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	03/24/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility failed to ensure the staff assisting English-only speaking residents were not speaking in a language the residents did not understand when providing care for two of seven sampled residents (Resident 3 and 5). This failure resulted in Resident 3 and 5's primary language not being respected and used in front of the residents and had the potential to affect the resident's communication and understanding with the staff. During a review of Resident 3's admission Record (AR), dated 3/24/26, indicated the resident was admitted to the facility on [DATE], with diagnoses including hypertension (HTN - high blood pressure), anemia (a condition where the body does not have enough healthy red blood cells) hemiplegia (weakness of one side of the body) and hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke). The same admission record further indicated the resident's primary language as English. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 2/18/26 indicated, Resident 3 had intact cognition (ability to think, understand and make daily decisions). The same MDS indicated Resident 3 required supervision or touching assistance to substantial/maximum assistance for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and bed mobility. During a review of Resident 5's AR dated 3/24/26 indicated, the resident was admitted to the facility on [DATE], with diagnoses including muscle weakness, osteoarthritis (chronic condition of the joints characterized by the breakdown of protective cartilage that cushions joint ends, leading to pain, stiffness, and reduced mobility) of the knee, asthma (a chronic, long-term lung disease that inflames and narrows the airways, causing recurring periods of wheezing, chest tightness, shortness of breath, and coughing), spinal stenosis (a chronic condition characterized by the narrowing of spaces within the spine, which puts pressure on the nerves and spinal cord), and lymphedema (a chronic condition characterized by localized swelling, most commonly in the arms or legs, caused by a buildup of protein-rich lymph fluid when the lymphatic system is damaged or blocked). The same admission record further indicated the resident's primary language as English. During a review of Resident 5's MDS dated [DATE] indicated the had mild memory problems and required set up or clean-up assistance with eating, and required substantial/maximal assistance by staff to being dependent on them for other ADLs and bed mobility. During an interview on 3/21/26 at 2:58 pm with Resident 3, the resident stated she hears everything, and has heard staff speaking in other languages amongst themselves. During an interview on 3/24/26 at 10:35 am with Resident 5, the resident stated just this morning there were two staff members in her room and they were speaking a foreign language to each other. She further states she only speaks English and does not know what they are saying they could be talking about her. During an interview on 3/24/26 at 1:23 pm Certified Nursing Assistant (CNA) 6 stated the staff should not be speaking a different language with each other that is different than the one the resident speaks.During a review of the facility's policy and procedures (P&P) titled Resident Rights reviewed 6/2/25 indicated Employees shall treat all residents with kindness, respect and dignity. The rights include the resident's right to. be treated with respect. be supported by the facility in exercising his or her rights.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain clean and sanitary ventilation intake screens for two of seven sampled residents (Resident 5 and 6). This failure resulted in extensive dust buildup on the ventilation intake screens and had the potential to expose residents to allergens (a substance that can cause an allergic reaction).During a concurrent observation and interview on 3/24/26 at 10:35 AM with Resident 5 in Resident 5's room, the intake screen for the ventilation system above the foot of her bed was observed covered with a thick layer of dust. The resident verified this and stated it has been like that for quite a while and she would not want the dust to fall on her and then inhale it. During a concurrent observation and interview on 3/24/26 at 11:19 AM with Resident 6 in the resident's room the intake screen for the ventilation system above the foot of his bed was observed covered with a layer of dust. The resident verified this and stated he has been at the facility for four years and in that time he has not witnessed anyone clean it. During a concurrent observation and interview with on 3/24/26 at 11:28 AM with the Maintenance Supervisor (MS) the intake screen for the ventilation system in room [ROOM NUMBER] was observed covered in a layer of dust. The MS verified this and stated the risk to the resident could be exposure to allergens, and he will make sure all affected screens are cleaned. During a record review of facility's P&P titled, Homelike Environment reviewed 6/2/26 indicated Residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximizes, to the extent possible. clean, sanitary and orderly environment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to follow the resident's care plan