

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555808	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Santa Monica Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1338 20th Street Santa Monica, CA 90404	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a discharge plan in the comprehensive care plan for three of three sampled residents (Residents 1,2, and 3). This deficient practice resulted in unsafe discharge, with a potential of worsened health outcomes, severe medical errors, and hospitalization. a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was readmitted on [DATE] (original admission date 6/1/2021). With diagnoses including but not limited to type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Cellulitis (bacterial skin infection) of right lower limb, and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/27/2026, the MDS indicated Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 (cognitively intact) During a review of Resident 1's Order Summary Report (OSR) dated 7/3/2026, the OSR indicated Resident 1 was to be discharged on 7/2/2026 to Boarding Care Facility (BCF) 1. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted on [DATE]. With a diagnoses including but not limited to traumatic subdural hemorrhage (brain bleed due to trauma to the head), fracture of unspecified parts of lumbosacral spine and pelvis (broken spine, broken pelvic bone), Intracerebral hemorrhage (stroke where a blood vessels bursts and causes bleeding directly into the brain) During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 5/22/2026, the MDS indicated Resident 2 had a brief interview for mental status BIMS score of 4 (severe cognitive impairment). During a review of Resident 2's OSR dated 7/3/2026, the OSR indicated Resident 2 was to be discharged on 7/2/2026 to BCF 1. During a review of Resident 2's Progress notes dated 7/3/20026, The progress notes indicated that there was an IDT meeting held with Resident 2 and his family member agreeing that Resident 2 will be transferred to Assisted Living (AS) 1. c. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted on [DATE]. With a diagnoses including but not limited to Malignant Neoplasm of Sigmoid Colon (Colon Cancer), chronic kidney disease (progressive kidney damage), and type 2 DM. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had a brief interview for mental status BIMS score of 11 (moderate cognitive impairment) During a review of Resident 3's OSR dated 7/3/2026, the OSR indicated Resident 3 was to be transferred on 6/13/2026 to General Acute Care Hospital (GACH) 1. During an interview with Assistant Director of Nursing (ADON), on 7/3/2026 at 2:16p.m, the ADON stated care plans are to be completed during the admission process, quarterly and as needed per resident. The importance of a care plan is to maintain residents' safety and inform them of their care. ADON stated that when a resident is being discharged (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the care plan will help notify the residents why they are being discharged and when they will be discharged . The ADON stated if there is no care plan this can cause frustration for the residents and confusion for the staff. Staff may not be informed of the plan for the residents and can cause medical mistakes during discharge for the residents. During a review of the facility's policy and procedures (P&P) titled Care plans, Comprehensive person- Centered, dated 1/29/2026, the P&P indicated, each resident's care plan is consistent with the residents rights to participate in the development and implementation of his or her plan of care. A care plan will be developed and implemented during any resident change or change in condition		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a notification of transfer to one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 experiencing emotional distress and uncertainty. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was readmitted on [DATE] (original admission date 6/1/2021). With diagnoses including but not limited to type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Cellulitis (bacterial skin infection) of right lower limb, and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/27/2026, the MDS indicated Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 (cognitively intact) During a review of Resident 1's Order Summary Report (OSR) dated 7/3/2026, the OSR indicated Resident 1 was to be discharged on 7/2/2026 to Boarding Care Facility (BCF) 1. During an interview on 7/3/2026 at 10:30am with Resident 1, Resident 1 stated he was not notified that he was being transferred to another facility. Resident 1 stated they have been living at the facility for years and are now being evicted. Resident 1 stated a nurse walked into their room and said pack your things you're going to BCF 1. Resident 1 stated he was never told that the facility was going to transfer them to BCF 1. Resident 1 stated they were in the process of choosing a facility to go to but had yet to formally decide where to go. This facility was chosen without his knowledge and feels like it's personal they are being evicted. During an interview with Licensed Vocational Nurse (LVN) 1, on 7/3/2026 at 11:48am LVN 1 stated Resident 1 has trust issue with transportation and needs concise communication. Per LVN 1 Resident 1 is excited to transfer but wants to visit the facility before making the decision which facility to go to. During an interview with Social Services Director (SSD), on 7/3/2026 at 12:45pm, the SSD stated they do not provide a transfer notice to residents who are being transferred. SSD stated the transfer form is given to the residents at the time of transfer not before. During an interview with the Assistant Director of Nursing (ADON), on 7/3/2026 at 2:16pm, the ADON stated it is important to notify residents that they are being transferred to prevent psychosocial distress. When residents don't know where they are going or why they can become frustrated and lose trust in their facility. During an interview with the Acting Administrator (AA), on 7/3/2026 at 2:25pm, the AA stated they get everything ready for the resident before being discharged either to home or to another facility. The AA stated the importance of keeping residents informed is to keep communication open between facility and residents. This is to prevent residents from feeling pushed out and feeling like the move is their choice. The AA stated that not informing the resident in a timely manner can cause the resident to become depressed and feel abused to a certain extent because this right now is his home. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, dated 1/29/2026, the P&P indicated that an appropriate notice will be provided to the resident and or legal representative of said transfer or discharge. The P&P also states that upon notifying the resident of the transfer or discharge, the resident will be allowed to appeal the transfer or discharge. If the resident chooses exercise their right to appeal they will not be transferred or discharged while the appeal is pending.		