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	06/04/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedures (P&P) titled, Change in a Resident's Condition or Status, reviewed 1/29/2026 by failing to accurately assess one of the four sampled residents (Resident 1) for risk of elopement after the resident by attempted to elope (when a resident leaves the facility grounds or a designated safe area without the staff knowing and/or without the supervision the resident needs) from the facility on 3/30/2026. This deficient practice resulted in Resident 1 successfully eloping from the facility on 5/27/2026 and 6/2/2026. Findings: Cross Reference F684 & F689 During a review of Resident 1's admission record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Paroxysmal (irregular) atrial fibrillation (AFib - is an intermittent heart condition where the upper chambers of the heart beat chaotically and out of sync with the lower chambers, heart failure (a serious, progressive condition where the heart muscle weakens or stiffens, preventing it from pumping enough oxygen-rich blood to meet the body's needs), and acute myocardial infarction (heart attack - occurs when blood flow to a section of the heart is suddenly blocked, depriving the heart muscle of oxygen and causing irreversible tissue damage). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/6/2026, the MDS indicated Resident 1 had severe cognitive impairment (a significant decline in thinking, memory, and reasoning that makes it impossible to live independently). The MDS indicated Resident 1 required staff setup or clean up assistance for most of Activities of Daily Living (ADLs such as toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, sit to stand, toilet transfer, and personal hygiene). The MDS indicated Resident 1 required staff supervision or touching assistance for walking between 10-to-150 feet. During a review of Resident 1's History and Physical (H&P - when a physician assesses and interviews a patient then documents findings) dated 2/2/2025 indicated Resident 1 had mild cognitive impairment of uncertain or unknown etiology. During a review of the physician orders dated 3/30/2026ˆindicated, Check Wander Guard Placement Q [every]. During a review of Resident 1'sˆSituation Background Assessment Recommendation (SBAR-a tool used in healthcare to improve patient safety by enabling fast, accurate, and concise information transfer between clinicians) dated 3/30/2026 at 6:23 pm., the SBARˆindicated, post-wandering, and that a wander guard was placed to the right wrist. The SBAR indicated, wonder guard close monitoring reorientation and redirection of behavior. During a review of Resident 1's Elopement Risk assessment dated [DATE] indicated that Resident 1 was not an elopement risk. During a review of Resident 1's Care Plan (CP - is a structured, individualized document created by healthcare professionals in collaboration with the patient to outline specific health conditions, treatment goals, and necessary services) initiated on 5/28/2026 with a focus, Elopement Risk: Places resident at significant risk of getting to a potentially dangerous place/stairs/outside of the facility, indicated Resident 1 had eloped on 5/27/2026 and that she (Resident 1) needed to be considered for a locked unit. The CP goals indicated, Resident safety will be maintained, and Resident will not leave facility unattended. TheˆCP interventions included the following:- Place resident in a room near (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses/station for close observation- Perform frequent safety rounds every 1/2 [half] hour- Initiate and follow through with Psychologist and Psychiatrist consult. During a review of Resident 1's SBAR dated 5/27/2026 at 11 pm., the SBAR indicated a high elopement risk level. The SBAR indicated, Around 11 pm (5/27/2026) noted resident wasn't in her room, search every room and bathroom she was nowhere to find, also check the around the building, unable to find her, MD notified, DON family and called the police, more notes on the progress. The SBAR indicated Resident 1 was returned to the facility from GACH 1 via ambulance service on 5/28/2026 at 5:05 am During a review of Resident 1's SBAR dated 6/2/2026 at 10:22 pm., the SBAR indicated Resident 1 left the facility and went to GACH 1. The same SBAR indicated that at, [10 pm] Charge nurse [Licensed Vocational Nurse] reported that the patient [Resident 1] was not found in her room during routine observation. Patient's (Resident 1) room and bathroom were immediately checked, and the patient was not located. Charge nurse and CNA [Certified Nursing Assistant] conducted a thorough search of the facility, including 3rd floor, lobby, and designated smoking area; however, the patient was not found. Upon further assessment of the patient's room, the wander guard was noted on the bedside table, indicating it had been removed. Immediate follow-up was initiated, checked in with [GACH 1] Emergency Department and patient was located sitting in the Emergency Department in the waiting area. Per Emergency Department nurse, the patient had already checked in for evaluation and would need to sign discharge paperwork if she wished to leave and return to the facility. Patient refused to return to the facility, stating, I don't want to go back to that place anymore. I want to stay here. During a review of Resident 1's Nursing Notes documented by LVN 8, dated 5/27/2026 3:28 pm., indicated the following, [Resident 1] would get up, walk to her room and back to the dining room. [Resident 1] came to the station to get water. [Resident 1] did a lot of walking back in front to the station. [Resident 1] stayed at the station for couple of minutes and go back to her room. The Nursing Notes further indicated LVN 8 usually tells Resident 1 to stay in her (Resident 1's) room because Resident 1 needs to be close to her heart monitoring (pacemaker- a device used to control an irregular heart rhythm). On 5/27/2026 at around 5 pm, dinner was served, medications were administered to Resident 1, that Resident 1 walked to the nurses' station, and that a(unidentified) staff usually monitors Resident 1's whereabouts. On 5/27/2026 at around 9:30 pm, LVN 8 was charting (documenting) at the nurses' station when Resident 1 came to the nurses' station, walked by the nurses' stations and then headed to back to Resident 1's room. On 5/27/2026 at 11 pm, during change of shift Resident 1 was not in her room. LVN 8 checked all the bathrooms and rooms on 3rd floor, however, Resident 1 was nowhere to be found. LVN 8 went downstairs and checked around the building, but was unable to find Resident 1, and that LVN 8 told a Registered Nurse (RN-unidentified) that Resident 1 was missing, on 5/27/2026 at 12:15 AM, a Police officer came and was later joined by 2 (two) police officers who asked questions regarding what the resident looks like, height, weight and race etc. The police officers were at the facility for more than an hour, asked permission to check all the rooms, also checked all the exits. The 2 police officers showed LVN 8 a picture of a person obtained from a street camera and LVN 8 identified and confirmed that, yes that's our resident (Resident 1). Few minutes the two police officers told us that they found the resident she's at GACH 1. ˆDuring a review of Resident 1's Nursing Notes dated 6/2/2026 11:25 pm., documented by Certified Nursing Assistant (CNA) 9 indicated the following: [Resident 1] received in bed alert and oriented, was not in pain, no shortness of breath or distress noted. On 6/2/2026 at 5 pm Resident 1 received medication, and dinner, and the resident was walking in the hallway. On 6/2/2026 at 8:30 pm, Resident 1 complained of chest pain and nitroglycerine [fast-acting prescription medication used to prevent and rapidly relieve chest pain] 0.4 milligrams [mg- units of measurement] was administered. After 5 minutes CNA 9 checked on Resident 1 and that Resident 1 told CNA 9 that, I am [Resident 1] doing okay. Resident 1 left the faciity on 6/2/2026 at 9:40 pm. During a concurrent observation of the facility smoking patio located on the first floor and interview with the Activities Coordinator (AC) on 5/30/2026 at 11:25 am, the facility patio was inspected/observed. The patio is located to the left and back of the facility (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reception desk and is separated by a door. Behind the door, is a hallway which is about 10 feet (ft) long with 2 bathrooms to the left side, and to the right is another hallway about 90 ft long with a door at the end which leads out to the smoking patio. The door remained unlocked. The smoking patio is not visible from the inside the facility. The smoking patio is connected to pathways to the left and to the right of the smoking patio which are about 50 ft long. Both pathways are secured with gates which have alarms. The alarm gate to the right side (Gate 1) of the smoking patio is triggers when opened. However, the gate to the left side (Gate 2) was observed to have brown paper jammed into the locking mechanism, preventing the gate from locking and triggering the alarm. The AC opened Gate 2 and confirmed and stated that the alarm did not trigger. The AC removed the paper that was jammed into the locking mechanism of the gate, closed and reopened the gate however, the alarm still did not trigger. The AC confirmed and stated that the paper should not be placed anywhere around any locking mechanism because the paper will prevent the gate from locking and preventing the alarm from engaging/triggering. The AC stated that the potential for jamming the locking mechanism of a gate can result in a resident leaving the facility without staff knowledge. The AC stated that the door should be locked. During an interview with Registered Nurse Supervisor (RNS) 2 on 5/30/2026, RN 2 stated that an elopement is when a resident leaves without staff knowledge or permission. RNS 2 stated that the interventions for residents who are an elopement risk included frequent visual monitoring (unable to state frequency) and placing a wander guard. RNS 2 stated that on 5/27/2026, she came in for her shift around 11 pm and was told that Resident 1 had not been located in the facility and that law enforcement was called. RNS 2 stated that when Resident 1 returned the following day, 5/28/2026, Resident 1 notified RNS that she (Resident 1) left the faciity on 5/27/2026 at around 8:30 pm using the facility back elevator. RNS 2 stated that it was during change of shift between the evening shift and night shift (3pm and 11pm), on 5/27/2026, that the facility discovered that Resident 1 had left the facility. During a concurrent interview and record review of Resident 1's medical chart with Licensed Vocational Nurse (LVN) 4 on 5/30/2026 at 12:39 pm, LVN 4 confirmed and stated that the SBAR dated 3/30/3036 indicated that Resident 1 attempted to elope on 3/30/2026. LVN 4 stated that residents must be reassessed with every attempt of elopement or successful elopement. LVN 4 stated that the residents score for elopement will generally increase on the resident elopement risk assessment form. LVN 4 stated that elopement risk score of 10 or greater indicates that a resident is at a high risk for eloping. LVN 4 confirmed that Resident 1's elopement risk assessment completed on 3/30/2026, indicated the resident scored 9 which did not show that Resident 1 was an elopement risk. LVN 4 confirmed and stated that the following questions on elopement risk assessment where inaccurately answered/responded to:- Yes, for a question asking if Resident 1 was cognitively intact.- No, for question asking if Resident 1 wandered around the unit.LVN 4 confirmed and stated that Resident 1's elopement risk assessment dated [DATE] was inaccurate. LVN 4 stated that the elopement risk assessment should have indicated that Resident 1 was a high elopement risk because in the past, Resident 1 attempted to elope from the facility on 3/30/2026. LVN 4 confirmed and stated that there was no care plan in place for Resident 1 for elopement before 5/28/2026. LVN 4 stated that a care plan should have been initiated as soon as the facility identified that Resident 1 was a high elopement risk with interventions outlined to notify nursing on elopement prevention strategies. During a concurrent observation of the smoking patio gate and interview with Kitchen Staff (KS) 1 on 6/3/2026 at 1:31 pm, the gate leading to the alley at the back of the facility was observed to be propped open with a black plastic bag.^ KS 1 stated she had propped the door open because she had to take something (did not specify) out quickly. KS 1 confirmed and stated she (KS 1) left the door propped open, unsupervised, making it easily accessible for residents to exit the facility, a resident could have eloped into the main road on the other side of the gate, get hit by a car, be assaulted, or fall. KS 1 stated staff were required to keep the door locked at all times and use a key to unlock and lock it when exiting and entering. KS 1 stated that there is a key available in the kitchen but does not bring the key when she takes the trash out. During an (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the Maintenance Supervisor (MS) on 6/3/2026 at 1:40 pm, MS stated that the alarm to the Gate 2 of the patio gate was functioning well and that when Kitchen staff went in and out of the gate, the kitchen staff tend to disarm the gate alarm and forgot to rearm the gate alarm. MS admitted and stated that the behavior of staff disarming the gate alarm had occurred a few times within the last week (was unable to state how many times). MS stated that he had checked the same gate (Gate 2) alarm on Friday 5/29/2026 after reports of the alarm not getting triggered when opened which is when he found that the alarm was not being rearmed. MS stated that he (MS) provided the dietary supervisor (DS) with an extra key to Gate 2 to ensure that the kitchen staff had one available for when they had to use the gate to return and emphasized the importance of rearming the alarm. The MS stated that the potential of leaving the gate alarm unarmed was that a resident can escape and get hurt, get run over or attacked by homeless people in the alley. During a concurrent observation and interview with Resident 1 on 6/3/2026 at 1:55 pm, Resident 1's room was not in direct view of the nurses' station. Resident 1's room is located opposite the nurses' station about 2 doors down (about 20 feet away). The back elevator was located to the right side of Resident 1's room away from the nurse's station about 25 feet from her room and not in direct view of the nurses' station. The main elevator was located to the left side of Resident 1's room just past the nurses' station and in view of the station. During the same concurrent observation and interview, Resident 1 was observed passing back and forth in the hallway, from her room to the nurses' station. Resident 1 stated that she returned from GACH 1 a few minutes prior to this same interview. She (Resident 1) stated that she walked to GACH 1 the previous night on 6/2/2026 because she was experiencing chest pain and she felt that nursing staff were not appropriately addressing. Resident 1 stated that she used the facility back elevator and the side gate on the smoking patio to exit the facility. Resident 1 stated that she did not hear any alarm trigger when she left the facility. Resident 1 was observed without a wander guard. Resident 1 stated that she removed the wander guard and left the wander guard on the bedside table and left the faciity on 6/2/2026 night. During a concurrent observation of Resident 1 and interview with RNS 1 on 6/3/2026, RNS 1 confirmed and stated that Resident 1 did not have a wander guard on. RNS 1 stated that Resident 1 needed to always wear a wander guard because the resident is a risk for elopement. During a concurrent interview and record review of Resident 1's medical chart with the Director of Nursing (DON) on 6/4/2026 at 10:34 am, the DON stated Resident 1 ambulated (walked) with steady gait and sometimes used a wheelchair. The DON stated Resident 1 displayed behaviors of wanting to go out and often stated that [Resident 1] has chest pain. The DON stated that the facility called 911 (emergency services) a few times (did not specify) in the past because Resident 1 complained of chest pain. The DON stated that on 6/2/2026, Resident 1 complained of chest and the facility administered Nitroglycerine to Resident 1. The DON stated that an elopement risk assessment must be completed upon resident's admission and at change of condition of an attempt or successful elopement. The DON stated that elopement risk assessment answers must be accurate in order to take care of specifics of the elopement risk. The DON stated that inaccurately answering questions on the assessment can affect the resident elopement risk scoring because there is a potential of scoring a resident as a no risk when in fact the resident is at a risk of elopement. The DON stated that when resident assessments are inaccurate, everything will be affected such as interventions provided for the resident and the facility may fail to safeguard and prevent a resident from eloping. The DON stated that if a resident attempts to elope or successfully elopes, she (DON) expects the resident's elopement risk assessment score to be 10 or higher and Interventions including placing a wander guard and frequent supervision initiated for the resident. The DON stated staff are trained to monitor residents that constantly wander the unit hourly or every two hours. The DON stated that no staff was assigned to monitor Resident 1. The DON admitted and stated that Resident 1 was not safe in the facility because Resident 1 was able to remove the wonder guard. The DON confirmed and stated that Resident 1's elopement risk assessment was inaccurate and there should have been a care plan initiated when Resident 1 attempted to elope on 3/30/2026. During a review of (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a policy and procedures (P&P) titled, Care Planning - Interdisciplinary Team, reviewed 1/29/2026, indicated, The interdisciplinary team is responsible for the development of resident care plans. The same P&P indicated, Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). During a review of a P&P titled, Care Plans, Comprehensive Person-Centered, reviewed 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 same P&P indicated under policy interpretation and implementation including:- The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required IvIDS assessment (Admission, Annual or Significant Change in-Status), and no more than 21 days after admission.- The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - 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 care, including the right to:Receive the services and/or items included in the plan of care: andSee the care plan and sign it after significant changes are made.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.ˆDuring a review of a P&P titled, Elopements - Residents Behavior and Facility Practices, reviewed 1/26/2026 indicated, Staff shall promptly report any resident who ties to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.If an employee observes a resident leaving the premises, he/she should:Attempt to prevent the departure in a courteous manner.Get help from other staff members in the immediate vicinity, if necessary; andInstruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall:a. Examine the resident for injuries;b. Notify the Attending Physician;c. Notify the resident's legal representative (sponsor) of the incident;d. Complete and file Report of incident/Accidente. Document the event in the resident's medical record. During a review of a P&P titled, Change in a Resident's Condition or Status, reviewed 1/29/2026, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). A significant change of condition is a major decline or improvement in the resident's status that:will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); impacts more than one area of the resident's health status;requires interdisciplinary review and/or revision to the care plan; andultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to staff accurately assess one out of three sampled residents (Resident 1) who was experiencing chest pain and had abnormal laboratory results by failing to ensure that:Licensed nursed comprehensively assessed Resident 1 after the resident complained of chest pain on 6/2/2026.Licensed nurses re-assessed Resident 1 after administering nitroglycerine [fast-acting prescription medication used to prevent and rapidly relieve chest pain] 0.4 milligrams [mg- units of measurement] for chest pain on 6/2/2026 at 8:30 pm.Review, Identify, and notify a physician of critical laboratory values for potassium (a vital mineral and electrolyte that the body uses to conduct electrical charges, maintain fluid balance, and support nerve signals, muscle contractions, and heart health) which was at 2.7 millimoles per liter (mmol/L - unit of measurement that quantifies the concentration of a substance in specific volume of blood with normal levels between 3.5 mmol/L to 5.0 mmol/L)As a result, Resident 1 successfully eloped (when a resident leaves the facility grounds or a designated safe area without the staff knowing and/or without the supervision the resident needs)form the facility on 5/27/2026 and 6/2/2026 and walked to general acute care hospital (GACH) 1 to seek medical services. This deficient practice placed Resident 1 at increased risk for accidents, injuries, hospitalization and death. Findings: Cross Reference F684 & F689 During a review of Resident 1's admission record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Paroxysmal (irregular) atrial fibrillation (AFib) is an intermittent heart condition where the upper chambers of the heart beat chaotically and out of sync with the lower chambers, heart failure (a serious, progressive condition where the heart muscle weakens or stiffens, preventing it from pumping enough oxygen-rich blood to meet the body's needs), and acute myocardial infarction (heart attack - occurs when blood flow to a section of the heart is suddenly blocked, depriving the heart muscle of oxygen and causing irreversible tissue damage). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/6/2026, the MDS indicated Resident 1 had severe cognitive impairment (a significant decline in thinking, memory, and reasoning that makes it impossible to live independently). The MDS indicated Resident 1 required staff setup or clean up assistance for most of Activities of Daily Living (ADLs such as toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, sit to stand, toilet transfer, and personal hygiene). The MDS indicated Resident 1 required staff supervision or touching assistance for walking between 10-to-150 feet. During a review of Resident 1's History and Physical (H&P - when a physician assesses and interviews a patient then documents findings) dated 2/2/2025 indicated Resident 1 had mild cognitive impairment of uncertain or unknown etiology. During a review of the physician orders dated 3/30/2026ˆindicated, Check Wander Guard Placement Q [every]. During a review of Resident 1'sˆSituation Background Assessment Recommendation (SBAR- a tool used in healthcare to improve patient safety by enabling fast, accurate, and concise information transfer between clinicians) dated 3/30/2026 at 6:23 pm., the SBARˆindicated, post-wandering, and that a wander guard was placed to the right wrist. The SBAR indicated, wonder guard close monitoring reorientation and redirection of behavior. During a review of Resident 1's Elopement Risk assessment dated [DATE] indicated that Resident 1 was not an elopement risk. During a review of Resident 1's Care Plan (CP - is a structured, individualized document created by healthcare professionals in collaboration with the patient to outline specific health conditions, treatment goals, and necessary services) initiated on 5/28/2026 with a focus, Elopement Risk: Places resident at significant risk of getting to a potentially dangerous place/stairs/outside of the facility, indicated Resident 1 had eloped on 5/27/2026 and that she (Resident 1) needed to be considered for a locked unit. The CP goals indicated, Resident safety will be maintained, and Resident will not leave facility unattended. TheˆCP (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions included the following:- Place resident in a room near nurses/station for close observation- Perform frequent safety rounds every 1/2 [half] hour- initiate and follow through with Psychologist and Psychiatrist consult. During a review of Resident 1's SBAR dated 5/27/2026 at 11 pm., the SBAR indicated a high elopement risk level. The SBAR indicated, Around 11 pm (5/27/2026) noted resident wasn't in her room, search every room and bathroom she was nowhere to find, also check the around the building, unable to find her, MD notified, DON family and called the police, more notes on the progress. The SBAR indicated Resident 1 was returned to the facility from GACH 1 via ambulance service on 5/28/2026 at 5:05 am During a review of Resident 1's SBAR dated 6/2/2026 at 10:22 pm., the SBAR indicated Resident 1 left the facility and went to GACH 1. The same SBAR indicated that at, [10 pm] Charge nurse [Licensed Vocational Nurse] reported that the patient [Resident 1] was not found in her room during routine observation. Patient's (Resident 1) room and bathroom were immediately checked, and the patient was not located. Charge nurse and CNA [Certified Nursing Assistant] conducted a thorough search of the facility, including 3rd floor, lobby, and designated smoking area; however, the patient was not found. Upon further assessment of the patient's room, the wander guard was noted on the bedside table, indicating it had been removed. Immediate follow-up was initiated, checked in with [GACH 1] Emergency Department and patient was located sitting in the Emergency Department in the waiting area. Per Emergency Department nurse, the patient had already checked in for evaluation and would need to sign discharge paperwork if she wished to leave and return to the facility. Patient refused to return to the facility, stating, I don't want to go back to that place anymore. I want to stay here. During a review of Resident 1's Nursing Notes documented by LVN 8, dated 5/27/2026 3:28 pm., indicated the following, [Resident 1] would get up, walk to her room and back to the dining room. [Resident 1] came to the station to get water. [Resident 1] did a lot of walking back in front to the station. [Resident 1] stayed at the station for couple of minutes and go back to her room. The Nursing Notes further indicated LVN 8 usually tells Resident 1 to stay in her (Resident 1's) room because Resident 1 needs to be close to her heart monitoring (pacemaker- a device used to control an irregular heart rhythm). On 5/27/2026 at around 5 pm, dinner was served, medications were administered to Resident 1, that Resident 1 walked to the nurses' station, and that a(unidentified) staff usually monitors Resident 1's whereabouts. On 5/27/2026 at around 9:30 pm, LVN 8 was charting (documenting) at the nurses' station when Resident 1 came to the nurses' station, walked by the nurses' stations and then headed to back to Resident 1's room. On 5/27/2026 at 11 pm, during change of shift Resident 1 was not in her room. LVN 8 checked all the bathrooms and rooms on 3rd floor, however, Resident 1 was nowhere to be found. LVN 8 went downstairs and checked around the building, but was unable to find Resident 1, and that LVN 8 told a Registered Nurse (RN-unidentified) that Resident 1 was missing, on 5/27/2026 at 12:15 AM, a Police officer came and was later joined by 2 (two) police officers who asked questions regarding what the resident looks like, height, weight and race etc. The police officers were at the facility for more than an hour, asked permission to check all the rooms, also checked all the exits. The 2 police officers showed LVN 8 a picture of a person obtained from a street camera and LVN 8 identified and confirmed that, yes that's our resident (Resident 1). Few minutes the two police officers told us that they found the resident she's at GACH 1. ˆDuring a review of Resident 1's Nursing Notes dated 6/2/2026 11:25 pm., documented by Certified Nursing Assistant (CNA) 9 indicated that On 6/2/2026 at 8:30 pm, Resident 1 complained of chest pain and nitroglycerine [fast-acting prescription medication used to prevent and rapidly relieve chest pain] 0.4 milligrams [mg- units of measurement] was administered. After 5 minutes CNA 9 checked on Resident 1 and that Resident 1 told CNA 9 that, I am [Resident 1] doing okay. Resident 1 left the faciity on 6/2/2026 at 9:40 pm. During an interview with Registered Nurse Supervisor (RNS) 2 on 5/30/2026, RN 2 stated that an elopement is when a resident leaves without staff knowledge or permission. RNS 2 stated that the interventions for residents who are an elopement risk included frequent visual monitoring (unable to state frequency) and placing a wander guard. RNS 2 stated that on 5/27/2026, she came in for her (continued on next page)

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	555808	A. Building B. Wing	06/04/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift around 11 pm and was told that Resident 1 had not been located in the facility and that law enforcement was called. RNS 2 stated that when Resident 1 returned the following day, 5/28/2026, Resident 1 notified RNS that she (Resident 1) left the faciity on 5/27/2026 at around 8:30 pm using the facility back elevator. RNS 2 stated that it was during change of shift between the evening shift and night shift (3pm and 11pm), on 5/27/2026, that the facility discovered that Resident 1 had left the facility. During a concurrent interview and record review of Resident 1's medical chart with Licensed Vocational Nurse (LVN) 4 on 5/30/2026 at 12:39 pm, LVN 4 confirmed and stated that the SBAR dated 3/30/3036 indicated that Resident 1 attempted to elope on 3/30/2026. LVN 4 stated that residents must be reassessed with every attempt of elopement or successful elopement. LVN 4 stated that the residents score for elopement will generally increase on the resident elopement risk assessment form. LVN 4 stated that elopement risk score of 10 or greater indicates that a resident is at a high risk for eloping. LVN 4 confirmed that Resident 1's elopement risk assessment completed on 3/30/2026, indicated the resident scored 9 which did not show that Resident 1 was an elopement risk. LVN 4 confirmed and stated that the following questions on elopement risk assessment where inaccurately answered/responded to:- Yes, for a question asking if Resident 1 was cognitively intact.- No, for question asking if Resident 1 wandered around the unit.LVN 4 confirmed and stated that Resident 1's elopement risk assessment dated [DATE] was inaccurate. LVN 4 stated that the elopement risk assessment should have indicated that Resident 1 was a high elopement risk because in the past, Resident 1 attempted to elope from the facility on 3/30/2026. LVN 4 confirmed and stated that there was no care plan in place for Resident 1 for elopement before 5/28/2026. LVN 4 stated that a care plan should have been initiated as soon as the facility identified that Resident 1 was a high elopement risk with interventions outlined to notify nursing on elopement prevention strategies. During the same concurrent observation and interview, Resident 1 was observed passing back and forth in the hallway, from her room to the nurses' station. Resident 1 stated that she returned from GACH 1 a few minutes prior to this same interview. She (Resident 1) stated that she walked to GACH 1 the previous night on 6/2/2026 because she was experiencing chest pain and she felt that nursing staff were not appropriately addressing. Resident 1 stated that she used the facility back elevator and the side gate on the smoking patio to exit the facility. Resident 1 stated that she did not hear any alarm trigger when she left the facility. Resident 1 was observed without a wander guard. Resident 1 stated that she removed the wander guard and left the wander guard on the bedside table and left the faciity on 6/2/2026 night. During a concurrent observation of Resident 1 and interview with RNS 1 on 6/3/2026, RNS 1 confirmed and stated that Resident 1 did not have a wander guard on. RNS 1 stated that Resident 1 needed to always wear a wander guard because the resident is a risk for elopement. During a concurrent interview and record review of Resident 1's medical chart with the Director of Nursing (DON) on 6/4/2026 at 10:34 am, the DON stated Resident 1 ambulated (walked) with steady gait and sometimes used a wheelchair. The DON stated Resident 1 displayed behaviors of wanting to go out and often stated that [Resident 1] has chest pain. The DON stated that the facility called 911 (emergency services) a few times (did not specify) in the past because Resident 1 complained of chest pain. The DON stated that on 6/2/2026, Resident 1 complained of chest and the facility administered Nitroglycerine to Resident 1. The DON stated that an elopement risk assessment must be completed upon resident's admission and at change of condition of an attempt or successful elopement. The DON stated that elopement risk assessment answers must be accurate in order to take care of specifics of the elopement risk. The DON stated that inaccurately answering questions on the assessment can affect the resident elopement risk scoring because there is a potential of scoring a resident as a no risk when in fact the resident is at a risk of elopement. The DON stated that when resident assessments are inaccurate, everything will be affected such as interventions provided for the resident and the facility may fail to safeguard and prevent a resident from eloping. The DON stated that if a resident attempts to elope or successfully elopes, she (DON) expects the resident's elopement risk assessment score to be 10 or higher and Interventions including placing a (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wander guard and frequent supervision initiated for the resident. The DON stated staff are trained to monitor residents that constantly wander the unit hourly or every two hours. The DON stated that no staff was assigned to monitor Resident 1. The DON admitted and stated that Resident 1 was not safe in the facility because Resident 1 was able to remove the wonder guard. The DON confirmed and stated that Resident 1's elopement risk assessment was inaccurate and there should have been a care plan initiated when Resident 1 attempted to elope on 3/30/2026. During a follow up interview with the DON 6/4/2026 at 12:02 pm, The DON stated that when a resident is readmitted to the facility, the RNS or desk nurse reviews the discharge summary to ensure that any recommendations or abnormal values are identified and reported to the resident's physician for further orders as needed. The DON stated that she also reviewed discharge summaries the following day for oversite and ensure that nothing was missing. The DON had not reviewed the discharge summary as of the time of this interview. The DON was unaware about Resident 1's potassium levels being at 2.7 mmol/L until this surveyor asked her about the levels. The DON stated that a level of 2.7mmol/L was significantly low and some of the signs and symptoms of hypokalemia included muscle cramps, weakness, shortness of breath, heart problems such as chest palpitations which may present as chest pain. The DON confirmed that a low potassium could have potentially caused Resident 1 to complain of chest pain. During an interview with Licensed Vocational Nurse (LVN) 7 on 6/4/2026 at 4:31 pm, LVN 7 stated that she was assigned as a desk nurse on 6/3/2026 when Resident 1 was readmitted to the facility on [DATE]. LVN 7 stated that duties of being a desk nurse included admissions and readmissions which included reviewing the admission paperwork or discharge summaries and ensuring that abnormal results were reported to the physician promptly. LVN 7 stated that she reviewed the admission orders but had not noticed the abnormal potassium levels. LVN 7 stated that a level of 2.7mmol/L must reported to the physician promptly. During a review of a policy and procedures (P&P) titled, Care Planning - Interdisciplinary Team, reviewed 1/29/2026, indicated, The interdisciplinary team is responsible for the development of resident care plans. The same P&P indicated, Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). During a review of the facility's P&P titled Change in a Resident's Condition or Status: reviewed 1/29/2026, the P&P indicated that, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)Policy Interpretation and Implementation1. The nurse will notify the resident's attending physician or physician on call when there has been a(an) .: d. significant change in the resident's physical/emotional/mental condition; During a review of a P&P titled, Charting and Documentation, reviewed 1/29/2026, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record:Objective observations;Medications administered;Treatments or services performed;Changes in the resident's condition;Events, incidents or accidents involving the resident; andProgress toward or changes in the care plan goals and objectives.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to have a system in place to ensure the safety of one of the three sampled residents (Resident 1) by failing to: Licensed nursed comprehensively assessed Resident 1 after the resident complained of chest pain on 6/2/2026.Licensed nurses re-assessed Resident 1 after administering nitroglycerine [fast-acting prescription medication used to prevent and rapidly relieve chest pain] 0.4 milligrams [mg- units of measurement] for chest pain on 6/2/2026 at 8:30 pm.Review, Identify, and notify a physician of critical laboratory values for potassium (a vital mineral and electrolyte that the body uses to conduct electrical charges, maintain fluid balance, and support nerve signals, muscle contractions, and heart health) which was at 2.7 millimoles per liter (mmol/L - unit of measurement that quantifies the concentration of a substance in specific volume of blood with normal levels between 3.5 mmol/L to 5.0 mmol/L) As a result, Resident 1 eloped from the facility on 5/27/2026 and 6/2/2026 during the night and walked to General Acute Care Hospital (GACH) 1 both times to seek medical services placing the resident at increased risk for accidents such as being run over by a vehicle or being attacked and death. Findings: Cross Reference F689 During a review of Resident 1's admission record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Paroxysmal (irregular) atrial fibrillation (AFib) is an intermittent heart condition where the upper chambers of the heart beat chaotically and out of sync with the lower chambers, heart failure (a serious, progressive condition where the heart muscle weakens or stiffens, preventing it from pumping enough oxygen-rich blood to meet the body's needs), and acute myocardial infarction (heart attack - occurs when blood flow to a section of the heart is suddenly blocked, depriving the heart muscle of oxygen and causing irreversible tissue damage). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/6/2026, the MDS indicated Resident 1 had severe cognitive impairment (a significant decline in thinking, memory, and reasoning that makes it impossible to live independently). The MDS indicated Resident 1 required staff setup or clean up assistance for most of Activities of Daily Living (ADLs such as toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, sit to stand, toilet transfer, and personal hygiene). The MDS indicated Resident 1 required staff supervision or touching assistance for walking between 10-to-150 feet. ˆ During a review of Resident 1's History and Physical (H&P - when a physician assesses and interviews a patient then documents findings) dated 2/2/2025 indicated Resident 1 had mild cognitive impairment of uncertain or unknown etiology. ˆ During a review of the physician orders dated 3/30/2026ˆindicated, Check Wander Guard Placement Q [every]. ˆ During a review of Resident 1'sˆSituation Background Assessment Recommendation (SBAR- a tool used in healthcare to improve patient safety by enabling fast, accurate, and concise information transfer between clinicians) dated 3/30/2026 at 6:23 pm., the SBARˆindicated, post-wandering, and that a wander guard was placed to the right wrist. The SBAR indicated, wonder guard close monitoring reorientation and redirection of behavior. ˆ During a review of Resident 1's Elopement Risk assessment dated [DATE] indicated that Resident 1 was not an elopement risk. ˆ During a review of Resident 1's Care Plan (CP - is a structured, individualized document created by healthcare professionals in collaboration with the patient to outline specific health conditions, treatment goals, and necessary services) initiated on 5/28/2026 with a focus, Elopement Risk: Places resident at significant risk of getting to a potentially dangerous place/stairs/outside of the facility, indicated Resident 1 had eloped on 5/27/2026 and that she (Resident 1) needed to be considered for a locked unit. The CP goals indicated, Resident safety will be maintained, and Resident will not leave facility unattended. TheˆCP interventions included the following: - Place resident in a room near nurses/station for close observation - Perform frequent safety rounds every 1/2 [half] hour - initiate and follow through with Psychologist and Psychiatrist (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consult. ˆ During a review of Resident 1's SBAR dated 5/27/2026 at 11 pm., the SBAR indicated a high elopement risk level. The SBAR indicated, Around 11 pm (5/27/2026) noted resident wasn't in her room, search every room and bathroom she was nowhere to find, also check the around the building, unable to find her, MD notified, DON family and called the police, more notes on the progress. The SBAR indicated Resident 1 was returned to the facility from GACH 1 via ambulance service on 5/28/2026 at 5:05 am ˆ During a review of Resident 1's SBAR dated 6/2/2026 at 10:22 pm., the SBAR indicated Resident 1 left the facility and went to GACH 1. The same SBAR indicated that at, [10 pm] Charge nurse [Licensed Vocational Nurse] reported that the patient [Resident 1] was not found in her room during routine observation. Patient's (Resident 1) room and bathroom were immediately checked, and the patient was not located. Charge nurse and CNA [Certified Nursing Assistant] conducted a thorough search of the facility, including 3rd floor, lobby, and designated smoking area; however, the patient was not found. Upon further assessment of the patient's room, the wander guard was noted on the bedside table, indicating it had been removed. Immediate follow-up was initiated, checked in with [GACH 1] Emergency Department and patient was located sitting in the Emergency Department in the waiting area. Per Emergency Department nurse, the patient had already checked in for evaluation and would need to sign discharge paperwork if she wished to leave and return to the facility. Patient refused to return to the facility, stating, I don't want to go back to that place anymore. I want to stay here. ˆ During a review of Resident 1's Nursing Notes documented by LVN 8, dated 5/27/2026 3:28 pm., indicated the following, [Resident 1] would get up, walk to her room and back to the dining room. [Resident 1] came to the station to get water. [Resident 1] did a lot of walking back in front to the station. [Resident 1] stayed at the station for couple of minutes and go back to her room. The Nursing Notes further indicated LVN 8 usually tells Resident 1 to stay in her (Resident 1's) room because Resident 1 needs to be close to her heart monitoring (pacemaker- a device used to control an irregular heart rhythm). On 5/27/2026 at around 5 pm, dinner was served, medications were administered to Resident 1, that Resident 1 walked to the nurses' station, and that a(unidentified) staff usually monitors Resident 1's whereabouts. On 5/27/2026 at around 9:30 pm, LVN 8 was charting (documenting) at the nurses' station when Resident 1 came to the nurses' station, walked by the nurses' stations and then headed to back to Resident 1's room. On 5/27/2026 at 11 pm, during change of shift Resident 1 was not in her room. LVN 8 checked all the bathrooms and rooms on 3rd floor, however, Resident 1 was nowhere to be found. LVN 8 went downstairs and checked around the building, but was unable to find Resident 1, and that LVN 8 told a Registered Nurse (RN-unidentified) that Resident 1 was missing, on 5/27/2026 at 12:15 AM, a Police officer came and was later joined by 2 (two) police officers who asked questions regarding what the resident looks like, height, weight and race etc. The police officers were at the facility for more than an hour, asked permission to check all the rooms, also checked all the exits. The 2 police officers showed LVN 8 a picture of a person obtained from a street camera and LVN 8 identified and confirmed that, yes that's our resident (Resident 1). Few minutes the two police officers told us that they found the resident she's at GACH 1. ˆ ˆDuring a review of Resident 1's Nursing Notes dated 6/2/2026 11:25 pm., documented by Certified Nursing Assistant (CNA) 9 indicated the following: [Resident 1] received in bed alert and oriented, was not in pain, no shortness of breath or distress noted. On 6/2/2026 at 5 pm Resident 1 received medication, and dinner, and the resident was walking in the hallway. On 6/2/2026 at 8:30 pm, Resident 1 complained of chest pain and nitroglycerine [fast-acting prescription medication used to prevent and rapidly relieve chest pain] 0.4 milligrams [mg- units of measurement] was administered. After 5 minutes CNA 9 checked on Resident 1 and that Resident 1 told CNA 9 that, I am [Resident 1] doing okay. Resident 1 left the faciity on 6/2/2026 at 9:40 pm. During a review of Resident 1 discharge summary from GACH dated 5/27/20 indicated the reason for visit was chest pain. During a review of Resident 1 after discharge summary from GACH dated 6/3/2026 indicated the reason for visit was chest pain. The same summary indicated diagnoses of epigastric pain (discomfort or a burning sensation felt in the upper abdomen, just below the ribs) and hypokalemia (a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition characterized by abnormally low levels of potassium in the blood, typically below 3.5) with Resident 1's value at 2.7mmol/L. The discharge summary indicated home care instructions which included, If you take certain types of diuretics, you will need to take potassium supplements. Talk to your health care provider.ˆ During a concurrent observation of the facility smoking patio located on the first floor and interview with the Activities Coordinator (AC) on 5/30/2026 at 11:25 am, the facility patio was inspected/observed. The patio is located to the left and back of the facility reception desk and is separated by a door. Behind the door, is a hallway which is about 10 feet (ft) long with 2 bathrooms to the left side, and to the right is another hallway about 90 ft long with a door at the end which leads out to the smoking patio. The door remained unlocked. The smoking patio is not visible from the inside the facility. The smoking patio is connected to pathways to the left and to the right of the smoking patio which are about 50 ft long. Both pathways are secured with gates which have alarms. The alarm gate to the right side (Gate 1) of the smoking patio is triggers when opened. However, the gate to the left side (Gate 2) was observed to have brown paper jammed into the locking mechanism, preventing the gate from locking and triggering the alarm. The AC opened Gate 2 and confirmed and stated that the alarm did not trigger. The AC removed the paper that was jammed into the locking mechanism of the gate, closed and reopened the gate however, the alarm still did not trigger. The AC confirmed and stated that the paper should not be placed anywhere around any locking mechanism because the paper will prevent the gate from locking and preventing the alarm from engaging/triggering. The AC stated that the potential for jamming the locking mechanism of a gate can result in a resident leaving the facility without staff knowledge. The AC stated that the door should be locked. ˆ During an interview with Registered Nurse Supervisor (RNS) 2 on 5/30/2026, RN 2 stated that an elopement is when a resident leaves without staff knowledge or permission. RNS 2 stated that the interventions for residents who are an elopement risk included frequent visual monitoring (unable to state frequency) and placing a wander guard. RNS 2 stated that on 5/27/2026, she came in for her shift around 11 pm and was told that Resident 1 had not been located in the facility and that law enforcement was called. RNS 2 stated that when Resident 1 returned the following day, 5/28/2026, Resident 1 notified RNS that she (Resident 1) left the faciity on 5/27/2026 at around 8:30 pm using the facility back elevator. RNS 2 stated that it was during change of shift between the evening shift and night shift (3pm and 11pm), on 5/27/2026, that the facility discovered that Resident 1 had left the facility. ˆ During a concurrent interview and record review of Resident 1's medical chart with Licensed Vocational Nurse (LVN) 4 on 5/30/2026 at 12:39 pm, LVN 4 confirmed and stated that the SBAR dated 3/30/3036 indicated that Resident 1 attempted to elope on 3/30/2026. LVN 4 stated that residents must be reassessed with every attempt of elopement or successful elopement. LVN 4 stated that the residents score for elopement will generally increase on the resident elopement risk assessment form. LVN 4 stated that elopement risk score of 10 or greater indicates that a resident is at a high risk for eloping. LVN 4 confirmed that Resident 1's elopement risk assessment completed on 3/30/2026, indicated the resident scored 9 which did not show that Resident 1 was an elopement risk. LVN 4 confirmed and stated that the following questions on elopement risk assessment where inaccurately answered/responded to: - Yes, for a question asking if Resident 1 was cognitively intact. - No, for question asking if Resident 1 wandered around the unit. LVN 4 confirmed and stated that Resident 1's elopement risk assessment dated [DATE] was inaccurate. LVN 4 stated that the elopement risk assessment should have indicated that Resident 1 was a high elopement risk because in the past, Resident 1 attempted to elope from the facility on 3/30/2026. LVN 4 confirmed and stated that there was no care plan in place for Resident 1 for elopement before 5/28/2026. LVN 4 stated that a care plan should have been initiated as soon as the facility identified that Resident 1 was a high elopement risk with interventions outlined to notify nursing on elopement prevention strategies. ˆ During a concurrent observation and interview with Resident 1 on 6/3/2026 at 1:55 pm, Resident 1's room was not in direct view of the nurses' station. Resident 1's room is located opposite the nurses' station about 2 doors down (about 20 feet away). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The back elevator was located to the right side of Resident 1's room away from the nurse's station about 25 feet from her room and not in direct view of the nurses' station. The main elevator was located to the left side of Resident 1's room just past the nurses' station and in view of the station. During the same concurrent observation and interview, Resident 1 was observed passing back and forth in the hallway, from her room to the nurses' station. Resident 1 stated that she returned from GACH 1 a few minutes prior to this same interview. She (Resident 1) stated that she walked to GACH 1 the previous night on 6/2/2026 because she was experiencing chest pain and she felt that nursing staff were not appropriately addressing. Resident 1 stated that she used the facility back elevator and the side gate on the smoking patio to exit the facility. Resident 1 stated that she did not hear any alarm trigger when she left the facility. Resident 1 was observed without a wander guard. Resident 1 stated that she removed the wander guard and left the wander guard on the bedside table and left the faciity on 6/2/2026 night. ^ During a concurrent interview and record review of Resident 1's medical chart with the Director of Nursing (DON) on 6/4/2026 at 10:34 am, the DON stated Resident 1 ambulated (walked) with steady gait and sometimes used a wheelchair. The DON stated Resident 1 displayed behaviors of wanting to go out and often stated that [Resident 1] has chest pain. The DON stated that the facility called 911 (emergency services) a few times (did not specify) in the past because Resident 1 complained of chest pain. The DON stated that on 6/2/2026, Resident 1 complained of chest and the facility administered Nitroglycerine to Resident 1. The DON stated that an elopement risk assessment must be completed upon resident's admission and at change of condition of an attempt or successful elopement. The DON stated that elopement risk assessment answers must be accurate in order to take care of specifics of the elopement risk. The DON stated that inaccurately answering questions on the assessment can affect the resident elopement risk scoring because there is a potential of scoring a resident as a no risk when in fact the resident is at a risk of elopement. The DON stated that when resident assessments are inaccurate, everything will be affected such as interventions provided for the resident and the facility may fail to safeguard and prevent a resident from eloping. The DON stated that if a resident attempts to elope or successfully elopes, she (DON) expects the resident's elopement risk assessment score to be 10 or higher and Interventions including placing a wander guard and frequent supervision initiated for the resident. The DON stated staff are trained to monitor residents that constantly wander the unit hourly or every two hours. The DON stated that no staff was assigned to monitor Resident 1. The DON admitted and stated that Resident 1 was not safe in the facility because Resident 1 was able to remove the wonder guard. The DON confirmed and stated that Resident 1's elopement risk assessment was inaccurate and there should have been a care plan initiated when Resident 1 attempted to elope on 3/30/2026. During a follow up interview with the DON 6/4/2026 at 12:02 pm, The DON stated that when a resident is readmitted to the facility, the RNS or desk nurse reviews the discharge summary to ensure that any recommendations or abnormal values are identified and reported to the resident's physician for further orders as needed. The DON stated that she also reviewed discharge summaries the following day for oversite and ensure that nothing was missing. The DON had not reviewed the discharge summary as of the time of this interview. The DON was unaware about Resident 1's potassium levels being at 2.7 mmol/L until this surveyor asked her about the levels. The DON stated that a level of 2.7mmol/L was significantly low and some of the signs and symptoms of hypokalemia included muscle cramps, weakness, shortness of breath, heart problems such as chest palpitations which may present as chest pain. The DON confirmed that a low potassium could have potentially caused Resident 1 to complain of chest pain. During an interview with Licensed Vocational Nurse (LVN) 7 on 6/4/2026 at 4:31 pm, LVN 7 stated that she was assigned as a desk nurse on 6/3/2026 when Resident 1 was readmitted to the facility on [DATE]. LVN 7 stated that duties of being a desk nurse included admissions and readmissions which included reviewing the admission paperwork or discharge summaries and ensuring that abnormal results were reported to the physician promptly. LVN 7 stated that she reviewed the admission orders but had not noticed the abnormal potassium (continued on next page)

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Santa Monica Rehabilitation Center	1338 20th Street Santa Monica, CA 90404

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	levels. LVN 7 stated that a level of 2.7mmol/L must reported to the physician promptly.^ During a review of a policy and procedures (P&P) titled, Care Planning - Interdisciplinary Team, reviewed 1/29/2026, indicated, The interdisciplinary team is responsible for the development of resident care plans. The same P&P indicated, Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). During a review of the facility's P&P titled Change in a Resident's Condition or Status: reviewed 1/29/2026, the P&P indicated that, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)Policy Interpretation and Implementation1. The nurse will notify the resident's attending physician or physician on call when there has been a(an) .: d. significant change in the resident's physical/emotional/mental condition; ^ During a review of a P&P titled, Charting and Documentation, reviewed 1/29/2026, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The same P&P indicated, The following information is to be documented in the resident medical record:Objective observations;Medications administered;Treatments or services performed;Changes in the resident's condition;Events, incidents or accidents involving the resident; andProgress toward or changes in the care plan goals and objectives.

