call off today, so we only had 1 (RNA) actually here. During an interview on 3/11/2026 at 11:44 a.m. with ADON, the ADON stated on 3/9/2026 One RNA called off due to an emergency and the one RNA on the floor went to an appointment with a resident that took longer than expected. The ADON stated that LVN 2 called at approximately 11:40 a.m. stating there was no RNA in the dining room and not enough assistance to feed the residents so I called the charge nurses to start assisting with feeding and then I did an in service to the charge nurses reminding them not to make decision to close the dinning room and remove residents, instead to follow the chain of command and notify. The ADON stated if a resident needs feeding assistance it is up to the charge nurses to monitor if they are being helped; the charge nurses should be supervising the CNA's. The ADON stated, if a CNA has multiple residents that require feeding assistance, then the assignment should be split, and some should be assigned to a different CNA, or the charge nurse can assist with feeding. The ADON stated, if a resident is not being assisted with feeding, then it places them at risk for inadequate nutrition and CNA's should document meal percentage intake as part of their regular documentation daily. A review of the facility's policy and procedures titled, Assisting the Resident with in-room meals, reviewed 6/2/2025 indicated:Preparation1. Review the resident's care plan and provide for any special needs of the resident.2. Assemble equipment and supplies needed.3. Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow.4. Ensure that the necessary non-food items (i.e., silverware, napkin, special devices, straw, etc.) are on the tray. Report or replace missing items.5. If food has been spilled on the tray, clean the tray before serving to the resident. If necessary, return the tray to the kitchen for a replacement tray.6. Check that hot foods are hot (but not scalding temperature) and cold foods are cold.7. To minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the danger zone (41 F to 135 F) will be kept to a minimum. Foods that are left on trays without a source of heat (for hot foods) or refrigeration (for cold. foods) longer than 2 hours will be discarded.8. Be sure the resident is prepared to receive the meal (i.e., offered bedpan or urinal, face and hands washed, hair combed, etc.).9. The resident should be positioned so his or her head and upper body are as upright as possible and with the head tipped slightly forward. If the resident is served his or her meal in bed, use wedges and pillows to achieve a nearly upright position.10. Be sure that everyone is served.11. Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, clothing or the resident's personal effects, the employee must wash his/her hands before serving food to the next resident.Steps in Procedure1. Place the tray on the overbed table or serving area. Be sure it is adjusted to a comfortable position and height for the resident.2. Arrange the dishes and silverware so that they can be easily reached by the resident.3. Place the drink within easy reach. Open beverage cartons as necessary.4. Assist (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident as necessary. However, encourage the resident to feed himself or herself as much as possible.5. Place the call light within easy reach of the resident.6. Once you are certain that you have given the resident adequate assistance, exit the room and allow the resident to eat his or her meal.7. Remove the tray when the resident has finished his or her meal. (Note: Allow the resident plenty of time to eat his or her meal.)8. Wash the resident's face and hands after removing the meal tray.9. Clean the overbed table and return it to its proper position.10. Reposition the bed covers. Make the resident comfortable.11. Place the call light within easy reach of the resident.12. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them they may now enter the room.13. Place the wash cloth and towel in the soiled laundry container.14. Wash your hands.Documentation1. The date and time the procedure was performed.2. The name and title of the individual(s) who performed the procedure.3. How much of the meal the resident consumed (i.e., 25%, 50%, 75%, etc.).4. If and how the resident participated, or any changes in the resident's ability to participate with the meal.5. Any special request(s) made by the resident concerning his or her eating time or food likes and dislikes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to handle linen according to the facility's policy and procedures titled, Departmental (Environmental Services) Laundry and Linen reviewed 6/2/2025. This deficient practice places all residents in the facility at risk for infection. Findings: On 3/6/2026 The California Department of Public Health (CDPH) received an anonymous complaint alleging the facility does not have enough linen and blankets. A review of a facility in service titled, Proper handling of Linen, dated 12/5/2025 indicated store clean linen in a designated clean area or cart, keep linen covered when transporting it to a patient room, only bring the amount of linen needed for each resident.A review of the sign in sheet for the in service titled, Proper handling of Linen, dated 12/5/2025 did not include the name of Certified Nursing Assistant (CNA) 1.A review of Resident 2's admission Record indicated the facility admitted this [AGE] year old female on 2/17/2026 with Diagnosis including hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction affecting the left side, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), metabolic encephalopathy (broad term for brain dysfunction caused by systemic illness, chemical imbalances or toxins), chronic disease kidney stage 4 (advance condition occurring just before kidney failure), dementia (a progressive state of decline in mental abilities), muscle weakness and polyneuropathies (A general term for simultaneous dysfunction of multiple peripheral nerves). A review of resident 2's Minimum Data Set (MDS-a resident assessment), dated 2/24/2026 indicated Resident 2's cognition (mental ability to make decisions for daily living) was not intact. Resident 2 was dependent (Helper does all the effort) for toileting, showering, bathing and transferring between surfaces. During a concurrent observation and interview on 3/9/2026 at 1:35 p.m. with the Certified Nursing Assistant (CNA) 1, inside of Resident 2's room, a large, open plastic bag filled with multiple bed pads, gowns, towels and sheets was noted on top of the nightstand next to Resident 2's bed. CNA 1 stated Resident 2 was already given a bed bath for the day. CNA 1 stated, I gathered all my linen this morning for all my residents and put it in this bag. Then I brought the bag to this room and put it there. Then when I need linen for my other residents, I get an empty plastic bag and take linen from this bag to my next resident's room. Lastly, CNA 1 stated, That is what I see everyone else do. During an interview on 3/9/2026 at 2:17 p.m. with CNA 2. CNA 2 stated that, when I arrive, I go to the linen cart and get linen for each of my residents that have a shower that day, place it in separate bags and take each bag to their room and place it inside of the closet. I do it this way so each resident can have their own linen for infection control. During an interview on 3/9/2026 at 2:28 p.m. with the Licensed Vocational Nurse (LVN) 2, LVN 2 stated, the CNAs (certified nursing assistants) were educated to gather linens in a plastic bag and place the linen inside of the resident's room so each resident should have their own, separate bag of linen. LVN 2 further stated having all the linen for every resident in one room can lead to cross contamination because once the linen is taken into the room it is considered dirty. During an observation on 3/9/2026 at 3:28 p.m. on the third floor 2 linen carts were seen with linen on the cart, and the linen cart cover was flipped up leaving all the linen exposed. A review of the facility policy and procedures titled,Departmental (Environmental Services) Laundry and Linen reviewed 6/2/2025 indicated:PurposeThe purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen.Standard Precautions1. Separate soiled and clean linen at all times. 2. Wash hands after handling soiled linen and before handling clean linen.3. Consider all soiled linen to be potentially infectious and handle with standard precautions.Bagging and Handling Soiled Linens1. All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture.2. Do not sort or pre-rinse soiled linens in resident-care areas.3. Place any linen saturated with blood or body fluids into a leak-resistant bag before placing it into the hamper.4. Handle soiled linen as little as possible to prevent agitation.5. If laundry chutes are used, only closed and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leak-resistant bags will be put into the chute. Loose items will not be placed in the laundry chute. 6. Keep soiled and clean linen, and their respective hampers and laundry carts, separate at all times.7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts.