STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Monica Rehabilitation Center	1338 20th Street Santa Monica, CA 90404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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, for five of five sampled residents (Residents 2, 10, 11, 17 and 47), the facility failed to:Develop/initiate and/or implement a comprehensive and individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the residents' needs for Residents 10 11, and Resident 47 in accordance with the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered with review date of 1/29/026.1. Resident 2 was on antibiotics (medication used to treat infection/s).2. Resident 10 had a diagnosis of dementia (a progressive state of decline in mental abilities).3. Resident 11 had a diagnosis of post-traumatic stress disorder (PTSD -a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).4. Resident 17 had multiple and consecutive refusals to participate in the Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) program in accordance with physician's orders date dated 4/6/2026, Resident 17 had mobility (the action of walking) concerns.5. Resident 47 had an indwelling urinary catheter (a hollow flexible tube inserted into the bladder to drain or collect urine). These deficient practices had the potential to negatively affect the delivery of necessary care and services leading to a decline in overall physical functioning, mobility, activities of daily living (ADL, basic activities such as eating, dressing, toileting), and quality of life for Residents 10, 11, 17 and 47, and had the potential to not address and provide necessary interventions and medical needs for Resident 2. Findings: 1. A review of Resident 2's admission record (face sheet – a document containing demographic and diagnostic information indicated the facility admitted Resident 5 on 7/02/2015 and re-admitted the resident to the facility on 3/17/2026, had the following diagnoses: hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), abnormalities of the gait (a person's manner of walking) and mobility (ability to move freely and easily), obstructive and reflux uropathy (Obstructive and reflux uropathy – a urinary tract condition that occurs when urine cannot drain properly causing the urine to back up into the kidneys), and unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 3/22/2026, indicated Resident 2 had intact cognition (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS also indicated, Resident 2 was dependent on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility staff with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting and self-care. During a review of Resident 2's history and physical (H&P – a physician's complete patient examination) dated 1/23/2026 indicated, Resident 2 can make needs known but cannot make medical decisions. During a review of Resident 2's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) with a physician order date of 4/29/2026 indicated, Resident 2 received cephalexin 500 milligrams (mg - unit dose measurement) capsule to be taken by mouth every 12 hours at 9 AM and 9 PM for urinary tract infection (UTI - an infection of the bladder or urethra [a tube where urine passes]) for 10 days, administered from 4/30/2026 through 5/09/2026. During a review of Resident 2's care plan (CP, a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), indicated there was no CP created for cephalexin use to treat Resident 2's UTI. During a review of Resident 2's Physician Vital Progress Notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 4/23/2026 indicated, Resident 2 failed voiding (the ability to pass urine voluntarily) trial attempt after a urinary catheter [a thin, flexible tube inserted into the bladder to drain urine when you cannot urinate naturally]) was removed. Resident 2 had urinary retention (when the bladder does not empty completely or does not empty at all). Resident 2's urinary catheter remained in place. The Progress Notes indicated Resident 2 was able to make needs known but could not make medical decisions. During a concurrent interview and record review on 5/21/2026 at 3:09 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 2 was on cephalexin and that there was no patient-centered care plan for use of cephalexin. LVN 4 confirmed Resident 2 had an order for cephalexin and was administered for 10 days from 4/29/2026 through 5/09/2026. LVN 4 also indicated that a CP for cephalexin use was needed to help nurses know what nursing interventions are to be provided to Resident 2. During a concurrent interview and record review on 5/21/2026 at 3:19 PM with the Director of Nursing (DON), DON stated Resident 2 did not have a CP for cephalexin. DON confirmed and stated that Resident 2 had an order for antibiotic cephalexin which was administered to the resident for 10 days from 4/29/2026 through 5/09/2026. DON also stated a CP is time sensitive and keeps licensed nurses knowledgeable on what problems to focus on for the resident. DON continued to state that not creating a CP for Resident 2's use of antibiotics, the licensed nurses would not be able to address and provide interventions for Resident 2's medical needs. A review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plans, Comprehensive Person-Centered, with a revision date of 1/29/2026, indicated, care plans are revised as information about the residents and residents' conditions change. 2. A review of Resident 10's admission Record indicated the facility admitted Resident 10 on 8/27/2025 and readmitted Resident 10 on 4/27/2026 with diagnoses including dementia, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN - high blood pressure). A review of Resident 10's H&P dated 4/30/2026 indicated Resident 10 is having memory loss and that he lacks the capacity to make medical decisions. A review of Resident 10's MDS dated [DATE], indicated Resident 10 is cognitively impaired. The MDS indicated Resident 10 required substantial/maximal assistance from staff with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review, on 5/22/2026, at 1:29 P.M., with the Assistant Director of Nursing (ADON), Resident 10's medical chart and care plans (CP) were reviewed. The ADON stated that Resident 10 had a diagnosis of dementia, however, Resident 10's care plans did not include the diagnosis dementia. The ADON stated that Resident 10 did not have a CP for dementia which is needed for Resident 10's safety and individualized care. The ADON stated that lack of CP for dementia could lead to worsening of Resident 10's dementia and possible abuse. During an interview, on 5/22/2026, at 5:01 P.M., with the Director of Nursing (DON), the DON stated that a dementia care plan is needed to assist with Resident 10's care. The DON stated that if a resident with dementia does not have a CP, the resident may not be given the proper care which may lead to residents further decline emotionally and physically. 3. A review of Resident 11's admission Record indicated the facility admitted Resident 11 on 1/10/2025 and readmitted Resident 11 on 2/17/2026 with diagnoses including dementia, bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety (a feeling of fear, dread, or unease causing worry about what might happen in the future). A review of Resident 11's H&P dated 5/11/2025, indicated under assessment that Resident 11 had PTSD. A review of Resident 11's MDS dated [DATE], indicated Resident 11 was cognitively intact. The MDS indicated Resident 11 staff assistance with ADL (tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. During an interview, on 5/18/2026, at 12:26 P.M., with Resident 11, Resident 11 stated that she has a history of PTSD following an assault a while back. During a concurrent interview and record review, on 5/22/2026, at 9:24 A.M., with Registered nurse supervisor (RNS) 2, Resident11's medical chart was reviewed. RNS 2 stated that Resident 11 H&P dated 5/11/2025 indicated that Resident 11 had PTSD. RNS 1 stated that Resident 11's CP needed to include PTSD diagnosis however, Resident 11 did not have a CP for PTSD. RNS 1 stated that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsure if anything was done. During a concurrent interview and record review at 11:03 am with the Minimum Data Set Nurse (MDSN), Resident 17's RNA flowsheet for April 2026 and the MDS dated [DATE] were reviewed. The MDSN stated staff develops comprehensive and individualized care plans for each resident to identify areas of concern and create goals and interventions to address the concerns. The MDSN stated that the interdisciplinary Team (IDT, is a collaborative groups of professionals from different medical and social specialties who work together to achieve shared patient centered goals) meetings are conducted upon admission, quarterly, and as needed if any area of concern is identified requiring a formal, interdisciplinary discussion. The MDSN reviewed Resident 17's RNA flowsheet for April 2026 and confirmed Resident 17 refused RNA multiple, consecutive times. The MDSN stated and confirmed that the facility did not develop a comprehensive care plan or conduct an IDT meeting to address Resident 17's continuous RNA refusals but should have. The MDSN stated and confirmed that Resident 17 was dependent for mobility. The MDSN stated Resident 17 rarely got out of bed and was at risk for functional decline. The MDSN stated staff should have developed a care plan to address Resident 17's mobility concerns and risk for functional decline but did not. The MDSN stated care plan development and IDT conferences were important to ensure the root cause of the issue was properly investigated and appropriate interventions were implemented to address the areas of concern. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated comprehensive care plans are used as a guide to ensure the appropriate care and services are provided to each resident. The DON stated care plans are used to ensure problem areas were accurately identified, goals were created, and interventions were implemented to address a resident's areas of concern. The DON stated it is important that care plans are accurate to ensure the staff are aware of the residents' status and the appropriate care and services provided. The DON stated resident refusals to participate in RNA should be documented in the resident's clinical record, care planned for, reported to the physician, nursing, and the resident's family, and addressed in an IDT meeting to ensure all staff are aware of the resident's refusal and the interventions in place to address the areas of concern. The DON stated any resident who is identified as having mobility deficits should have an individualized care plan with goals and interventions to address those areas of concern to maintain the resident's mobility and prevent functional decline. The DON stated care plan development and IDT conferences were important to ensure reasons for refusal were properly investigated and appropriate goals and interventions were implemented to prevent functional decline. The DON stated lack of care planning and IDTs for resident(s) identified areas of concern can result in functional decline, missed interventions, and delays in necessary care and services. During a review of the facility's policy and procedures (P&P) titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, revised 1/21/2026, the P&P indicated that, if a resident/representative refuses care or treatment, an appropriate member of the IDT would meet with the resident/representative to determine why the resident was requesting, refusing, or discontinuing care or treatment, try to address their concerns and discuss alternative options, and discuss potential outcomes or consequences of the decision. During a review of the facility's P&P titled, Care Plans Comprehensive Person-Centered, revised 1/29/2026, the P&P indicated that, a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The IDT, in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. A comprehensive, person-centered care plan described (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of two sampled residents (Resident 45 and Resident 48) when the facility failed to:For Resident 45:1. The facility failed to ensure that facility staff administered oxygen to Resident 45 when the oxygen saturation (O2 Sat- a measurement of how much oxygen the blood is carrying as a percentage) level was less than 92 percent (% - unit of measurement) per physician order. This deficient practice resulted in Resident 45 receiving more oxygen than required and can negatively impact the resident's well-being with the potential for hospitalization. For Resident 48:2. The facility failed to label a clear bag in which the Bilevel Positive Airway Pressure (BiPAP- a non-invasive gentle breathing automatic air pump/machine connected by a tube to a face mask which pushes air into the lungs to keep the airways open, and changes the air pressure depending on whether breathing in or out) machine and tubing/mask for Resident 48 according to the facility's policy and procedures (P&P), titled CPAP/BiPAP Support reviewed 1/26/2026. This deficient practice had the potential for the residents to develop respiratory infection and hospitalization. Findings: 1. A review of Resident 45's admission Record indicated the facility originally admitted the resident on 12/5/2024 and was readmitted the resident on 2/3/2026, with diagnoses of, but not limited to, respiratory failure and chronic obstructive pulmonary disease (COPD-a chronic (ongoing) lung disease causing difficulty in breathing), muscle weakness and dementia (a progressive state of decline in mental abilities). A review of Resident 45's History and Physical (H&P), dated 1/24/2026, indicated the resident had fluctuating capacity to understand and make decisions. A review of Resident 45's Emphysema (a progressive lung disease that damages the tiny air sacs (alveoli) in the lungs, destroying their elasticity and making it difficult to exhale/breath out)/COPD care plan, initiated 9/1/2025, indicated Resident 45 to receive oxygen as ordered. A review of Resident 45's Order Summary Report indicated on 2/3/2026 the physician ordered the facility staff to: Monitor Resident 45's oxygen saturation (amount of oxygen in the blood) every shift and notify the physician if the level was below 92% Administer oxygen inhalation at two (2) liters per minute via nasal cannula (NC) as needed to keep oxygen saturation level greater than 92% every shift for COPD monitoring. A review of Resident 45's Quarterly Minimum Data Set (MDS - a resident assessment tool) dated 2/20/2026, indicated the resident had severely impaired cognition (the mental ability to make decisions of daily living). The MDS also indicated Resident 45 required substantial to total assistance from staff with bed mobility, dressing, toileting, personal hygiene, and bathing. A review of Resident 45 medication administration record (MAR) for May 2026, indicated for all shifts from 5/1/2026 to 5/20/2026, Resident 45's oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) was no lower than 97%. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/19/2026 at 8:46 AM, inside Resident 45's room, Resident 45 was observed receiving oxygen lying in bed. During a concurrent interview and observation on 5/20/2026 at 10:11 AM, Certified Nursing Assistant (CNA) 1 stated Resident 45 wears oxygen at all times. CNA 1 stated the resident receives breathing treatment when needed. During a concurrent interview and record review on 5/20/2026 at 12:36 PM with Registered Nurse Supervisor (RNS) 2, Resident 45's physician orders and May 2026 medication administration record (MAR) was reviewed. RNS 2 stated that Resident 45 uses oxygen at all times. RNS further stated Resident 45's physician order for oxygen is as needed and the nursing staff should only administer oxygen when the oxygen saturation was less than 92%. RNS 2 stated Resident 45 should not be receiving oxygen since the resident's oxygenation level has never been below 97%. RNS further stated receiving oxygen when not appropriate can make the resident more confused especially due to her diagnosis of COPD. During an interview on 5/21/2026 at 4:38 PM, the Director of Nursing (DON) stated based on the physician order, Resident 45 should only receive oxygen when the oxygen saturation was below 92%. The DON further stated a possible outcome of over oxygenation was an increase of Resident 45's carbon dioxide level. A review of the facility's policy and procedures titled, Oxygen Administration, dated 1/26/2026, indicated, The purpose is to provide guidelines for safe oxygen administration. The first step of preparation indicated to verify that there is a physician's order for the procedure and to review the physician's orders or facility protocol for oxygen administration. The policies and procedures indicated to observe the resident upon set-up and periodically thereafter to be sure oxygen is being tolerated. 2. A review of Resident 48's admission Record indicated the facility admitted Resident 48 on 6/13/2025 and readmitted Resident 48 on 4/7/2026 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), atrial fibrillation (Afib - heart condition causing an irregular, often rapid heart rate), and diabetes (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 48's care plan initiated 2/24/2026 indicated, Focus: the resident is at risk for altered respiratory status . on BiPAP at bedtime. Goal: the resident will be free from infection through the review date. Interventions: BiPAP machine non disposable tubing car: Wash tubing in warm soapy water, rinse and let air dry. A review of the physician's orders dated 4/13/2026 indicated, BiPAP machine non disposable tubing care; wash tubing in warm soapy water, rinse and let air dry every Monday. A review of Resident 48's MDS dated [DATE], indicated Resident 48 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 48 was dependent on staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. A review of the physician's orders dated 4/18/2026 indicated, BiPAP machine tubing care; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disposable, change tubing weekly every Monday. During a concurrent observation and interview on 5/19/2026, at 8:12 A.M., with Resident 48, in Resident 48's room, a BiPAP machine on top of the nightstand and the mask/part of the tubing were in Resident 48's nightstand top drawer stored in a Ziplock bag that was not labeled with the resident's name or dated. Resident 48 stated she has a breathing machine that she uses at night however, Resident 48 stated she did not know when the facility cleaned/washed it. During a concurrent observation and interview on 5/20/2026, at 2:13 P.M., with Licensed Vocations Nurse 4 (LVN4), in Resident 48's room, a BiPAP machine mask/part of the tubing were in Resident 48's nightstand top drawer stored in a Ziplock bag that was not labeled with the resident's name or dated. LVN 4 stated that resident 48's has a BiPAP machine which she uses at night, LVN 4 stated that charge nurses are responsible for washing the BiPAP mask/tubing and they do so every Monday. LVN 4 stated that once the mask/tubing are cleaned, the facility staff need to place the mask in a bag labeled with the resident's name and date it was cleaned. LVN 4 stated that Resident 48's BiPAP machine was on the nightstand while the mask/tubing were in the top drawer on the nightstand. LVN 4 stated the mask/tubing in the nightstand top drawer was in a mask bag that was not labeled with the resident's name or date. LVN 4 states the mask bag needed to be labeled with the resident's name and the date it was changed. LVN 4 stated the BiPAP mask/tubing is cleaned to prevent bacteria or respiratory infections. LVN 4 stated if the mask cleaned or the bag is not changed, it may lead to respiratory infections such as pneumonia (an infection/inflammation in the lungs) and possibly hospitalization. During an interview on 5/22/2026, at 4:52 P.M., with the Director of Nursing (DON), the DON stated that BiPAP mask/tubing need to be changed/cleaned weekly for infection control. The DON stated that the mask/tubing of the BiPAP machine needs to be placed in a clean bag that is dated and signed for oncoming staff to know when it was cleaned. The DON stated that if the bag is not dated/labeled, facility staff may continuously use it without cleaning it which may lead to the resident having a respiratory infection, possible skin irritation/infection due to a dirty mask. A review of the Facility P&P titled CPAP/BiPAP Support, reviewed 1/26/2026, indicated that: Purpose 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2. To improve arterial oxygenation (Pa02) in resident with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. 3. To promote resident comfort and safety. General Guidelines for Cleaning. 4. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recomi.11ended. Rinse with warm water and allow it to air dry (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between uses. A review of the Facility P&P titled Infection Control, reviewed 1/26/2026, indicated, Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation 1 . This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payer source. 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions; d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure 35 out of 132 Soft-and-Bite-Sized (SB6) texture modified meal lunch trays were prepared according to the International Dysphagia Diet Standardization Initiative (IDDSI: standardized framework [0-7 levels] that uses consistent terminology, colors, and testing methods to define texture-modified foods and thickened liquids for people with swallowing difficulties [dysphagia]. Level 6-designed for individuals with mild dysphagia or chewing difficulties. Requiring foods to be soft, tender, and moist, with pieces no larger than 15 millimeters (mm-unit of measurement) x 15 mm [about the standard with of a fork]) according to the IDDSI guidelines, dated January 2019, and facility's document titled Diet Descriptions This deficiency had the potential to result in decreased intake related to inconsistent and large size meats, meal dissatisfaction and increased choking and aspiration (inhalation of food or liquids into the lungs) food risk for 35 residents requiring Soft-and-Bite-Sized texture meals. Findings: During an observation of the tray line service for lunch, interview, and record review in the kitchen on 05/18/26 at 12:11 PM, a meal tray requiring SB6 texture was observed containing several irregularly shaped strands and chunks of Braised Pork Shoulder. During a concurrent observation of the SB7 texture tray and interview with Registered Dietitian (RD), the RD stated that the recipe for SB6 texture trays contained instructions to prepare appropriate textures. The RD retrieved a printed copy of the recipe for Braised Pork Shoulder from a binder located inside the Dietary Supervisor's (DS) office. A review of the recipe of braised pork shoulder did not contain instructions on how to prepare SB6 texture. The RD stated that kitchen staff can obtain the recipe by logging on to the menu program on the computer located in the DS's office. A review of the facility's SB6 Braised Pork Shoulder recipe retrieved from the facility menu software, the menu specified that the food processor knife setting to produce food pieces no larger than 15 mm x 15 mm in size. During an observation of a sample SB6 meal tray on 05/18/26 at 12:55 PM, the sample SB6 meal tray was observed to have several pieces of pork larger than 15 mm x 15 mm. During an observation and concurrent interview with the DS on 05/20/26 at 10:50 AM, the DS observed the SB6 test tray of Braised Pork Shoulder. The DS stated that the SB6 test tray could put residents at risk for choking. During a concurrent observation of the SB6 test tray and interview with the Speech-Language Pathologist (SLP: healthcare professional who assesses, diagnoses, and treats communication, cognitive [mental]-communication, and swallowing disorders) on 5/21/26 at 12:30 PM, the SLP observed the SB6 test tray. The SLP stated and agreed that the chunks of Braised Pork Shoulder were not aligned with the specifications of the SB6 dietary guidelines and may pose a risk of choking for residents with dysphagia (the medical term for difficulty or discomfort in swallowing). During a review of the Diet Manual document titled Diet Descriptions, the diet descriptions indicated that texture modified diets are prescribed by a Physician or SLP for residents that has difficulty chewing and/or swallowing. The diet descriptions indicated that SB6 texture is used in the dietary management of dysphagia with food texture described as soft, tender, and moist where the food was to be no greater than 15 mm x 15 mm pieces. During a review of the IDDSI guideline website titled IDDSI, dated January 2019, the IDSSI guideline indicated that Level 6 Soft & Bite Sized foods were to be no bigger than 15mm x 15mm about the standard width of a fork. The guideline indicated the bite sized pieces have to be easily mashed/broken down with the pressure of a fork and safe to swallow.

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	555808	A. Building B. Wing	05/22/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and distribution practices, by failing to:Ensure kitchen staff practiced sanitary glove use during meal preparation.Prevent the contamination of food contact surfaces from cloths and rags.Ensure the kitchen's can opener blade was kept clean.Ensure the floors under kitchen equipment were not heavily soiled with debris.These deficient practices had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in 132 of 133 residents who received food from the facility kitchen.Findings:1. During an observation of the facility's kitchen on 05/18/26 at 12:10 PM, [NAME] 1 was observed assembling meals during lunch service with gloved hands and proceeded to open a steam oven and reach into a pan to pick up a vegetarian patty with his gloved hand, plated the vegetable patty, and continued to assemble lunch meals. During continued observation, a second vegetarian meal was called for, Cook1 opened the steam oven, reached into a pan wearing the same gloves and picked up one patty, plated the vegetable patty, and proceeded to assemble lunch meals. During continued observation while wearing the same gloves, a tray ticket was called for Soft-and-Bite-sized (SB6) texture meatloaf, after which [NAME] 1 plated a slice of meatloaf using a spatula, then proceeded to separate the meatloaf into smaller pieces using his thumb and index finger. During continued observation while wearing the same gloves, a tray ticket called for SB6 chicken breast, after which [NAME] 1 picked up a piece of cooked chicken breast from a pan on the steam table with his gloved hands and proceeded to separate the chicken meat with his gloved hands on top of the wooden countertop section of the steam table where meals were served. During an interview with the Dietary Supervisor (DS) on 05/21/26 at 11:30 AM, the DS stated that the glove policy was not followed and that [NAME] 1's food handling was a risk for cross-contamination. During a review of the Facility's policy and procedures (P&P) titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices dated 1/29/2026, the policy indicated that gloves were considered single-use items and had to be discarded after completing the task for which they were used. The policy indicated that food service employees were trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. During a review of the 2022 FDA Food Code section 3-304.15, the FDA food code indicated that single-use gloves were to be used for only one task, used for no other purpose, and discarded when soiled, or when interruptions occurred in the operation. During a document review of the 2022 FDA Food Code, Annex 3 section 3-304.11 the FDA food code indicated that pathogens could be transferred to food from utensils that have been stored on surfaces which had not been cleaned and sanitized. The FDA food code defined gloves as a utensil and therefore gloves had to meet the applicable requirements related to utensil construction, cleaning, and storage. 2. During an observation in the facility's kitchen on 05/18/26 at 7:49 AM, a wet, pink-colored cloth, with visible remnants of food debris, was crumpled and left unattended on a food preparation counter next to a sink where meat was being thawed. During an observation in the facility's kitchen on 05/18/26 at 8:05 AM, three bundles of wet, pink-colored cloths were left unattended across the length of a wooden countertop section of the steam table where meals were served. During an observation in the facility's kitchen on 05/18/26 at 9:36 AM, a wet, pink-colored cloth was left hanging over the edge of the food preparation counter, where a drawer filled with clean kitchen utensils was ajar immediately below the cloth. During an observation in the facility's kitchen on 05/18/26 at 9:40 AM, a bundle of three wet, pink-colored cloths were left unattended in a pile on the wooden countertop section of the steam table where meals were served. During an observation in the facility's kitchen on 05/18/26 10:10 AM, a cart was placed near the food preparation counter containing a metal pan inside of which was one whole, uncut honeydew melon and a wet, pink-colored cloth. Dietary Aide 1 (DA1) removed the rag and the melon from the pan, proceeded to peel and dice (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that melon, along with multiple other melons, and placed the diced product into the same metal pan. During an observation in the facility's kitchen on 05/20/26 at 9:25 AM, a green towel that appeared to be used and moist was left unattended on a wire-rack where washed kitchen serving ware were stored, making contact with beverage pitchers. During a concurrent observation, on the rack below a wet, pink-colored cloth was observed bundled and left making contact with a stack of washed ceramic bowls used to serve residents in the facility. During an interview with the Dietary Supervisor (DS) on 05/21/26 at 11:30 AM, the DS stated that kitchen staff were supposed to keep kitchen rags and towels submerged in sanitizer solution, which was kept in dedicated, red-colored buckets. The DS stated that kitchen rags left on food-contact surfaces in the kitchen posed a risk for contamination of foods which put facility residents at risk for foodborne illnesses. During a review of the 2022 FDA Food Code section 3-304.14(B), the FDA Food Code section indicated that cloths in-use for wiping counters and other equipment surfaces had to be held between uses in chemical sanitizer. The FDA Food Code 2022 indicated in Annex 3 section 3-304.14 that soiled wiping cloths, especially when moist, could become breeding grounds for pathogens that could be transferred to food. 3. During an observation in the facility's kitchen on 05/18/26 at 10:09 AM, the manual (hand operated) can opener blade had built-up debris on the tip, edge, and face of the blade. Dietary Aide 1 (DA1) was observed using the can opener to open several cans in preparation for lunch service. During an interview with the Dietary Supervisor (DS) on 05/21/26 at 11:30 AM, the DS stated that kitchen staff cleaned the can opener blade every other day on routine. The DS observed the condition of the can opener blade and stated that the blade did not appear to have been cleaned routinely. The DS stated the use of the blade was a risk for contamination and a risk for foodborne illness to residents. During a review of the Weekly Cleaning Schedule provided by the DS dated May 2026, the can opener blade was not included in the weekly cleaning schedule. During a review of the Monthly Cleaning Schedule provided by DS dated May 2026, the can opener blade was not included in the monthly cleaning schedule During a document review of the 2022 FDA Food Code section 4-204.19, the FDA Food Code section indicated that cutting or piercing surfaces of a can opener that directly contacted food in the container being opened had to be protected from contamination. During a document review of the 2022 FDA Food Code Annex 3 section 4-501.11, the FDA Food Code section indicated that the cutting or piercing parts of can openers could accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury. During a document review of the manufacturer's instructions for the can opener, the manufacturer's instructions indicate the can opener had to be cleaned daily or after each extended use. 4. During an observation in the facility's kitchen on 05/18/2026 at 9:46 AM, an uncooked ball of dough approximately 2 inches in diameter was found on the floor under the steam table where food was held and served. During continued observation a sealed single serving of apple juice was on the floor under the steam table where food was held and served. During continued observation, a chunk of light brown patty approximately 2 x 3 inches was observed on the floor between the oven and stove. During continued observation, a piece of a dark brown hamburger meat patty approximately 2 x 1 inches was on the floor under the stove along with smaller chunks and pieces of food such as a diced carrot, pieces of peas and corn. During an interview with the Dietary Supervisor (DS) on 05/21/26 at 11:30 AM, the DS stated that deep cleaning of floors was performed monthly by the maintenance department, which included the moving of equipment and appliances, and washing floors. The DS stated kitchen staff swept and mopped daily in open and accessible areas. The DS states the visible debris was a vector (host) for rodents and other pests which was an unsanitary condition for a kitchen. During an interview with the Maintenance Supervisor (MS) on 5/21/26 at 12:40 PM, the MS stated that deep cleaning occurred near the end of each month, including moving equipment and pressure washing floors and using a degreaser solution. The MS was unable to produce logs, policies, or documentation to support the statement. Upon observation of findings of debris, the MS stated that the debris was a risk for breeding pests. During a document review of the 2022 FDA Food Code section 6-501.12, the Food Code indicated that physical facilities (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had to be cleaned as often as necessary to keep them clean. The Food Code indicated in Annex 3 section 6-501.12 that cleaning of the physical facilities was an important measure in ensuring the protection and sanitary preparation of food and that a regular cleaning schedule had to be established and followed to maintain the facility in a clean and sanitary manner.

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	555808	A. Building B. Wing	05/22/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of one sampled resident (Resident 63) was wearing an identification (ID) armband (a resident identification system used to help facility personnel provide medical and nursing care) according to the facility's policy and procedures titled, Resident Identification System, dated 1/9/2026. This failure had the potential to result in physical and psychosocial harm to the resident. Findings: During a review of Resident 63's admission record, dated 6/4/2025, the admission record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses not limited to dementia (a progressive state of decline in mental abilities), psychotic disturbance (a mental state where a person loses touch with reality), hypertension (high blood pressure), and anxiety (a feeling of fear of what might happen next). During a review of Resident 122's history and physical (H&P- a doctor's thorough medical report), dated 6/6/2025, the H&P indicated the resident did not know the month or the year and was not aware of the current situation. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 63 had severe cognitive (the mental ability to make decisions of daily living) impairment. During an observation on 5/18/2026 at 8:45 A.M. in Resident 63's room, Resident 63 was not wearing an identification (ID) armband. During an interview on 5/20/2026 at 10:35 A.M. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 63 can remove his own ID armband. LVN 1 stated if a resident does not wear an ID armband, can cause harm to the resident due to mistaken identity or medication error. During an interview on 5/20/2026 at 10:48 A.M. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated that if a resident does not wear an ID armband, can result in the resident to receive wrong medication or wrong therapy services. During an interview on 5/21/2026 at 12:40 P.M. with the Director of Nursing (DON), the DON stated if a resident does not wear an ID armband, the staff will not be able to identify the resident. The DON stated if a resident is not correctly identified, the resident can receive the wrong medication or services. During a review of the facility's policy and procedures (P&P) titled, Resident Rights, dated 6/2/2025, the P&P indicated, The resident has a right to communication with and have access to people and services, both inside and outside the facility. During a review of the facility's P&P titled, Resident Identification System, dated 1/9/2026, the P&P indicated that the facility has a wristband identification system to help assure medication and treatments are administered to the right resident.

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	555808	A. Building B. Wing	05/22/2026

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review the facility failed to maintain dignity (providing care that respects a resident's self-esteem, identity, and personal choices) and respect for one of one sampled resident (Resident 80) as per the facility's policy and procedure (P&P) tiled Dignity revised on1/29/2026, when Certified Nursing Assistant (CNA) 2 stood over Resident 80 when feeding the resident. This failure had the potential to violate Resident 80's right to personal dignity, and respect, and could negatively affect Resident 80's psychosocial well-being and have impact on Resident 80's self-esteem (sense of personal worth and value).Findings: During a review of Resident 80's admission Record, the admission Record indicated the facility admitted Resident 80 on 11/27/2024 and readmitted Resident 80 on 10/27/2026 with diagnoses including gastro enteritis reflux disease (GERD - chronic acid reflux caused by the muscle between the stomach and food pipe doesn't close properly, letting harsh stomach acid splash upward), traumatic brain injury (TBI - a disruption in normal brain function caused by an external force), and anxiety (a feeling of fear, dread, or unease causing worry about what might happen in the future). During a review of Resident 80's Minimum Data Set (MDS - resident assessment tool) dated 2/27/2026, the MDS indicated Resident 80 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 80 required setup/clean up to dependence on assistance from staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. During an observation on 5/19/2026, at 8:02 A.M., in Resident 80's room, CNA 2 was seen standing over Resident 80 while putting a spoon on food into her mouth. During an interview on 5/19/2026, at 8:02 A.M., with CNA 2, CNA 2 stated that she needed to be seated when helping Resident 80 to eat per facility policy and for the resident's dignity. During an interview on 5/22/2026, at 5:01 P.M., with the Director of Nursing (DON), the DON stated that when assisting a resident with eating facility staff were expected to be sitting during the process for the resident's dignity. The DON stated that if staff were standing while assisting residents with eating, the residents could feel belittled. During a review of the Facility's P&P titled Dignity, revised 1/29/2026, the P&P indicated: Policy StatementEach resident shall be cared for in a manner that promotes and enhances his or her sense of well?being, level of satisfaction with life, and feelings of self-worth and self-esteem.1.Residents are treated with dignity and respect at all times.2. The facility 'culture supports dignity and respect for 'residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.3. Individual needs and preferences. of the resident are identified through the assessment process.e. provided with a dignified dining experience.

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	555808	A. Building B. Wing	05/22/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call light was within reach for two of two sampled residents (Resident 110 and Resident 122). This failure practice resulted in Resident 122 feeling frustrated and the potential to not meet the needs of the resident and had the potential for Resident 110 to not communicate needs to the staff, lead to poor outcomes and hospitalization. Findings: 1. A review of Resident 110's admission record indicated the facility admitted Resident 110 on 01/21/2025 with diagnoses that included atrial fibrillation (irregular heartbeat), anxiety disorder (excessive, persistent, and disproportionate fear or worry), hypertension (abnormally high blood pressure), dysphagia (difficulty or discomfort in swallowing) and schizophrenia (brain disorder that affects a person's ability to interpret reality characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions,). A review of Resident 110's Minimum Data Set (MDS - a resident assessment tool) dated 04/17/2026, indicated Resident 110 had severe cognitive impairment (The mental ability to make decisions of daily living), was dependent for eating and toileting, required partial/moderate assistance with oral hygiene and upper body dressing, Resident 110 required substantial maximal assistance with shower/bathes, lower body dressing, putting off/taking off footwear and, personal hygiene. During an initial tour on 5/18/26 at 11:07 am Resident 110's call light was observed to be clipped on to Resident 27's (Resident 110's roommate's) bed sheet. Resident 27 had 2 functional call lights on her bed. One (1) call light belonged to Resident 110 and the other call light was for Resident 27. During an interview on 5/18/2026 Licensed Vocational Nurse (LVN) 2 refused to answer when asked why Resident 110's call light was attached to Resident 27's bed. LVN2 was observed removing Resident 110's call light from Resident 27's bed, sanitizing the call light and handing it (call light) to Resident 110. During an interview with the Director of Nursing (DON) on 5/21/2026 at 4:20 am, DON stated call light response is the responsibility of every staff. DON stated call lights must be accessible to all residents to communicate their needs to the staff, DON stated failure to have an accessible call light could cause delay in care for assistance, could lead to poor outcomes and even unnecessary hospitalization. A review of facility policy and procedures (P&P) titled Answering the Call light dated 1/29/2026 indicated, the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed. 2. During a review of^Resident 122's admission record, dated^4/1/2026, the admission record indicated^Resident 122 was admitted to the facility on [DATE]^with diagnoses not limited to hemiplegia (the severe or complete loss of voluntary motor function on one entire side of the body) affecting the right side, encephalopathy (damage or malfunction of the brain's structure or function), muscle weakness, and chronic obstructive pulmonary disease (COPD- is a progressive group of long-term lung diseases that cause restricted airflow and make it difficult to breathe). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 122's MDS dated [DATE], the MDS indicated Resident 122 required total physical assistance with bed mobility, transfer, and toileting. During a review of Resident 122's care plan (CP) titled, ADL (Activities of daily living) self-care performance deficit, dated 4/2/2026, the CP indicated the resident is totally dependent (person who needs someone else for basic needs) on staff for personal hygiene, dressing, and oral care. The CP also indicated to encourage resident to use bell to call for assistance. During an observation on 5/18/2026 at 8:56 A.M. in Resident 122's room, the call light was hanging under off the resident's bed and out of reach of the resident. During a concurrent observation and interview on 5/20/2026 at 9:02 A.M. with Resident 122 in Resident 122's room, the Resident 1's call light was out of reach of the resident. Resident 122 stated, sometimes I am sitting wet and I want to be changed. It's frustrating that the call light is out of reach. Resident 1 stated that he felt humiliated (made to feel ashamed or embarrassed) sitting in their own urine. During a concurrent observation and interview on 5/20/2026 at 9:16 A.M. with Certified Nursing Assistant (CNA) 3 in Resident 122's room, CNA 3 observed Resident 122's call light was out of reach. CNA stated if a resident's call light was out of reach, the resident's needs would be unmet with the potential for the resident to feel frustrated and neglected. During an interview on 5/20/26 at 10:48 A.M. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated that if a resident's call light is out of reach, the resident will be unable to call for help, and the resident can feel frustrated. During an interview on 5/21/26 at 12:40 P.M. with the Director of Nursing (DON), the DON stated if a resident's call light is out of reach, the resident's needs will not be met, and the resident will be unable to call for help or assistance. The DON stated that when the call light is not within reach can cause harm to the resident if staff was unaware the resident needed help. During a review of the facility's policy and procedures (P&P) titled, Answering the Call Light, dated 1/29/2026, the P&P indicated, The facility will ensure that the call light is accessible to the resident when in bed. During a review of the facility's P&P titled, Resident Rights, dated 6/2/2025, the P&P indicated, The facility shall treat all residents with kindness, respect, and dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report changes of condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) to the physician for two of six sampled residents (Residents 17 and 126) by failing to:Report Resident 17's multiple, consecutive Restorative Nursing Aide (nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) refusals in April 2026 to the physician in accordance with the facility's Policy and Procedure (P/P) titled, Change in a Resident's Condition or Status.Report Resident 126's multiple refusals to wear a helmet when walking with a merry walker (adapted mobility aid that combines a walking frame which encircles the individual and built in seat designed for individuals with balance issues, weakness, and cognitive [mental action or process of acquiring knowledge and understanding] impairments) in accordance with physician's orders, dated 5/2/2026, and facility's P/P titled, Change in a Resident's Condition or Status. These failures resulted in Residents 17 not receiving services and interventions to improve mobility (ability to move), activities of daily living (ADLs, basic activities such as eating, dressing, toileting), and overall physical functioning and well-being and placed Resident 126 at risk for injury.Findings: 1. During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 5/23/2025 and re-admitted Resident 17 on 6/20/2025 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue), osteoarthritis (loss of protective cartilage that cushions the ends of your bones), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 17 was cognitively (The mental ability to make decisions of daily living) intact. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) for eating, substantial/maximal assistance (helper does more than half the effort) upper body dressing, and was dependent (helper does all the effort or requires the assistance of two of more helpers to complete the activity) for hygiene, bathing, lower body dressing, rolling to both sides, sit to stand, and bed to chair transfers (moving from one place to another). During a review of Resident 17's Order Summary Report, the Order Summary Report indicated a physicians order, dated 4/6/2026, for RNA to provide active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercises to Resident 17's both arms, five times a week. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/6/2026, for RNA to provide AAROM exercises to Resident 17's both legs, five times a week. During a review of Resident 17's RNA Documentation Survey Report (RNA Flowsheet, daily record of RNA services provided for each month) for April 2026, the RNA flowsheet indicated for the RNA to provide AAROM exercises to Resident 17's both arms, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 4/6/2026 to 4/10/2026, 4/14/2026 to 4/17/2026, 4/20/2026 to 4/24/2026, and 4/27/2026 to 4/30/2026. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 17's RNA Documentation Survey Report (RNA Flowsheet) for April 2026, the RNA flowsheet indicated for the RNA to provide AAROM exercises to Resident 17's both legs, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 4/6/2026 to 4/10/2026, 4/14/2026 to 4/17/2026, 4/20/2026 to 4/24/2026, and 4/28/2026 to 4/30/2026. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a concurrent observation and interview on 5/18/2026 at 12:29 pm with Resident 17, in Resident 17's room, Resident 17 was lying in bed. Resident 17 moved both shoulders, elbows, wrists, hands, hips, knees, and ankles fully. Resident 17 stated he did not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have concerns about his range of motion (ROM, full movement potential of a joint) but stated he was unable to sit, walk, or care for himself and needed Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and services) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities). During an interview on 5/20/2026 at 2:11 pm with Restorative Nursing Aide 1 (RNA 1), RNA 1 stated Resident 17 refused RNA services constantly for at least a month and was rarely seen by RNA due to continuous refusals to participate. RNA 1 stated Resident 17 refused RNA because RNA assisted Resident 17 with ROM exercises only and Resident 17 wanted to walk and get out of bed. RNA 1 stated RNA was unable to assist Resident 17 with walking or out of bed activities because the RNA order was for ROM to both arms and legs only. RNA 1 stated she reported Resident 17's constant RNA refusals to the Director of Rehabilitation (DOR), Assistant Director of Nursing (ADON), and Director of Nursing (DON) in the weekly RNA meetings multiple times but nothing was done. During an interview on 5/20/2026 at 2:45 pm with Restorative Nursing Aide (RNA) 2, RNA 2 stated Resident 17 has constantly refused to participate in RNA because the resident wanted to walk and get out of bed and did not want to participate in ROM exercises. RNA 2 stated she documented and reported Resident 17's continuous refusals to participate in RNA in the weekly RNA meetings but unsure if anything was done. During an interview on 5/21/2026 at 2:59 pm with the Director of Rehabilitation (DOR), the DOR stated he was notified by RNA 1 and RNA 2 in multiple RNA weekly meetings that Resident 17 constantly refused to participate in RNA because he wanted to walk and did not want to participate in ROM exercises. The DOR stated if a resident continuously refused RNA, the physician should be notified, and PT or OT should re-evaluate the resident to determine if the RNA program should be modified and/or if the resident required skilled therapy services. The DOR stated he was unsure if the physician was notified but should have been. The DOR stated lack of notification to the physician for Resident 17's continuous RNA refusals could result in a functional decline. During a concurrent interview and record review on 5/21/2026 at 4:55 pm with the Assistant Director of Nursing (ADON), the ADON stated a COC was considered anything residents experienced that was different from his or her baseline. The ADON stated multiple, consecutive RNA refusals was a COC and must be immediately reported to the charge nurse and discussed in the weekly RNA meetings. The ADON stated if a resident refused RNA services three times consecutively, a licensed nurse must initiate a COC, re-assess the resident, notify the physician, and implement any recommended interventions. The ADON reviewed Resident 17's RNA Flowsheet for April 2026. The ADON stated RR on the RNA Flowsheets indicated Resident 17 refused RNA services that day. The ADON confirmed Resident 17 refused RNA services for AAROM to both legs 17 times in April 2026. The ADON confirmed Resident 17 refused RNA services for AAROM to both arms 18 times in April 2026. The ADON stated staff did not notify the physician of Resident 17's continuous RNA refusals despite knowledge and discussion of Resident 17's multiple refusals in the weekly RNA meetings but should have to ensure Resident 17 received the appropriate services and did not experience a functional decline. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated staff must notify the physician if a resident refused RNA services three or more times because it was considered a COC which meant any occurrence that differed from a resident's baseline. The DON stated once staff identified a resident had a COC, a licensed nurse created a COC Evaluation, notified the physician, notified the resident's family or responsible party, implemented interventions, updated the comprehensive care plan, and monitored the resident to ensure effectiveness. The DON stated the physician should have been notified, the reason for refusal should have been investigated, action should have been implemented once RNA discussed the multiple refusals during the routine RNA meetings, and Rehab should have been consulted for re-assessment but was not. The DON stated Resident 17 could potentially have a functional decline if the physician was not notified and interventions to maintain or improve mobility were not implemented. 2. During a review of Resident 126's admission Record, the admission Record indicated (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility originally admitted Resident 126 on 2/7/2025 and re-admitted Resident 126 on 1/6/2026 with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), muscle weakness, and Alzheimer's disease (a type of disease that affects memory, thinking, and behavior). During a review of Resident 126's Fall Risk Assessment, dated 1/4/2026, the Fall Risk Assessment indicated Resident 126 had a history of three of more falls in the last three months and had a total score of 18, indicating Resident 126 was a high fall risk. During a review of Resident 126's Order Summary Report, the Order Summary Report indicated a physician's order, dated 5/2/2026, for Resident 126 to wear a helmet at all times when walking with the merry walker. During a review of Resident 126's MDS, dated [DATE], the MDS indicated Resident 126 had severe cognitive impairment. The MDS indicated Resident 126 was independent with eating and oral hygiene and required set-up or clean up assistance (helper sets up or cleans up) for rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance as individual completes the activity) for upper body dressing, and partial/moderate assistance (helper does less than half the effort) for sit to stand and bed to chair transfers. The MDS indicated walking was not attempted during the assessment period due to medical condition or safety concerns. During a review of Resident 126's Electronic Medication Administration Record (eMAR, digital version of a patient's medication chart that heath care providers use to track medication orders and document when medications are administered) Progress Notes for the May 2026, the eMAR Progress Notes indicated Resident 126 refused to wear a helmet when walking on the following days: 5/4/2026 (multiple times), 5/5/2026 (multiple times), 5/6/2026 to 5/9/2026, 5/12/2026 to 5/16/2026, and 5/19/2026 (removed helmet more than three times). During an observation on 5/19/2026 at 2:35 pm, in the hallway, Resident 126 was walking without a helmet with a merry walker, unattended. Resident 126 took a few steps with the merry walker, closed her eyes, put her hand on her forehead, and sat down repeatedly for a total distance of about 400 feet. During a concurrent observation, interview, and record review on 5/19/2026 at 2:48 pm with Licensed Vocational Nurse 10 (LVN 10), LVN 10 observed and confirmed Resident 126 was walking in the hallway without a helmet. LVN 10 reviewed Resident 126's physician's orders and confirmed Resident 126 was to always wear a helmet when walking. LVN 10 stated a helmet was ordered by the physician to protect Resident 126's head when walking because she was a high fall risk and had multiple falls in the past. LVN 10 stated Resident 126 constantly refused to wear the helmet despite staff encouragement and assistance. LVN 10 reviewed Resident 126's eMAR Progress Notes for May 2026 and confirmed nursing documented Resident 126 refused to wear the helmet when walking at least 12 times for the month of May and did not report Resident 126's multiple refusals to the physician. LVN 10 stated Resident 126's refusals to wear the helmet as ordered when walking should have been reported to the physician after the third refusal but was not. LVN 10 stated it was important staff notified the physician of Resident 126's constant refusal to wear the helmet when walking because it impacted Resident 126's safety and plan of care. During an observation and interview on 5/19/2026 at 3:15 pm with the Assistant Director of Nursing (ADON), the ADON observed Resident 126 walking in the hallway and confirmed Resident 126 was not wearing a helmet. The ADON stated nursing staff was aware Resident 126 had a physician's order for Resident 126 to always wear a helmet when walking but did not enforce it because Resident 126 constantly refused. The ADON stated a COC was considered anything residents experienced that was different from his or her baseline. The ADON stated Resident 126's multiple, consecutive refusals to wear a helmet when walking as ordered was a COC and must be immediately reported to the physician for possible re-assessment and changes in the plan of care. The ADON stated if Resident 126 refused to wear a helmet when walking as ordered, the physician should have been notified after the third refusal but was not. The ADON stated any licensed nurse must initiate a COC after the third refusal, re-assess the resident, investigate the reason for refusal, notify the physician, and implement any recommended interventions. The ADON stated it was important the physician was notified of Resident 126's refusal (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wear a helmet when walking as ordered to ensure the reason for refusal was investigated appropriately and any interventions or changes in the plan of care were implemented. During an interview on 5/22/2026 at 5:09 pm with the DON, the DON stated the physician ordered a helmet to protect Resident 126's head when walking because Resident 126 was a high fall risk and had multiple falls in the past. The DON stated staff must notify the physician if Resident 126 refused to wear a helmet when walking as ordered upon the third refusal because it was considered a COC which meant any occurrence that differed from a resident's baseline. The DON stated once staff identified a resident had a COC, a licensed nurse created a COC Evaluation, notified the physician, notified the resident's family or responsible party, implemented interventions, updated the comprehensive care plan, and monitored the resident to ensure effectiveness. The DON stated the physician should have been notified after Resident 126's third refusal to wear a helmet when walking as ordered, the reason for refusal should have been investigated, and action should have been implemented to ensure the facility provided the appropriate care for Resident 126. The DON stated lack of physician notification could compromise Resident 126's safety and plan of care. During a review of the facility's P/P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, revised 1/21/2026, the P/P indicated the healthcare practitioner/provider must be notified of refusal of treatment. During a review of the facility's P/P titled, Change in a Resident's Condition or Status, revised 1/29/2026, the P/P indicated the facility would promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The P/P indicated the nurse would notify the resident's attending physician or physician on call when there had been refusal or treatment or medications two or more consecutive times.

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	555808	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to protect residents' right to privacy when computer screens were left open and unattended displaying the residents' personal and medical information on the computer screens for three of the three residents (Residents 46, 81, and 105) according to the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Resident Rights with a revision date of 1/29/2026, and the facility's P&P titled Confidentiality of Information and Personal Privacy with a revision date of 1/29/2026 This deficient practice had the potential to result in unauthorized person to view personal and medical information for Residents 46, 81, and 105. Findings: During a concurrent observation and interview on 5/19/2026 at 10:01 AM, laptop computer was observed sitting on top of a medication cart (a mobile workstation used by nurses to securely store, organize, and administer daily medications to residents) with computer screen open and unattended. The screen displayed Resident 81's patient information such as full name, room number, date of birth , code status (dictates the life-saving medical interventions a resident will-or will not-receive if their heart stops or they stop breathing), phone number, and vital signs. One minute after LVN 6 was found, LVN 6 was asked to read and confirmed that the name on the top right corner of the screen was LVN 6's name. LVN 6 stated LVN 6 did not leave Resident 81's information on the computer screen open and unattended. LVN 6 also stated no one else has LVN 6's password to open patient information. LVN 6 was asked the potential harm may come to Resident 81 when Resident 81's personal and medical information was not kept private and confidential, LVN 6 stated somebody may come back and use [Resident 81's] information, fraudulently use the information, trauma, anxiety, and becoming hysterical. During a concurrent observation and interview on 5/19/2026 at 10:34 AM in the hallway, a laptop computer was observed sitting on top of a medication cart with computer screen open and unattended. The screen displayed Resident 46's patient information such as full name, room number, date of birth , code status (dictates the life-saving medical interventions a resident will-or will not-receive if their heart stops or they stop breathing), phone number, and vital signs. Licensed vocational nurse (LVN) 7 was nowhere to be seen and two staff did not know where LVN 7 was. After a few seconds, LVN 7 was observed coming from a resident's room. LVN 7 stated and confirmed that LVN 7's name was on the top right corner of the laptop screen. LVN 7 stated, I had to leave the computer to help with another resident. LVN 7 stated that the Health Insurance Portability and Accountability Act (HIPAA - privacy rule which establishes national standards to protect individuals' medical records and other individually identifiable health information) is a privacy law so we don't expose patient information in any capacity. LVN 7 stated leaving Resident 46's patient and medical information on the computer screen open and unattended risks the resident's information to be stolen, exposing Resident 46's medical condition, personal information and to unsafe conditions. LVN 7 also stated that leaving Resident 46's medical information exposed can result in the resident feeling embarrassed, shame, upset, paranoid and depressed. During a concurrent observation and interview on 5/20/2026 at 10:21 AM, laptop computer was observed sitting on top of a medication cart with computer screen open and unattended. The screen displayed Resident 105's patient information such as full name, room number, date of birth , code status (dictates the life-saving medical interventions a resident will-or will not-receive if their heart stops or they stop breathing), phone number, and vital signs. A few seconds later, LVN 8 read and confirmed that LVN 8's was on the top right corner of the laptop screen. LVN 8 stated, I was trying to open another patient information so I left [Resident 105's] tab there so I can help the other nurses. LVN 8 stated HIPAA law protects the residents privacy, and identification. LVN 8 stated examples of violating HIPAA law include not closing totally the computer screen showing the identification of the patient, giving information to other people. LVN 8 also stated that exposing residents personal and medical information, can result in stealing [Resident 105's] information for (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	example date of birth , insurance information; [Resident 105] would feel scared, depressed, may cause financial harm and emotional harm. During an interview on 5/21/2026 at 3:26 PM, LVN 9 stated HIPAA law is when patient information must be kept safe and not shared; it's a privacy thing. LVN 9 HIPAA laws violation is not limited to, giving personal information of resident other others that are not authorized; going into a chart, paper and electronic. LVN 9 also stated the potential for violating HIPAA law includes information may be sold to others using information fraudulently; medications, if addicts know a resident is on medications they might use the resident's information to get medications. During an interview of 5/21/2026 at 3:32 PM with Director of Nursing (DON), the DON stated HIPAA law is to protect the identity of patients. DON stated examples of violate HIPAA law violation is not limited to, speaking about the patient in the hallway or somewhere where others could hear; the computer station screen must be hidden. DON stated that, when somebody can use the residents information as their own or sell it; distress emotionally and mentally. During a record review of the facility's policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Resident Rights with a revision date of 1/29/2026 indicated, federal and state laws guarantee residents privacy and confidentiality. During a record review of the facility's P&P titled Confidentiality of Information and Personal Privacy with a revision date of 1/29/2026 indicated, the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of one sample resident (Resident 126) was free from unnecessary physical restraint (a device or method used to limit a patient's movement to prevent self-harm or harm to others), by failing to ensure:1. Resident 126's left side of the bed was not pushed against a wall, and a bedside table and a Merri walker (ambulation device designed for individuals with balance, mobility, or cognitive impairments) was not placed on Resident 126's bedside table right lateral side to prevent Resident 129 from getting out of bed and ambulating (walking).2. Obtain a physician's order for the Merri walker for Resident 126. This deficient practice violated the right to be free from physical restraints and had the potential to cause significant negative implications including delirium, pressure injuries, and psychological trauma leading to compromised patient dignity, autonomy and resulting in severe physical deconditioning, reduced dignity and self esteem, and death for Resident 126. Findings: A review of Resident 126's admission record indicated the Resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (a decline in mental function-specifically memory, reasoning, and communication-severe enough to disrupt daily life), Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, cognitive skills, and the ability to carry out simple daily tasks), anxiety disorder (mental health condition characterized by excessive, persistent, and disproportionate fear or worry about everyday situations), depression (mood disorder that causes persistent, intense feelings of sadness, emptiness, and a loss of interest in activities) and failure to thrive (decline in physical, cognitive, and functional health). A review of Resident 126's Minimum Data Set (MDS-resident assessment tool), dated, 5/20/2026, indicated Resident 126's cognitive (mental ability to make decisions for daily living) was severely impaired, Resident 126 was independent with eating and oral hygiene, required/moderate assistance with toileting hygiene, shower/bathe and personal hygiene, Resident 126 required supervision touching assistance with upper body dressing, substantial maximal assistance with lower body dressing and was dependent for putting on/taking off footwear and ambulation was not attempted. During a facility tour on 5/18/2026 at 9:35am, Resident 126's bed was observed to be in the lowest position, the left lateral side of the bed was observed to be pushed on to the wall, the right lateral side of Resident 126's bed had a raised Bedside table (height adjustable overhead table designed to keep essential items within easy reach of Resident) and Merri walker (ambulation device designed for individuals with balance, mobility, or cognitive impairments) were placed directly behind each other on to the right lateral bed railing completely obstructing Resident 126's ability to get out of bed and/or sit at the edge of the bed with feet to the floor. During an interview on 518/2026 at 9:40 am, licensed vocational nurse (LVN) 1 stated the bedside table and Merri walker had been placed on Resident 126's right lateral side to prevent Resident 129 from getting out of bed and ambulating. Resident 126's roommate also indicated that if the bedside and Merri walker were moved, she (Resident 126) would get up and try to walk. During an initial interview on 5/18/2026 at 9:55 am, Director of Nursing (DON) stated the manner in which the bedside table and merry walker were placed on Resident 126's right lateral side constituted a physical restraint. DON stated Resident 129 did not have a physicians order for physical restraints. During a follow up interview on 5/21/2026 at 4:20 pm, DON stated a physician's order and justification for physical restraints must be documented to apply Restraints on a Resident, DON stated placing a restraint on a resident without a doctor's order is a violation of the Residents rights to autonomy and Residents dignity. DON stated the physical restraints could cause patient decline, cause physical injuries and harm to the Resident. A review of facility policy and procedures (P&P) titled use of Restraints dated 04/2017 indicated, Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention of falls. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted. Restraints shall only be used upon written order of a physician and after obtaining consent from the resident and/or representative.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) related to Pre -admission Screening and Resident Review (PASRR -a safety check done before someone enters a Medicaid-certified nursing home to ensure the facility can meet their specific needs, or if they would be better served in the community) was accurately documented [NAME] to the facility's policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessments, dated 1/21/2026 for two of two sampled residents (Resident 5 and Resident 127). This deficient practice had the potential to negatively affect the plan of care and delivery/provision of necessary care and services for Resident 5 and Resident 127. Findings: 1. A review of Resident 5's admission Record indicated the facility admitted Resident 5 on 9/20/2018, and readmitted resident 5 on 1/10/2026 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a serious mental health condition characterized by a persistent low mood, deep sadness, or a loss of interest in activities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). A review of Resident 5's Minimum Data Set (MDS – resident assessment tool) dated 2/25/2026, indicated Resident 5 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 5 dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. The MDS further indicated that .is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? . 0, No. A review of Resident 5's PASRR level I screening dated 4/6/2023 indicated .Re: Positive level I screening indicates a level II Mental Health Evaluation is Required. A review of Resident 5's PASRR level II screening dated 5/5/2023 indicated .Are specialized services recommended: Yes. During a concurrent interview and record review on 5/22/2026, at 3:13 P.M., with the MDS Nurse (MDSN), Resident 5's MDS assessment dated [DATE] section A, PASRR level I and Level II dated 4/6/2023 and 5/5/2023, were reviewed. The MDS Nurse stated the MDS section A indicated that Resident 5 had no mental illness, however, the PASRR level I and Level II assessments dated 4/6/2023 and 5/5/2023indicated that resident 5 was positive for mental illness, schizophrenia. The MDS nurse stated that MDS assessment is not accurate and having an inaccurate MDS assessment may lead to resident being provided with the wrong services and plan of care. The MDS nurse stated he will modify the MDS assessment section A to reflect that Yes, resident does have mental illness, schizophrenia. During an interview on 5/22/2026, at 4:47 P.M., with the Director of nursing (DON), the DON stated that MDS assessment is an overall resident assessment to determine the care plan for the resident. The DON stated that if the MDS assessment is inaccurate, then the proper care plan may not be (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided for the resident causing a risk for further decline. A review of the facility's policy and procedures (P&P), titled, Certifying Accuracy of the Resident Assessments, dated 1/21/2026, indicated, Policy Statements: Any person completing a portion of the Minimum Data Set/MOS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. Policy Interpretation and Implementation Any health care professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident that is relevant to the professionals' qualifications and knowledge. Any person who completes any portion of the MOS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MOS may have different observation periods. The Resident Assessment Coordinator is responsible for ensuring that an MOS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the Resident Assessment Coordinator, who is a registered nurse. Inquiries concerning the signing of the MOS should be referred to the Assessment Coordinator, Director of Nursing Services, or to the Administrator. 2. A review of Resident 127's admission Record indicated the facility originally admitted the resident on 2/27/2025 and re-admitted the resident on 1/24/2026 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), difficulty swallowing and cerebral infarction (also known as a stroke in which blood flow stops to part of the brain). A review of the facility's Centers of Medicare and Medicaid Services (CMS-a federal agency that administers major healthcare programs) Final Validation Reports (FVR-facility's documentation of successful MDS file submission), indicated Resident 127's Annual MDS, Assessment Reference Date (ARD-observation end date) was 3/7/2026. The CMS FVR indicated the assessment was completed late and a prior record with an ARD within 366 days of the submitted record could not be found. During a concurrent interview and record review with MDSN on 5/21/2026 at 3:12 PM Resident 127 most recent annual MDS assessment was reviewed. MDSN stated that Resident 127's MDS was completed late. MDSN stated Resident 127's annual MDS was submitted on 4/8/2026. The annual assessment was started on 3/7/2026 and should have been completed by 3/21/2026. During an interview on 5/21/2026 at 4:41 PM, the DON stated that the MDS assesses the whole being (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the resident from physical, functional care. emotional. The DON stated that MDS should be accurate to reflects the needs of the resident. should be submitted on time. A review of the facility's P&P titled, Resident Assessments, dated 1/29/2026, indicated the Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments. The P&P also indicated, OBRA (Omnibus Budget Reconciliation Act of 1987 - a federal nursing home law designed to improve the quality of care for residents and protect their rights in long-term care facilities) -Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare /in/or Medicaid certified nursing homes. OBRA assessments include: a. admission Assessment; b. Quarterly Assessment; c. Annual Assessment; d. Significant Change in Status Assessment (SCSA); e. Significant Correction to Prior Comprehensive Assessment (SCPA); f. Significant Correction to Prior Quarterly Assessment (SCQA); and g. Discharge Assessment (return anticipated and return not anticipated).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to submit the required complete information contained in the Minimum Data Set (MDS- standardized data collection tool used to assess cognitive and functional status, and care needs) for one of 27 sampled residents (Resident 4) within 14 days after discharge/expiration date ([DATE]) to the Centers for Medicare & Medicaid Services (CMS: a federal agency within the United States Department of Health and Human Services) System. This deficient practice had the potential for Resident 4's death to go unreported.Findings: During a review of Resident 4's admission record, the admission record indicated the facility re-admitted the resident on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body)^ after cerebral infarction (also known as a stroke in which blood flow stops to part of the brain). During a review of Resident 4's Discharge summary, dated [DATE] at 7:47 PM, the discharge summary indicated a certified nursing assistant (CNA [unidentified]) noticed the resident was not breathing. The summary indicated a licensed vocational nurse (LVN [unidentified]) entered the room, found the resident unresponsive and cardiopulmonary resuscitation (CPR - an emergency treatment that's done when someone's breathing or heartbeat has stopped) was started. The summary indicated paramedics arrived at the facility around 7:08PM [on [DATE]] and took over chest compressions and tried to revive Resident 4 for 20 minutes. The summary indicated paramedics announced Resident 4's time of death at 7:28PM on [DATE]. During a concurrent interview and record review on [DATE] at 3:27 PM, Resident 4's electronic health record was reviewed with the Minimum Data Sheet Nurse (MDSN). The MDSN stated Resident 4 passed away in the facility on [DATE]. The MDSN stated when a person died in the facility, the facility was required to complete a death in the facility assessment. The MDSN stated a death in the facility assessment was not started, completed or transmitted for Resident 4. The MDSN stated the assessment had to be completed within 14 days of the resident's passing which would have been by [DATE] and should have been transmitted by [DATE]. The MDSN stated the MDS should have been submitted per CMS rules so that the facility billed accurately for services provided. During an interview on [DATE] at 4:41 PM, the Director of Nursing (DON) stated the MDS assessed the whole being of the resident from physical, functional care. emotional. The DON stated the MDS had to be accurate and submitted on time to reflect the care the resident received. A review of the facility's policy and procedure (P&P) titled, Resident Assessments, dated [DATE], the P&P indicated the Resident Assessment Coordinator was responsible for ensuring that the Interdisciplinary Team conducted timely and appropriate resident assessments. The P&P indicated OBRA(Omnibus Budget Reconciliation Act of 1987 - a federal nursing home law designed to improve the quality of care for residents and protect their rights in long-term care facilities) -Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare /in/or Medicaid certified nursing homes. OBRA assessments include:a. admission Assessment;b. Quarterly Assessment;c. Annual Assessment;d. Significant Change in Status Assessment (SCSA);e. Significant Correction to Prior Comprehensive Assessment (SCPA);f. Significant Correction to Prior Quarterly Assessment (SCQA); andg. Discharge Assessment (return anticipated and return not anticipated).

