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	05/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to follow their policy and procedures (P&P) titled, Care Plans [a written step by step outlining a specific health or personal care needs and actions with goals to be med], Comprehensive Person-Centered, with a review date of 1/29/2026 for one of the three sampled residents (Resident 1). By failing to develop and implement a care plan for Resident 1 who was admitted with a history of falls and identified as a moderate risk for falls on 1/2/2026. As a result of this deficient practice Resident 1 had a fall on 3/17/2026 as well as an injury of unknown origin on 4/28/26.Findings:During a review of Resident 1's admission record, the admission record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy (a general term for brain dysfunction, disease, or damage caused by exposure to poisonous substances with symptoms from mild confusion and memory loss to severe delirium), dementia (a progressive state of decline in mental abilities), and falls. During a review of Resident 1's admission fall risk assessment dated [DATE], the fall risk assessment indicated Resident 1 was a moderate risk for falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 1 had severe cognitive (a significant loss of mental capacity, such as thinking, learning, remembering, and reasoning) impairment (any problem with mental processes related to thinking, learning, remembering, and decision-making). The MDS indicated Resident 1 required staff supervision and/or touching assistance and partial/moderate assistance for most of Activities of Daily Living (ADLs such as oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene). The MDS indicated Resident 1 was able to walk. During a review of the physician order dated 3/18/2026, the order indicated, Device: Spine Brace [back brace - an external medical support device worn to limit movement, stabilize the spine, and improve posture after an injury or surgery] for T12 [Thoracic spine: mid back - the twelfth and lowest bone] to S1 [Sacrum-triangular structure at base of the back between hip bones; top most of sacrum] fx [fracture - broken or cracked bone] to stabilize the spine, reduce pain, and restrict movement.During a review of the physician order dated 3/17/2026 indicated, Patient [Resident 1] was transferred to [General Acute Care Hospital - GACH] r/t [related to] unwitnessed fall. During a review of the physician order dated 4/28/2026, the physician's order indicated transfer to GACH via 911 [emergency telephone number used to fire, police and medical assistance] for further evaluation (possible dislocation [a joint injury where the bones are forced out of their normal positions] of left wrist and left shoulder). During a review of Resident 1's Situation Background Assessment Recommendation (SBAR- a tool used in healthcare to improve patient safety by enabling fast, accurate, and concise information transfer between clinicians) dated 3/17/2026, the SBAR indicated Aimless wandering and has been bumping into walls, objects and other residents in the hallway. Patient [Resident 1] was noted displaying increased aimless wandering and has been bumping into walls, objects and other residents in the hallway. The SBAR indicate, Patient [Resident 1] is unable to navigate the environment safely, resulting in risk of falls or injury. During a review of Resident 1's SBAR dated 3/17/2026 at 10:29 pm, the SBAR (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
	555808	A. Building B. Wing	05/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 1 was found on the floor beside her (Resident 1) bed facing the wall. The SBAR indicated Resident 1 was transferred to GACH due to an unwitnessed fall. During a review of Resident 1's SBAR dated 4/28/2026 at 7 pm, the SBAR indicated, Resident [Resident 1] noted with change in condition which included discoloration to left shoulder and wrist with limited movement and pain. The SBAR indicated, During assessment, resident [Resident 1] demonstrated limited movement of the left upper extremity, including the wrist and shoulder. Resident [Resident 1] declined to lift the left arm and did not allow the left hand to be touched. When attempts were made; resident vocalized distress. Discoloration/ecchymosis was noted to the left upper extremity, including the forearm and shoulder area. there was a skin tear noted to the left forearm/wrist. Resident [Resident 1] verbalized pain to the affected area. No witnessed fall or incident was reported prior to discovery. Cause of injury is unknown at this time. RN supervisor was notified, and immediate assessment was completed. Vital signs were obtained, and pain assessment was attempted; pain medication was offered and refused. Due to limited movement, reported pain, and clinical findings, 911 was activated, and the resident [Resident 1] was transferred to acute for further evaluation. During an interview with Resident 1's Resident Representative (RP: an individual authorized to act on behalf of a nursing home resident) on 5/20/26 at 11:45 am, RP stated that Resident 1 had fallen while in the facility multiple times. RP stated that Resident 1 had fractured part of her spine and was required to wear a brace which she felt nursing staff were not applying as often as they should have. RP stated that another time Resident 1 fractured her wrist and shoulder and was in so much pain. RP stated that those fractures negatively affected Resident 1's life who was in pain and unable to walk as frequently as she did before. RP stated that Resident 1 enjoyed taking walks but was now confined to bed. During a concurrent interview and record review with the Director of Nursing (DON) on 5/22/2026 at 12:40 pm, the DON stated that Resident 1 was alert to self only and was confused. The DON stated that Resident 1 ambulated (walked) without an assistive devise (equipment used to assist in walking safely). The DON stated that a fall risk assessment was completed upon admission and when a resident suffered a fall. The DON stated that a care plan had to be developed upon identifying a resident was at risk for falls to prevent falls and to implement interventions such as frequent visual monitoring of the resident, bed in lowest position, and floor mats. The DON stated that it was important to develop a fall risk care plan with interventions listed to minimize or prevent residents at risk for falls from actually falling because the staff would be aware about what interventions to carry out. The DON stated that when a resident fell, the fall risk assessment must be updated as well as the care plan to ensure that the interventions must be updated to address the causative factors. The DON confirmed that Resident 1 did not have a fall risk care plan developed upon admission when she (Resident 1) was identified as a moderate risk for falls. The DON confirmed that there was still no care plan developed when Resident 1 had an unwitnessed fall on 3/17/2026 and an injury of unknown origin on 4/28/2026. During a review of a P&P titled, Care plan, Comprehensive Person-Centered, with a review date of 1/29/2026, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan included under policy interpretation and implementation the following: The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of careThe comprehensive person-centered care - describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Assessments of residents are ongoing, and care plans are revised as information about the residents' conditions change.The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition. During a review of the P&P titled, Falls - Clinical Protocol, reviewed 1/29/2026, indicated, For an individual who has fallen, the staff and (continued on next page)

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	05/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	practitioner will begin to try to identify possible causes within 24 hours of the fall. The same P&P indicated, After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. The P&P indicated that the staff and physician where to identify pertinent interventions to try and prevent subsequent falls and address the risks, monitor, and document the response to the interventions implemented.