of wandering risk for one of seven sampled residents (Resident 7). This failure resulted in Resident 7 having an elopement incident on 3/10/26 at 3:20 am. During a review of Resident 7's AR dated 3/25/26 indicated, the resident was admitted to the facility on [DATE], with diagnoses encephalopathy (a broad term for any diffuse disease, damage, or malfunction of the brain that alters its structure or function), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain), schizophrenia (a mental illness that is characterized by disturbances in thought), and anemia. During a review of Resident 7's History and Physical (H&P) dated 6/12/25, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 7's MDS dated [DATE] indicated, the resident both short- and long-term memory problems and was independent with eating, toileting and bed mobility and transfers, but required set up or clean-up assistance to supervision or touching assistance with other ADLs.During a review of Resident 7's Elopement Risk Evaluation dated 3/8/26 indicated the resident was at risk for elopement and Comments: Wanderguard and frequent visual checks.During a review of Resident 7's Wandering risk care plan initiated 3/8/26 indicated interventions of bracelet alarm for alarm doors, check resident's location every 30 minutes, and make sure all staff are aware of elopement risk. During a concurrent interview and record review with Registered Nurse Supervisor (RNS) 2, on 3/24/26 at 4:13 pm, Resident 7's progress note dated 3/8/26 was reviewed. RNS 2 stated she had received the order from the doctor for WanderGuard, but since the resident is not able to give consent she called the resident representative to get consent and it was endorsed to follow-up by the next shift. Further review of the progress notes for the 3/9/26 indicated no follow-up was conducted by any of the shifts before the resident had an elopement incident on 3/10/26 in the early morning hours. RNS 2 verified this information and stated I don't know if the next shift followed up with the consent and for WanderGuard. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 4, on 3/24/26 at 4:43 pm the resident's order summary report through 3/17/26 was reviewed. The LVN 4 verified there was no order for monitoring of WanderGuard or wandering behaviors and therefore not documentation for them. The LVN 4 further stated if there was an order then the WanderGuard would have been placed and monitored, as well as, wandering behaviors. During a review of the facilities policy and procedures titled Wandering and Elopements reviewed 1/26/26 indicated, The facility will identify resident who are at risk of unsafe wandering and strive to prevent harm while maintaining, the least restrictive environment for residents. If identified as at risk for wandering, elopement, or safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure resident's refrigerator/ freezer storage P&P was followed by failing to ensure:The resident nutrition room cabinets were free from undated and unlabeled open box of cornflakes and bag of potato chips and all food in the resident's refrigerators were labeled and dated properly as well as the food being stored in a manner that would provide air circulation.During an observation with concurrent interview on 3/20/26 at 1:07 pm with Infection Preventionist Nurse (IPN) in the 2nd floor nutrition room, a cabinet was observed with undated and unlabeled open box of corn flakes and bag of potato chips. The IPN removed the items from the cabinets and stated they should not be stored there and should be labeled with the resident name and date of expiration everything should have a date name and date it was opened.During further observation in the same resident nutrition room there was a variety of bags inside the resident's refrigerator that were not appropriately labeled and dated the IPN verified and stated the food in the refrigerator should be labeled with the resident name and had an opened date so they know when to throw it out, but they clean it out every three days. During an observation with concurrent interview on 3/20/26 at 1:18 pm the resident refrigerator in the 3rd floor nutrition room was observed with an opened plastic to-go container with no resident name or received date, and again there were various bags of food without proper dates noted and crowded in the refridgerator. A sign that was posted next to the resident's refrigerator indicated Resident Food Only! Please label all food before putting them in the refrigerator. Put resident's name, the date, and the expiration date. Unlabeled food will be thrown away. Resident food left in the fridge for more than 72 hours will be thrown away. The IPN verified the some of the food bags were missing some information required. A review of the facility's P&P titled Resident's Refrigerator/Freezer Storage - Dietary Services reviewed 6/2/25 indicated, food items should be stored to allow air circulation. Avoid overcrowding in the refrigerators and freezers. Leftover food or unused portions of packaged foods should be discarded. No food will be stored beyond 72 hours from date received. All items should be properly covered, dated and labeled. Food items should have the following appropriate dates: 1. Delivery date - when received 2. Open Date - opened containers.