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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 observation, interview, and record review, the facility failed to accurately assess and code the Minimum Data Set (MDS, a resident assessment tool) assessments for three of 11 sampled residents (Residents 47, 2, and 105) according to the facility's policy and procedures (P&P) titled, Resident Assessments, revised 1/29/202, by failing to:1. Ensure the section relating to insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood) use for Resident 47 was accurately coded.2. Ensure Section GG 0115A (assessment item that tracks Functional Limitation in Range of Motion (ROM- is how far a person can move a joint or muscle in different directions)) was coded accurately to indicate functional limitations (limited ability to move a joint [where two bones meet] that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in range of motion (ROM, full movement potential of a joint) of Resident 2's left arm. 3. Ensure Section GG 0115A and GG 0115B (captures any functional limitations in the ROM of the lower extremities, including the hip, knee, ankle, and foot) were coded accurately to indicate functional limitations in ROM of Resident 105's both arms and both legs. These deficient practices had the potential to incorrectly reflect Resident 47's plan of care and care and services received by the resident and result in delayed or missed identification of joint ROM changes, inaccurate care planning, and inadequate provision of treatments and services for Residents 2 and 105. Findings: 1. A review of Resident 47's admission Record indicated the facility admitted the resident on 4/30/2026, with diagnoses of urinary tract infection (UTI- an infection in the bladder/urinary tract), muscle weakness and fibromyalgia (a long term condition that involves widespread body pain). A review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 5/7/2026, indicated the resident's cognitive skills (the mental ability to make decisions of daily living)) were intact and was independent with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated Resident 47 received insulin injections during the last seven days or since admission if less than seven days. A record review on 5/21/2026 at 11:45 AM of Resident 47's active, discontinued and completed physician orders since the resident's admission on [DATE] indicated the resident never received insulin. A concurrent review of Resident 47's medication administration record (MAR – a log of the medications given to the resident) indicated the resident never received insulin. During a concurrent interview and record review on 5/21/2026 at 3:33 PM with the Minimum Data Set Nurse (MDSN), Resident 47's MDS and medication administration records were reviewed. MDSN stated Resident 47's MDS indicated Resident 47 received insulin. MDSN further stated Resident 47 never received insulin while admitted at the facility and the MDS was incorrect. During an interview on 5/21/2026 at 4:41 PM, the Director of Nursing (DON) stated the MDS needs to be accurate as it reflects the resident's plan of care. The DON further stated an inaccurate MDS can lead to ineffective patient care. A review of the facility's policy and procedures (P&P) titled, Resident Assessments, dated 1/29/2026, indicated assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decline. The P&P also indicated Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. The P&P further indicated all resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan. 2. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 7/2/2015 and re-admitted Resident 2 on 3/17/2026 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death) and muscle weakness. During a review of Resident 2's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment, dated 3/17/2026, the OT Evaluation indicated Resident 2 had ROM impairments in the left shoulder, elbow, forearm, wrist, and hand. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) for eating, substantial/maximal assistance (helper does more than half the effort) for oral hygiene, and was dependent (helper does all the effort or requires the assistance of two of more helpers to complete the activity) in toileting hygiene, bathing, dressing, rolling to both sides, and transfers. Section GG 0115A of the same MDS for functional limitations in ROM was coded as zero indicating that Resident 2 had no ROM limitations in both arms. During an observation and interview on 5/18/2026 at 11:34 am with Resident 2, in Resident 2's room, Resident 2 was lying in bed wearing a splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to the left hand and left elbow. Resident 2's left elbow was bent to a 90-degree angle, the wrist was bent downwards, and the fingers of the hand were curled inwards toward the palm. Resident 2 stated he was unable to move his left arm independently and required assistance from staff to move the left arm. During a concurrent interview and record review on 5/21/2026 at 11:03 am with the MDSN, the MDSN stated the MDS was an assessment tool completed upon admission, quarterly, and upon a significant change of condition to identify the needs of the residents in the facility. The MDSN stated the facility monitored for changes in joint ROM by the MDS (section GG 0115A and GG0115B), joint mobility assessments (JMA, a brief assessment of a resident's ROM in both arms and both legs) and evaluations performed by the Rehabilitation Department (Rehab), and staff report. The MDSN stated Section GG 0115A of the same MDS indicates that if a resident has functional ROM limitations in both arms. The MDSN stated he observes if a resident can actively move his or her arms and legs to perform Activities of Daily Living (ADL, basic activities such as eating, dressing, toileting), physically moved a resident's arms and legs through ROM, and gathered information from Rehab which included reviewing the results of the resident's JMAs or evaluations when coding Section GG 0115A and GG 0115B. The MDSN reviewed Resident 2's MDS assessment, dated 3/22/2026. MDSN stated and confirmed that Section GG 0115A of the MDS assessment was coded a zero which means that Resident 2 has no ROM limitations in both arms. The MDSN reviewed Resident 2's OT Evaluation, dated 3/17/2026, and confirmed the JMA indicated Resident 2 had ROM limitations in the left shoulder, elbow, forearm, wrist, and hand. The MDSN stated Section GG0115A of the MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, dated 3/22/2026, was coded incorrectly and should have been coded a one since Resident 2 had ROM limitations in the left arm because he was paralyzed and was unable to use the left arm functionally. The MDSN stated it was important that the MDS was coded accurately to ensure the facility provided the residents with the appropriate care and services. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated, it was important the MDS was coded accurately to ensure the facility was able to assess if the care provided was appropriate for the residents' needs. The DON stated incorrect coding of the MDS can potentially result in an inaccurate assessment of the resident which could negatively impact the care and services he or she received. 3. During a review of Resident 105's admission Record, the admission Record indicated the facility originally admitted Resident 105 on 12/10/2024 and re-admitted Resident 105 on 6/18/2025 with diagnoses including right-sided hemiplegia and hemiparesis following cerebral infarction, aphasia (loss of ability to understand or express speech, caused by brain damage), and muscle weakness. During a review of Resident 105's JMA, dated 1/22/2026, the JMA indicated Resident 105 had minimal (less than 25 percent [%-unit of measurement] ROM loss) ROM limitations to both hips, shoulders, elbows, wrists, and fingers and moderate (26 to 50% ROM loss) ROM limitations in both knees and both ankles. During a review of Resident 105's MDS, dated [DATE], the MDS indicated Resident 105 had severe cognitive impairment for daily decision making. The MDS indicated Resident 105 was dependent in eating, hygiene, bathing, dressing, rolling to both sides and transfers. Section GG 0115A of the MDS for functional limitations in ROM was coded zero which indicated Resident 105 had no ROM limitations in both arms. Section GG 0115B of the MDS for functional limitations in ROM was coded zero which indicated Resident 105 had no ROM limitations in both legs. During a concurrent observation and interview on 5/20/2026 at 9:30 am, in Resident 105's room, Resident 105 was lying in bed with both arms straight and resting at the sides of the body with a slight bend in the right elbow and both knees bent. Family Member (FM) 1 stated Resident 105 was paralyzed in the right arm and right leg, could not move the left leg independently, and minimally moved the left arm. FM 1 stated Resident 105's both knees were stuck and could not be straightened. Certified Occupational Therapy Assistant (COTA) 1 entered Resident 105's room to provide therapy services. COTA provided passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to Resident 105's both arms and both legs. COTA moved Resident 105's right shoulder to less than shoulder height and minimally moved the right elbow and wrist. COTA 1 stated Resident 105's both knees and right elbow were contracted (loss of motion of a joint associated with stiffness and joint deformity). COTA 1 stated Resident 105 did not move the left arm functionally and had no active movement in the right arm. During a concurrent interview and record review on 5/21/2026 at 11:03 am with the MDSN, the MDSN stated the MDS was an assessment tool completed upon admission, quarterly, and upon a significant change of condition to identify the needs of the residents in the facility. The MDSN stated the facility monitored for changes in joint ROM by the MDS (section GG 0115A and GG 0115B), JMAs and evaluations performed by the Rehab, and staff report. The MDSN stated Section GG 0115A indicated if a resident had functional ROM limitations in both arms. The MDSN stated Section GG 0115B indicated if a resident had functional ROM limitations in both legs. The MDSN stated he observed a resident actively move his or her arms and legs to perform ADLs, physically moved a resident's arms and legs (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through ROM, and gathered information from Rehab which included reviewing the results of the resident's JMAs or evaluations when coding Section GG 0115A and GG 0115B. The MDSN reviewed Resident 105's MDS assessment, dated 3/12/2026, and stated and confirmed that Section GG 0115A of the MDS assessment was coded as zero which means that Resident 105 had no ROM limitations in both arms. The MDSN reviewed Resident 105's MDS assessment, dated 3/12/2026, and confirmed Section GG 0115B of the MDS assessment was coded a zero which meant Resident 105 had no ROM limitations in both legs. The MDSN reviewed Resident 105's JMA, dated 1/22/2026, and confirmed the JMA indicated Resident 105 had ROM limitations in both shoulders, elbows, wrists, hands, hips, knees, and ankles. The MDSN stated Sections GG 0115A and GG 0115B of the MDS assessment, dated 3/12/2026, were coded incorrectly and should have been coded a two in both sections since Resident 105 had ROM limitations in both arms and both legs and could not use both arms and both legs functionally for ADLs. The MDSN stated it is important that the MDS is coded accurately to ensure the facility provided the residents with the appropriate care and services. During an interview on 8/7/2025 at 2:28 pm, the DON stated it is important the MDS is coded accurately to ensure the facility was able to assess if the care provided was appropriate for the residents' needs. The DON stated incorrect coding of the MDS could potentially result in an inaccurate assessment of the resident which could negatively impact the care and services he or she received. During a review of the facility's policy and procedures (P&P) titled, Resident Assessments, revised 1/29/2026, the P&P indicated the resident assessment coordinator was responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments. The P/P indicated all persons who completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. The P/P indicated the information in the MDS assessments would consistently reflex information in the progress notes, plans of care, and resident observations and interviews.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure that a pre-admission screening Resident Review (PASRR -a detailed assessment that determines if someone with a mental illness [like serious mental illness, intellectual disability, or related conditions] needs specialized services and the most appropriate place to receive them) level II for residents identified with mental disorder were evaluated to receive care and services in the most integrated setting appropriate to their needs for one of two sampled residents (Resident 11), in accordance with the facility's policy and procedures (P&P) titled PASRR Completion Policy with review date of 4/15/2026. This deficient practice had the potential to negatively affect the appropriate care and services rendered and required for Resident 11.Findings: A review of Resident 11's admission Record indicated the facility admitted Resident 11 on 1/10/2025 and readmitted Resident 11 on 2/17/2026 with diagnoses including dementia (a progressive state of decline in mental abilities), bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety (a feeling of fear, dread, or unease causing worry about what might happen in the future). A review of Resident 11's Minimum Data Set (MDS - resident assessment tool) dated 4/20/2026, indicated Resident 11 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 11 staff assistance with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. During a review of resident 11's PASARR level I (is a mandatory, preliminary screening used to identify an individual applying to Medicaid-certified nursing facility has, or is suspected of having a mental illness, intellectual disability, or developmental disability) dated 4/22/2025, the PASARR level 1 indicated the assessment was positive for a serious mental illness (SMI - a mental health condition that significantly disrupts a person's ability to function in daily life, impacting their thoughts, feelings, and behaviors) and that level II mental health evaluation was required. During a review of resident 11's notice of attempted evaluation dated 4/27/2025, the evaluation notice indicated that unable to complete level II evaluation for serious mental illness (SMI). During a concurrent interview and record review, on 5/22/2026, at 1:53 P.M., with the Minimal Data Set Nurse (MDSN), Resident 11's PASARR level I, and notice of attempted evaluation were reviewed. The MDSN stated that Resident 11's PASRR level I done on 4/22/2025 was positive for SMI, MDSN stated that when a resident has a positive level I PASRR, the facility is supposed to coordinate with the county to ensure that a PASRR level II is done to make sure that the placement for the resident is accurate as well as the plan of care. MDSN stated that if the PASRR level II is not done, it may jeopardize the care of the resident in that the facility may not be the proper placement for the resident. MDSN stated that Resident 11's PASRR level II (is a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC).) was not done and that he would apply for the PASRR level II for Resident 11. During an interview on 5/22/2026, at 4:47 P.M., with the Director of Nursing (DON), the DON stated that the completion of PASRR level II is important to determine the placement of the resident, to see if the resident is appropriate for the nursing home. The DON stated that if PASRR level II is not done, the resident's placement may be improper, resident may not be properly referred to the psychiatry services and improper care and activity may be provided to the resident. A review of the facility's P&P titled, PASRR Completion Policy with review date of 4/15/2026, indicated,Policy StatementThe Center will a make sure that all admissions have the appropriate Patient assessment and Resident Review (PASRR) completed1. Center Administrator will designate either me Admissions Director or Social Worker to make sure that the PASSRR and/or Level of Care (LOC) is done on all potential residents. If the referral indicates anything which might constitute an SMI or ID, the PASRR must be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed prior to admission. If the resident is deemed hospital exempted that must be clearly documented in the transfer documents prior to admission from the acute care facility.2. Administrator will also designate a backup i!n case the designated person is not available.3. Administrator is accountable for monitoring the process of completing the necessary paperwork for the admission.4. Business Office Manager (BOM) must have copies of the LOC and/or PASSRR in the Business Office resident file.