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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** Based on interview, and record review, for two of twelve sampled residents (Residents 1 and 9):For Resident 1:A. The facility failed to provide adequate supervision and implement effective interventions to prevent elopement (when a resident leaves the facility grounds or a designated safe area without the staff knowing and/or without the supervision the resident needs) for one of three sampled residents (Resident 1) who had moderate cognitive impairment by failing to:1. Monitor and supervise the whereabouts of Resident 12. Accurately assess Resident 1's risk for elopement on 3/30/26 when Resident 1 displayed wandering behavior and attempted to elope from the facility.3. Create and implement a Risk for elopement care plan after Resident 1 attempted to elope on 3/30/2026 and eloped on 5/27/2026.4. Ensure that the patio gate leading to the alley had a functioning alarm system to alert staff when opened.On 3/30/2026, Resident 1 attempted to elope from the facility.As a result, Resident 1 eloped from the facility on 5/27/2026 and 6/2/2026 during the night. On the same dates, Resident 1 walked to General Acute Care Hospital (GACH) 1 to seek medical attention/services. For Resident 9:B. The facility failed to ensure staff closely supervised and monitored Resident 9, and ensured Resident 9 was within staff reach to prevent the resident from falls and or injuries. The facility was aware that Resident 9 is confused (a condition when unable to think as clearly or quickly as normally one can do), has a history of falls, and impulsive behavior (actions that are taken without sufficient thought or considerations of consequences) of getting up from a wheelchair (WC) without assistance.As a result, Resident 9 fell out of a wheelchair (WC) on 5/21/2026 at 11:45 AM. Xray (a low radiation light passed through the body to see body and organs) of the left ribs dated 5/22/2026, indicated Resident 9 had non-displaced rib fractures. On 5/22/2026, the facility transferred Resident 9 to General Acute Care Hospital (GACH) for further evaluations and imaging tests. Findings: Cross Reference F684 A. During a review of Resident 1's admission record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Paroxysmal (irregular) atrial fibrillation (AFib) is an intermittent heart condition where the upper chambers of the heart beat chaotically and out of sync with the lower chambers, heart failure (a serious, progressive condition where the heart muscle weakens or stiffens, preventing it from pumping enough oxygen-rich blood to meet the body's needs), and acute myocardial infarction (heart attack - occurs when blood flow to a section of the heart is suddenly blocked, depriving the heart muscle of oxygen and causing irreversible tissue damage). ^ During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool) dated 5/6/2026, the MDS indicated Resident 1 had severe cognitive impairment (a significant decline in thinking, memory, and reasoning that makes it impossible to live independently). The MDS indicated Resident 1 required staff setup or clean up assistance for most of Activities of Daily Living (ADLs such as toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, sit to stand, toilet transfer, and personal hygiene). The MDS indicated Resident 1 required staff supervision or touching assistance for walking between 10-to-150 feet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ˆ During a review of Resident 1's History and Physical (H&P – when a physician assesses and interviews a patient then documents findings) dated 2/2/2025 indicated Resident 1 had mild cognitive impairment of uncertain or unknown etiology. ˆ During a review of the physician orders dated 3/30/2026ˆindicated, Check Wander Guard Placement Q [every]. ˆ During a review of Resident 1'sˆSituation Background Assessment Recommendation (SBAR- a tool used in healthcare to improve patient safety by enabling fast, accurate, and concise information transfer between clinicians) dated 3/30/2026 at 6:23 pm., the SBARˆindicated, post-wandering, and that a wander guard was placed to the right wrist. The SBAR indicated, wonder guard close monitoring reorientation and redirection of behavior. ˆ During a review of Resident 1's Elopement Risk assessment dated [DATE] indicated that Resident 1 was not an elopement risk. ˆ During a review of Resident 1's =Care Plan (CP - is a structured, individualized document created by healthcare professionals in collaboration with the patient to outline specific health conditions, treatment goals, and necessary services) initiated on 5/28/2026 with a focus, Elopement Risk: Places resident at significant risk of getting to a potentially dangerous place/stairs/outside of the facility, indicated Resident 1 had eloped on 5/27/2026 and that she (Resident 1) needed to be considered for a locked unit. The CP goals indicated, Resident safety will be maintained, and Resident will not leave facility unattended. TheˆCP interventions included the following: - Place resident in a room near nurses/station for close observation - Perform frequent safety rounds every 1/2 [half] hour - initiate and follow through with Psychologist and Psychiatrist consult. ˆ During a review of Resident 1's SBAR dated 5/27/2026 at 11 pm., the SBAR indicated a high elopement risk level. The SBAR indicated, Around 11 pm (5/27/2026) noted resident wasn't in her room, search every room and bathroom she was nowhere to find, also check the around the building, unable to find her, MD notified, DON family and called the police, more notes on the progress. The SBAR indicated Resident 1 was returned to the facility from GACH 1 via ambulance service on 5/28/2026 at 5:05 am (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	^ During a review of Resident 1's SBAR dated 6/2/2026 at 10:22 pm., the SBAR indicated Resident 1 left the facility and went to GACH 1. The same SBAR indicated that at, [10 pm] Charge nurse [Licensed Vocational Nurse] reported that the patient [Resident 1] was not found in her room during routine observation. Patient's (Resident 1) room and bathroom were immediately checked, and the patient was not located. Charge nurse and CNA [Certified Nursing Assistant] conducted a thorough search of the facility, including 3rd floor, lobby, and designated smoking area; however, the patient was not found. Upon further assessment of the patient's room, the wander guard was noted on the bedside table, indicating it had been removed. Immediate follow-up was initiated, checked in with [GACH 1] Emergency Department and patient was located sitting in the Emergency Department in the waiting area. Per Emergency Department nurse, the patient had already checked in for evaluation and would need to sign discharge paperwork if she wished to leave and return to the facility. Patient refused to return to the facility, stating, I don't want to go back to that place anymore. I want to stay here. ^ During a review of Resident 1's Nursing Notes documented by LVN 8, dated 5/27/2026 3:28 pm., indicated the following, [Resident 1] would get up, walk to her room and back to the dining room. [Resident 1] came to the station to get water. [Resident 1] did a lot of walking back in front to the station. [Resident 1] stayed at the station for couple of minutes and go back to her room. The Nursing Notes further indicated LVN 8 usually tells Resident 1 to stay in her (Resident 1's) room because Resident 1 needs to be close to her heart monitoring (pacemaker- a device used to control an irregular heart rhythm). On 5/27/2026 at around 5 pm, dinner was served, medications were administered to Resident 1, that Resident 1 walked to the nurses' station, and that a(unidentified) staff usually monitors Resident 1's whereabouts. On 5/27/2026 at around 9:30 pm, LVN 8 was charting (documenting) at the nurses' station when Resident 1 came to the nurses' station, walked by the nurses' stations and then headed to back to Resident 1's room. On 5/27/2026 at 11 pm, during change of shift Resident 1 was not in her room. LVN 8 checked all the bathrooms and rooms on 3rd floor, however, Resident 1 was nowhere to be found. LVN 8 went downstairs and checked around the building, but was unable to find Resident 1, and that LVN 8 told a Registered Nurse (RN-unidentified) that Resident 1 was missing, on 5/27/2026 at 12:15 AM, a Police officer came and was later joined by 2 (two) police officers who asked questions regarding what the resident looks like, height, weight and race etc. The police officers were at the facility for more than an hour, asked permission to check all the rooms, also checked all the exits. The 2 police officers showed LVN 8 a picture of a person obtained from a street camera and LVN 8 identified and confirmed that, yes that's our resident (Resident 1). Few minutes the two police officers told us that they found the resident she's at GACH 1. ^ ^During a review of Resident 1's Nursing Notes dated 6/2/2026 11:25 pm., documented by Certified Nursing Assistant (CNA) 9 indicated the following: [Resident 1] received in bed alert and oriented, was not in pain, no shortness of breath or distress noted. On 6/2/2026 at 5 pm Resident 1 received medication, and dinner, and the resident was walking in the hallway. On 6/2/2026 at 8:30 pm, Resident 1 complained of chest pain and nitroglycerine [fast-acting prescription medication used to prevent and rapidly relieve chest pain] 0.4 milligrams [mg- units of measurement] was administered. After 5 minutes CNA 9 checked on Resident 1 and that Resident 1 told CNA 9 that, I am [Resident 1] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing okay. Resident 1 left the faciity on 6/2/2026 at 9:40 pm. ^ During a concurrent observation of the facility smoking patio located on the first floor and interview with the Activities Coordinator (AC) on 5/30/2026 at 11:25 am, the facility patio was inspected/observed. The patio is located to the left and back of the facility reception desk and is separated by a door. Behind the door, is a hallway which is about 10 feet (ft) long with 2 bathrooms to the left side, and to the right is another hallway about 90 ft long with a door at the end which leads out to the smoking patio. The door remained unlocked. The smoking patio is not visible from the inside the facility. The smoking patio is connected to pathways to the left and to the right of the smoking patio which are about 50 ft long. Both pathways are secured with gates which have alarms. The alarm gate to the right side (Gate 1) of the smoking patio is triggers when opened. However, the gate to the left side (Gate 2) was observed to have brown paper jammed into the locking mechanism, preventing the gate from locking and triggering the alarm. The AC opened Gate 2 and confirmed and stated that the alarm did not trigger. The AC removed the paper that was jammed into the locking mechanism of the gate, closed and reopened the gate however, the alarm still did not trigger. The AC confirmed and stated that the paper should not be placed anywhere around any locking mechanism because the paper will prevent the gate from locking and preventing the alarm from engaging/triggering. The AC stated that the potential for jamming the locking mechanism of a gate can result in a resident leaving the facility without staff knowledge. The AC stated that the door should be locked. ^ During an interview with Registered Nurse Supervisor (RNS) 2 on 5/30/2026, RN 2 stated that an elopement is when a resident leaves without staff knowledge or permission. RNS 2 stated that the interventions for residents who are an elopement risk included frequent visual monitoring (unable to state frequency) and placing a wander