

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 07/16/2026
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 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 observation, interview, and record review the facility failed to document the resident's assessment accurately in the medical record for one of five sampled residents (Resident 1). This failure resulted in inaccurate/ incomplete documentation of Resident 1's special treatments, procedures, and programs in the Minimum Data Set (MDS - a resident assessment tool), and had the potential to affect the services and treatments rendered. During a review of Resident 1's admission Record, dated 7/17/26 indicated, the resident was admitted to the facility on [DATE] with diagnoses including; chronic obstructive pulmonary disease (COPD - chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure) muscle weakness, abnormalities of gait and mobility, sleep apnea (chronic medical condition where a person's breathing repeatedly stops and starts during sleep), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and vascular dementia (memory and thinking problems caused by decreased blood flow to the brain). During a review of Resident 1's History and Physical (H&P) dated 7/13/26 indicated Resident 1 did not have decision make had the capacity to understand and make decisions. During a review of Resident 1's MDS dated [DATE] indicated, Resident 1 had severe cognitive (thinking, remembering, reasoning and judgment processes in the brain) impairment and was dependent to requiring substantial/maximum assistance with activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's care plan for at risk for altered respiratory status/difficulty breathing, BiPAP (bilevel positive airway pressure - a non-invasive breathing device used to push pressurized air into the airways) at bedtime and oxygen when needed revised 5/1/26 indicated, interventions of resident uses CPAP (continuous positive airway pressure - a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) for sleep, at bedtime for sleep apnea. During a review of Resident 1's Order Summary Report dated 7/12/26 indicated orders for: Apply BiPAP during bedtime, Apply BiPAP during naps within the day and Oxygen at 1 to 2 liters/minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). as needed. During an observation on 7/16/26 at 2:35 pm Resident 1 is observed sitting in wheelchair at bedside with BiPAP on and eyes closed (napping). During a concurrent telephone interview and record review on 7/22/26 at 10:57 am with the MDS nurse, Resident 1's MDS Section O Special Treatments, Procedures, and Programs dated 7/14/26 was reviewed. The MDS nurse verified the assessment was missing indications of the ordered respiratory treatments of intermittent Oxygen therapy and BiPAP, the MDS nurse stated they missed documenting those treatments in the assessment but it is important for the assessment to be accurate to follow the plan of care. During a review of the facility's policy and procedures (P&P) titled Certifying Accuracy of the Resident Assessment reviewed 1/21/26 indicated, person who completes (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555808 If continuation sheet Page 1 of 3

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any portion of the MDS assessment. is required to sign the assessment certifying the accuracy of that portion of that assessment. During a review of the facility's P&P titled, Charting and Documentation reviewed 1/29/26 indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehensive care plans were updated and revised for one of five sampled residents (Resident 1) after hospitalization. This failure had the potential to affect resident care, services and treatments. During a review of Resident 1's admission Record, dated 7/17/26 indicated, the resident was admitted to the facility on [DATE] with diagnoses including; chronic obstructive pulmonary disease (COPD - chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure) muscle weakness, abnormalities of gait and mobility, sleep apnea (chronic medical condition where a person's breathing repeatedly stops and starts during sleep), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and vascular dementia (memory and thinking problems caused by decreased blood flow to the brain). During a review of Resident 1's History and Physical (H&P) dated 7/13/26 indicated Resident 1 did not have decision make had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 7/14/26 indicated, Resident 1 had severe cognitive (thinking, remembering, reasoning and judgment processes in the brain) impairment and was dependent to requiring substantial/maximum assistance with activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Order Summary Report dated 7/12/26 indicated orders for: Apply BIPAP (A BiPAP [Bilevel Positive Airway Pressure] machine is a non-invasive ventilator used to assist breathing) during bedtime, Apply BIPAP during naps within the day and Oxygen at 1 to 2 liters/minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). as needed. During a concurrent telephone interview and record review on 7/22/26 at 10:57 am with the MDS nurse, Resident 1's care plan for altered respiratory status revised 5/1/26 was reviewed. The MDS nurse verified care plan had not been revised after the resident's recent hospitalization (7/10/26-7/12/26) and stated it should have been to capture the new interventions for the BiPAP that were ordered. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered reviewed 1/29/26 indicated, The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The interdisciplinary team reviews and updates the care plan. when there has been a significant change in the resident's condition. when the resident has been readmitted to the facility from the hospital stay.		