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and services to improve two of six sampled resident's (Resident 17 and 126) abilities to carry out activities of daily living (ADL, basic activities such as mobility, eating, dressing, toileting, and communicating) by failing to:Ensure staff assisted Resident 17 out of bed daily to maintain and improve mobility (ability to move). 2. Ensure Resident 126 who had communication difficulties and a language barrier was provided access to a communication aid (tool designed to assist persons with speech and language difficulties in expressing their needs and understanding to others) and/or alternative communication strategies to facilitate communication with residents and staff. These deficient practices had the potential for Resident 17 to experience a functional decline in mobility and ADLs and prevent Resident 126 from communicating her needs, resulting in frustration, isolation, and delay in care. Findings: 1. During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 5/23/2025 and re-admitted Resident 17 on 6/20/2025 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue), osteoarthritis (loss of protective cartilage that cushions the ends of your bones), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 17 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) for eating, substantial/maximal assistance (helper does more than half the effort) upper body dressing, and was dependent (helper does all the effort or requires the assistance of two of more helpers to complete the activity) for hygiene, bathing, lower body dressing, rolling to both sides, sit to stand, and bed to chair transfers (moving from one place to another). During a concurrent observation and interview on 5/18/2026 at 12:29 pm with Resident 17, in Resident 17's room, Resident 17 was lying in bed. Resident 17 stated he was unable to sit, walk, or care for himself and needed Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities). Resident 17 stated staff did not assist him out of bed but would like to get out of bed more often. During an observation on 5/19/2026 at 1:00 pm, Resident 17 was lying in bed. During a concurrent observation and interview on 5/20/2026 at 2:00 pm with Resident 17, in Resident 17's room, Resident 17 was lying in bed. Resident 17 stated staff had not offered or assisted Resident 17 to get out of bed. During an interview on 5/20/2026 at 2:45 pm with Restorative Nursing Aide (RNA-nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) 2, RNA 2 stated Resident 17 did not get out of bed regularly and only got out of bed for appointments. RNA 2 stated that Resident 17 constantly refused to participate in RNA because he wanted to walk and get out of bed and did not want to participate in range of motion (ROM, full movement potential of a joint) exercises only. During an interview on 5/20/2026 at 3:01 pm with Certified Nursing Assistant (CNA) 5, CNA 5 stated that Resident 17 was always in bed and was assisted out of bed for showers twice a week and appointments only. CNA 5 stated Resident 17 should be out of bed every day to improve his mobility. During an observation on 5/20/2026 at 4:00 pm, Resident 17 was lying in bed. During an observation on 5/21/2026 at 10:35 am, Resident 17 was lying in bed. During a concurrent observation and interview on 5/22/2026 at 11:40 am with Resident 17, Resident 17 was lying in bed. Resident 17 stated staff did not offer to assist him out of bed and wished staff offered more frequently. During an interview on 5/22/2026 at 11:56 am, CNA 6 stated that Resident 17 was always in bed and was only assisted out of bed for appointments. CNA 6 stated nursing offered to assist Resident 17 out of bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every two days and Resident 17 often refused when asked. CNA 6 stated Resident 17 required minimal assistance of one person to get out of bed and was not difficult to assist to a chair if needed. CNA 6 explained that residents should be assisted out of bed every day to support their physical abilities, and staff should keep offering assistance daily, even if residents refused. During an interview on 5/22/2026 at 5:09 pm, the Director of Nursing (DON) stated staff should always offer to assist and help residents out of bed into a chair at least one to two times a day despite history of refusals to prevent physical and functional decline. The DON stated if residents did not get out of bed every day, it could increase the risk of skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), contractures (loss of motion of a joint associated with stiffness and joint deformity), decreased social participation, and functional decline. 2. During a review of Resident 126's admission Record, the admission Record indicated the facility originally admitted Resident 126 on 2/7/2025 and re-admitted Resident 126 on 1/6/2026 with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), muscle weakness, and Alzheimer's disease (a type of disease that affects memory, thinking, and behavior). During a review of Resident 126's MDS, dated [DATE], the MDS indicated Resident 126 had severe cognitive impairment, was rarely/never understood, and could rarely/never understand others. The MDS indicated Resident 126 was independent with eating and oral hygiene and required set-up or clean up assistance (helper sets up or cleans up) for rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance as individual completes the activity) for upper body dressing, and partial/moderate assistance (helper does less than half the effort) for sit to stand and bed to chair transfers. During a concurrent observation and interview on 5/18/2026 at 12:52 pm, in Resident 126's room, Resident 126 was lying in bed, reaching out arms, and speaking in her primary language. CNA 7 entered Resident 126's room. Resident 126 looked at CNA 7, reached out both arms and spoke to CNA 7 in the resident's primary language. CNA 7 stated she did not know what Resident 126 needed because Resident 126 did not speak English and only spoke her primary language which was Farsi. CNA 7 stated one staff member in the facility spoke Farsi but could not assist with care because she worked on a different floor. CNA 7 said she was unsure how to communicate with Resident 126 and did not know how to determine what Resident 126 needed. The Assistant Director of Nursing (ADON) entered Resident 126's room. Resident 126 outstretched both arms and spoke to the ADON in her primary language. The ADON stated she did not know what Resident 126 needed because Resident 126 spoke only Farsi and did not know how to communicate with her. The ADON stated Resident 126 was supposed to have a communication board with pictures and phrases in Farsi but confirmed there was no communication board in Resident 126's room. The ADON left the room and CNA 7 began feeding Resident 126 lunch. Resident 126 shook head when offered certain foods and tried communicating with CNA 7 in her primary language. CNA 7 stated she did not know what Resident 126 wanted or why Resident 126 was refusing to eat certain foods because she was unable to communicate with her. CNA 7 stated Resident 126 needed a communication board to assist with communication but confirmed there was no communication board in Resident 126's room. CNA 7 stated that being able to communicate with residents was important to ensure their needs could be understood and met. During an interview on 5/18/2026 at 1:23 pm with the ADON, the ADON stated Resident 126 had a communication board in the past but did not know where it was. The ADON stated the communication board should always be in Resident 126's room and accessible to both Resident 126 and staff. The ADON stated Social Services assessed all residents for communication abilities and issued communication devices such as communication boards as needed to the residents in the facility. The ADON stated it was important for staff to be able to communicate with residents for safety and to ensure the residents' needs were met. During an interview on 5/18/2026 at 1:50 pm with the Social Services Director (SS), SS stated the Social Services Department assessed all residents for communication abilities and issued communication aids such as communication boards as needed to the residents in the facility. SS stated Resident 126 had a communication board with (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pictures and phrases in Farsi in the past but did not know where it was. SS stated Resident 126's communication board should always be in Resident 126's room and accessible to both Resident 126 and staff to facilitate communication. SS stated that effective communication between residents and staff was essential because it helped residents understand what staff were doing and allowed staff to properly meet the residents' needs. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated the facility provided communication aids such as communication boards to facilitate communication between residents and staff for residents who had communication or language barriers. DON stated it is important for residents and staff to be able to communicate effectively to ensure the residents understood their plan of care and staff could meet the resident's needs. During a review of the facility's policy and procedures (P&P) titled, Translation and/or Interpretation of Facility Services, revised 2001, the P/P indicated the facility's language access program would ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. The P/P indicated that to provide meaningful access to services provided by the facility, translation and/or interpretation must be provided in a way that was culturally relevant and appropriate to the LEP individual. During a review of the facility's P&P titled ADLs, Supporting, revised 1/29/2026, the P&P indicated, Residents were provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 interview and record review, for two of two sampled residents (Resident 11 and Resident 105), the facility failed to:1. Transfer Resident 11 to General Acute Care Hospital (GACH -full service community hospital) on 2/13/2026. Resident 11 experienced a change of condition (COC - a significant deviation in a person's health, functional status that requires timely recognition, response to prevent complication or death) on 2/13/2026, according to physician's order dated 2/13/2026, and the facility's policy and procedures (P&P) titled Change in a Residents Condition or Status with review date of 1/29/2026. 2. Notify the physician and document why the facility did not transfer Resident 11 to GACH until 2/14/2026.These deficient practices resulted in one day delay of the appropriate care and services placing Resident 11 at increased risk for further decline/complication in the resident health and death.3. Ensure an Occupational Therapist (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) assessed Resident 105 for a right-hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to determine the appropriateness, fit, and splint wear time tolerance (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits). 4. Ensure a Certified Occupational Therapy Assistant (COTA, healthcare professional who assists and works under the direction of Occupational Therapists to help patients develop, recover, and enhance the skills needed for daily living) did not apply Resident 105's right-hand splint prior to an OT splint evaluation and establishment of splinting goals and plan of care. These deficient practices had the potential to result in a skin breakdown (tissue damage caused by friction, shear, moisture, or pressure), fractures (broken bones), range of motion (ROM, full movement potential of a joint) decline leading to contractures (loss of motion of a joint associated with stiffness and joint deformity), discomfort, pain, and injury for Resident 105. Findings: 1. During a review of Resident 105's admission Record, the admission Record indicated the facility originally admitted Resident 105 on 12/10/2024 and re-admitted Resident 105 on 6/18/2025 with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), aphasia (loss of ability to understand or express speech, caused by brain damage), and muscle weakness. During a review of Resident 105's OT Evaluation and Plan of Treatment (OT Eval), dated 2/18/2026, the OT Eval did not indicate goals or an assessment for Resident 105's right-hand splint. During a review of Resident 105's Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 105 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment for daily decision making. The MDS indicated Resident 105 was dependent (helper does all the effort or requires the assistance of two or more helpers for the resident to complete the activity) upon staff for eating, hygiene, bathing, dressing, rolling to both sides and transfers (moving from one surface to another). During a review of Resident 105's Occupational Therapy Treatment Encounter Note (OTTEC), dated 4/3/2026, the OTTEC indicated Certified Occupational Therapy Assistant 1 (COTA 1) applied a splint to Resident 105's right hand for one hour. During a concurrent observation and interview on 5/20/2026 at 9:30 am, in Resident 105's room, Resident 105 was lying in bed with both arms straight and resting at the sides of the body with a (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slight bend in the right elbow and both knees bent. Family member 1 (FM 1) stated Resident 105 was paralyzed in the right arm and right leg, could not move the left leg independently, and minimally moved the left arm. FM 1 stated Resident 105's right hand progressively became tighter over the year, was very painful, and rested in a fisted position. Certified Occupational Therapy Assistant (COTA) 1 entered