guard. RNS 2 stated that on 5/27/2026, she came in for her shift around 11 pm and was told that Resident 1 had not been located in the facility and that law enforcement was called. RNS 2 stated that when Resident 1 returned the following day, 5/28/2026, Resident 1 notified RNS that she (Resident 1) left the faciity on 5/27/2026 at around 8:30 pm using the facility back elevator. RNS 2 stated that it was during change of shift between the evening shift and night shift (3pm and 11pm), on 5/27/2026, that the facility discovered that Resident 1 had left the facility. ^ During a concurrent interview and record review of Resident 1's medical chart with Licensed Vocational Nurse (LVN) 4 on 5/30/2026 at 12:39 pm, LVN 4 confirmed and stated that the SBAR dated 3/30/3036 indicated that Resident 1 attempted to elope on 3/30/2026. LVN 4 stated that residents must be reassessed with every attempt of elopement or successful elopement. LVN 4 stated that the residents score for elopement will generally increase on the resident elopement risk assessment form. LVN 4 stated that elopement risk score of 10 or greater indicates that a resident is at a high risk for eloping. LVN 4 confirmed that Resident 1's elopement risk assessment completed on 3/30/2026, indicated the resident scored 9 which did not show that Resident 1 was an elopement risk. LVN 4 confirmed and stated that the following questions on elopement risk assessment where inaccurately answered/responded to: - Yes, for a question asking if Resident 1 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No, for question asking if Resident 1 wandered around the unit. LVN 4 confirmed and stated that Resident 1's elopement risk assessment dated [DATE] was inaccurate. LVN 4 stated that the elopement risk assessment should have indicated that Resident 1 was a high elopement risk because in the past, Resident 1 attempted to elope from the facility on 3/30/2026. LVN 4 confirmed and stated that there was no care plan in place for Resident 1 for elopement before 5/28/2026. LVN 4 stated that a care plan should have been initiated as soon as the facility identified that Resident 1 was a high elopement risk with interventions outlined to notify nursing on elopement prevention strategies. ^ During a concurrent observation of the smoking patio gate and interview with Kitchen Staff (KS) 1 on 6/3/2026 at 1:31 pm, the gate leading to the alley at the back of the facility was observed to be propped open with a black plastic bag.^ KS 1 stated she had propped the door open because she had to take something (did not specify) out quickly. KS 1 confirmed and stated she (KS 1) left the door propped open, unsupervised, making it easily accessible for residents to exit the facility, a resident could have eloped into the main road on the other side of the gate, get hit by a car, be assaulted, or fall. KS 1 stated staff were required to keep the door locked at all times and use a key to unlock and lock it when exiting and entering. KS 1 stated that there is a key available in the kitchen but does not bring the key when she takes the trash out. ^ During an interview with the Maintenance Supervisor (MS) on 6/3/2026 at 1:40 pm, MS stated that the alarm to the Gate 2 of the patio gate was functioning well and that when Kitchen staff going and out of the gate, the kitchen staff tend to disarm the gate alarm and forgot to rearm the gate alarm. MS admitted and stated that the behavior of staff disarming the gate alarm had occurred a few times within the last week (was unable to state how many times). MS stated that he had checked the same gate (Gate 2) alarm on Friday 5/29/2026 after reports of the alarm not getting triggered when opened which is when he found that the alarm was not being rearmed. MS stated that he (MS) provided the dietary supervisor (DS) with an extra key to Gate 2 to ensure that the kitchen staff had one available for when they had to use the gate to return and emphasized the importance of rearming the alarm. The MS stated that the potential of leaving the gate alarm unarmed was that a resident can escape and get hurt, get run over or attacked by homeless people in the alley. ^ During a concurrent observation and interview with Resident 1 on 6/3/2026 at 1:55 pm, Resident 1's room was not in direct view of the nurses' station. Resident 1's room is located opposite the nurses' station about 2 doors down (about 20 feet away). The back elevator was located to the right side of Resident 1's room away from the nurse's station about 25 feet from her room and not in direct view of the nurses' station. The main elevator was located to the left side of Resident 1's room just past the nurses' station and in view of the station. During the same concurrent observation and interview, Resident 1 was observed passing back and forth in the hallway, from her room to the nurses' station. Resident 1 stated that she returned from GACH 1 a few minutes prior to this same interview. She (Resident 1) stated that she walked to GACH 1 the previous night on 6/2/2026 because she was experiencing chest pain and she felt that nursing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were not appropriately addressing. Resident 1 stated that she used the facility back elevator and the side gate on the smoking patio to exit the facility. Resident 1 stated that she did not hear any alarm trigger when she left the facility. Resident 1 was observed without a wander guard. Resident 1 stated that she removed the wander guard and left the wander guard on the bedside table and left the faciity on 6/2/2026 night. ^ During a concurrent observation of Resident 1 and interview with RNS 1 on 6/3/2026, RNS 1 confirmed and stated that Resident 1 did not have a wander guard on. RNS 1 stated that Resident 1 needed to always wear a wander guard because the resident is a risk for elopement. ^ During a concurrent interview and record review of Resident 1's medical chart with the Director of Nursing (DON) on 6/4/2026 at 10:34 am, the DON stated Resident 1 ambulated (walked) with steady gait and sometimes used a wheelchair. The DON stated Resident 1 displayed behaviors of wanting to go out and often stated that [Resident 1] has chest pain. The DON stated that the facility called 911 (emergency services) a few times (did not specify) in the past because Resident 1 complained of chest pain. The DON stated that on 6/2/2026, Resident 1 complained of chest and the facility administered Nitroglycerine to Resident 1. The DON stated that an elopement risk assessment must be completed upon resident's admission and at change of condition of an attempt or successful elopement. The DON stated that elopement risk assessment answers must be accurate in order to take care of specifics of the elopement risk. The DON stated that inaccurately answering questions on the assessment can affect the resident elopement risk scoring because there is a potential of scoring a resident as a no risk when in fact the resident is at a risk of elopement. The DON stated that when resident assessments are inaccurate, everything will be affected such as interventions provided for the resident and the facility may fail to safeguard and prevent a resident from eloping. The DON stated that if a resident attempts to elope or successfully elopes, she (DON) expects the resident's elopement risk assessment score to be 10 or higher and Interventions including placing a wander guard and frequent supervision initiated for the resident. The DON stated staff are trained to monitor residents that constantly wander the unit hourly or every two hours. The DON stated that no staff was assigned to monitor Resident 1. The DON admitted and stated that Resident 1 was not safe in the facility because Resident 1 was able to remove the wonder guard. The DON confirmed and stated that Resident 1's elopement risk assessment was inaccurate and there should have been a care plan initiated when Resident 1 attempted to elope on 3/30/2026. ^ During a review of a policy and procedures (P&P) titled, Care Planning - Interdisciplinary Team, reviewed 1/29/2026, indicated, The interdisciplinary team is responsible for the development of resident care plans. The same P&P indicated, Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). ^ During a review of a P&P titled, Elopements – Residents Behavior and Facility Practices, reviewed 1/26/2026 indicated, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff shall promptly report any resident who ties to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. If an employee observes a resident leaving the premises, he/she should: Attempt to prevent the departure in a courteous manner. Get help from other staff members in the immediate vicinity, if necessary; and Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. When a departing individual returns to the facility, 1i1e Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Notify the Attending Physician; c. Notify the resident's legal representative (sponsor) of the incident; d. Complete and file Report of incident/Accident e. Document the event in the resident's medical record. During a review of the P&P titled, Safety and Supervision of Residents, reviewed 1/29/2026, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. the same P&P indicated under the policy interpretation and implementation indicated: Facility-Oriented Approach to Safety 1. Our facility-oriented approach to safety addresses risks for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 3. When accident hazards are identified, the QAPI/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. 5. The QAPI Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. Individualized, Resident-Centered Approach to Safety (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	06/04/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently; b. Evaluating the effectiveness of interventions; c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions. Systems Approach to Safety 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition. Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include: . e. Unsafe Wandering . B.ˆDuring a review of Resident 9's admission Records, the Records indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses including history of falling, unspecified abnormalities of gait and mobility (when the pattern in which you walk and move is not normal), malignant neoplasm of left female breast (the development of cancer in the female breast), vascular dementia without behavioral disturbance (a brain disorder that affects a person's ability to carry out daily activities and that may cause changes in mood and personality caused by a reduced blood flow to the brain), anxiety disorder (a condition when often worried or anxious about many things and finds it hard to control). ˆ During a review of Resident 9's H&P dated 4/11/2026, the H&P indicated Resident 9 had a history of dementia (a brain disorder that affects a person's ability to carry out daily activities and that may cause changes in mood and personality), malignant left breast cancer (the development of cancer in the breast), cannot make medical decisions. ˆ During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) to make decisions on self-care activities. The MDS indicated Resident 9 was dependent on staff for toileting hygiene, transferring from bed to chair/chair to bed, shower/bath, personal hygiene, eating, and dependent on wheelchair for mobility. ˆ During a review of Resident 9's initial Fall Risk assessment dated [DATE], Resident 9's fall risk assessment score was 12 (a score of less than 25 is an indicator the resident is a low to moderate fall risk). ˆ During a revie of Resident 9's CP created on 10/12/2025 and revised on 1/13/2026 indicated Res[TRUNCATED]