Resident 105's room to provide therapy services. COTA 1 provided passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to Resident 105's both arms and both legs. COTA 1 moved Resident 105's right shoulder to less than shoulder height and minimally moved the right elbow and wrist. COTA 1 straightened all the fingers of Resident 105's right hand with increased time and slow ROM stretches. COTA 1 stated Resident 105 did not move the left arm functionally and had no active movement in the right arm. COTA 1 applied a splints to Resident 105's right hand and both knees at the end of the therapy session. During a concurrent interview on 5/20/2026 at 2:35 pm with the Director of Rehabilitation (DOR), the DOR who was an Occupational Therapist stated the purpose of splints was to improve or maintain a resident's ROM and prevent contractures. The DOR stated a licensed OT or Physical Therapist (PT, profession aimed in restoration, maintenance, and promotion of optimal physical function) must assess a resident's need for splints if indicated. The DOR stated a licensed therapist must determine the splint wear tolerance and schedule by periodically assessing the splint for safety, comfort or need for modification. The DOR stated that after the therapist assesses a resident for the correct type of splint and establishes the wear tolerance, the therapist transitions the splinting plan of care to nursing and to Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) program. The DOR stated the standard of practice in therapy for a resident requiring a new splint includes: performing the initial evaluation of the resident's ROM, assessment of the type of splint to issue, application of the splint, periodic splint checks to determine the splint wear schedule, tolerance, and if modification is required, training the RNA and nursing on the use of splint and any precautions and documentation of all findings in the resident's clinical record. During a follow up concurrent interview and record review on 5/22/2026 at 2:01 pm with the DOR, the DOR reviewed OT Eval, dated 2/18/2026, and all therapy records for Resident 105. The DOR stated and confirmed that the OT did not assess Resident 105 for a right-hand splint. The DOR reviewed Resident 105's clinical record and therapy notes and confirmed there was no documented evidence that OT assessed Resident 105 for the right-hand splint. The DOR stated he did not know when Resident 105 obtained the right-hand splint but confirmed the facility's splint vendor delivered the right-hand splint to the facility on 3/19/2026. The DOR stated he (DOR) typically assesses the splint fit with the vendor when the vendor delivers a splint for a resident to the facility. However, the DOR stated that DOR did not and does not document residents assessment or monitoring. The DOR stated and confirmed that COTA 1 was the first staff to apply a splint to Resident 105's right hand on 4/3/2026. The DOR stated OT must initially assess Resident 105 for the right-hand splint to determine the correct fit and projected wear time prior to the application of Resident 105's right hand splint and that COTA 1 did not assess Resident 105 for use of right hand splint. The DOR stated lack of splint assessments by licensed therapists can result in improper and incorrect splint placement, skin breakdown, and injury. During an interview on 5/22/2026 at 3:20 pm with Certified Occupational Therapy Assistant (COTA) 2, COTA 2 stated the role of a COTA is to carry out a resident's therapy plan of care established by a licensed OT. COTA 2 stated a licensed therapist must perform the first assessment on a resident for a splint to determine the type of splint, wear time, and how to properly apply the splint prior to handing off the plan of care to a COTA. COTA 2 stated the licensed therapist must be the first person to apply (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a splint to a resident's arm or leg. COTA 2 stated that COTAs are not qualified to apply a splint on a resident without the splint being first assessed and issued by a licensed therapist. COTA 2 stated if a COTA applied splints prior to a licensed therapist first assessing the resident, it can lead to harm and injury. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated the Rehabilitation Department (Rehab, a specialized healthcare unit designed to help individuals regain, improve, or maintain the physical, mental, or cognitive skills needed for daily living) was responsible for splint assessments, determining the correct type of splint to issue, and establishing the splint wear time for all residents in the facility. The DON stated a formal assessment by Rehab was required prior to issuing splints to the residents. The DON stated issuing splints to residents without a formal assessment or placement of splints by unqualified staff could potentially result in the residents experiencing a functional decline, pain, discomfort, injury and skin breakdown. During a review of the facility's policy & procedures (P&P) titled, Splint Application, revised 1/29/2026, the P&P indicated, a splint is a device that is placed on the resident's limb to help improve or correct performance, or prevent further deformity. Therapy assessed the resident for the appropriate splint and sets up a program for splint application (donning (putting on) and doffing (removing)), and then all residents who are currently wearing splint for upper and lower extremities will be monitored by RNAs to ensure correct usage and optimal splint condition. A resident was referred to therapy by either the doctor or nursing to determine if a splint is needed. Once the resident is screened/evaluated, therapy may work with the resident on getting an appropriate splint. During a review of the California Business and Professions Code, Division 2, Chapter 5.6. Section 2570.3(j) indicated The supervision of an OT assistant means that the responsible OT shall at all times be responsible for all OT services to the client. The OT who is responsible for appropriate supervision shall formulate and document in each client's record, with his or her signature, the goals and plan for that client, and shall make sure that the OT assistant assigned to that client functions under appropriate supervision. During a review of a journal article, titled Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services, published by the American Journal of Occupational Therapy (AJOT), November/December 2020, volume 74, Supplement 3, the journal article indicated that, The OT must be directly involved in the delivery of services during the initial evaluation and regularly throughout the course of intervention planning, implementation, and review and outcome evaluation. The OT assistant delivered safe and effective OT services under the supervision and in partnership with the OT. The OT directed the evaluation process and is responsible for directing all aspects of the initial contact during the OT evaluation, including: determining the need for services, defining problems within the domain of OT to be addressed, determining the client's goals and priorities, determining specific further assessment needs, and determining specific assessment tasks that can be delegated to the OT assistant. During a review of the facility's undated Job Description titled, Occupational Therapy, the job description indicated that, OTs plan, develop, organize, implements, evaluates, and directs the execution of OT services as well as its programs and activities in accordance with guidelines issued by the governing body and it's respective affiliate state chapter, current state and federal laws and regulations, and respective practice act(s) in the state. During a review of the facility's undated Job Description titled, Occupational Therapy Assistant, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	job description indicated that OTAs practice under the direction of a registered OT. The Occupational Therapy Assistant job description indicated that OTAs implement the OT treatment plan as established by the OT in accordance with the American Occupational Therapist (AOTA) and in accordance with guidelines issued by the governing body and it's respective affiliate state chapter, current state and federal laws and regulations, and respective practice act(s) in the state. 2. A review of Resident 11's admission Record indicated the facility admitted Resident 11 on 1/10/2025 and readmitted Resident 11 on 2/17/2026 with diagnoses including dementia (a progressive state of decline in mental abilities), bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety (a feeling of fear, dread, or unease causing worry about what might happen in the future). A review of Resident 11's COC dated 2/13/2026, at 12:25 P.M., indicated. situation identified: increased generalized weakness.the attending physician was notified and a new order was received to transfer the resident to the hospital for further evaluation. A review of Resident 11's physician order dated 2/13/2026 at 12:45 P.M., indicated transfer to GACH . increased generalized weakness for further evaluation. A review of Resident 11's Transfer to Hospital Summary note dated 2/14/2026, at 11:25 A.M., indicated .Resident was picked up.via gurney (a hospital bed on wheels) to be transferred to (GACH) as ordered for increased generalized weakness and for further eval . A review of Resident 11's GACH records dated 2/14/2026, indicated . History of present illness indicated Resident 11 presented to emergency department (ED - a hospital unit that provides immediate medical care for life-threatening or severe health issues) from Skilled Nursing Facility (SNF-the facility) due to generalized weakness . heart rate 58 beats per minute (bpm -number of times the heart beats per minute [normal range 60-100]) , blood urea nitrogen (BUN - measures the amount of waste product [urea] circulating in your blood, liver creates this waste when it processes protein. Healthy kidneys filter this waste out of your blood, and it leaves your body when you pee) 28 milligram per deciliter (mg/dl -unit of measure [normal range 7 to 20]) A review of Resident 11's MDS dated [DATE], indicated Resident 11 is cognitively intact. The MDS indicated Resident 11 required staff assistance with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. During a concurrent interview and record review, on 5/22/2026, at 10:03 A.M., with Registered Nurse Supervisor (RNS) 2, Resident 4's electronic medical chart was reviewed. RNS 2 stated that the facility process is that if the resident cannot be transferred to GACH as ordered, then the facility needs to inform the physician. RNS 2 stated that Resident 11 had a COC completed on 2/13/2026 for increase generalized weakness and the physician was notified on the same day. RNS 2 stated that the physician gave an order to transfer Resident 4 to GACH on 2/13/2026. RNS 2 stated per facility documentation, the facility transferred Resident 11 GACH on 2/14/2026 (a day later). RNS 2 stated that there is no documented evidence that the facility notified the physician why Resident 4 was not transferred to GACH on 2/13/2026 as per the physician's order. RNS 2 stated that the physician needs to be updated if a resident is not transferred to the hospital as ordered to keep the physician updated with what is going on with the resident and to prevent the resident from further decline. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/22/2026, at 4:43 P.M., with the Director of Nursing (DON), the DON stated that if a resident has an order to be transferred to GACH and the facility staff is not able to transfer the resident, the ordering physician needs to be notified for further instructions. The DON stated that, If the physician is not notified, this may lead to a further decline of the residents health and cause a delay in care of the resident. A review of the facility's P&P, titled, Change in a Residents Condition or Status with review date of 1/29/026, indicated, Policy Statement Our facility promptly notifies the resident, his or her attending physician, and the resident representative of change; 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 Implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. Accident or incident involving the resident; b. Discovery of injuries of an unknown source; c: Adverse reaction to medication; d. Significant change in the resident's physical/emotional/mental condition; e. Need to alter. the resident's medical treatment significantly; f. Refusal of treatment or medications two (2) or more consecutive times); g. Need to transfer the resident to a hospital/treatment center; h. Discharge without proper medical authority; and/or i. Specific instruction to notify the physician of changes in _the resident's condition. 2. A significant change of condition is a major decline or improvement in the residents' status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. Impacts more than one area of the resident's health status; c. Requires interdisciplinary review and/or revision to the care plan; and (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Ultimately is based :on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure that low air loss mattress (LAL -a medical-grade mattress that prevents and treats pressure ulcers [bedsores] by constantly blowing air through tiny holes in the fabric, keeping the patient's skin cool and dry) guidelines were adhered to for appropriate pressure redistribution support in accordance with the facility's policy and procedures (P&P) titled Support Surface Guidelines dated 1/29/2026, for one of one sampled residents (Resident 80). This deficient practice had the potential to significantly compromise Resident 80's safety, leading to serious skin breakdown, infection, increased discomfort and hospitalization.Findings: A review of Resident 80's admission Record indicated the facility admitted Resident 80 on 11/27/2024 and readmitted Resident 80 on 10/27/2026 with diagnoses including gastro enteritis reflux disease (GERD - ongoing acid reflux caused by the muscle between the stomach and food pipe doesn't close properly, letting harsh stomach acid splash upward), traumatic brain injury (TBI - a disruption in normal brain function caused by an external force), and anxiety (a feeling of fear, dread, or unease causing worry about what might happen in the future). A review Resident 80's Braden Scale (a scoring system used by healthcare providers to predict a person's risk of developing bedsores [pressure ulcers]) for predicting pressure sore risk dated 12/4/2025 indicated, Resident 80's Braden score was 12. scoring 10-12 indicates high risk for pressure ulcers. A review of Resident 80's Minimum Data Set (MDS - resident assessment tool) dated 2/27/2026, indicated Resident 80 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 80 required setup/clean up to dependence on assistance from staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. A review of the physician order dated 3/16/2026, indicated LAL mattress for wound management . During an observation on 5/18/2026, at 11:01 A.M., in Resident 80's room, LAL mattress setting indicated 320 pounds (lbs -unit of measure), the label on the LAL mattress pump indicated that resident 11's setting needed to be 150-180 lbs. During a concurrent observation and interview, on 5/18/2026, at 12:48 P.M., with Treatment Nurse (TN), the LAL mattress was set at 320 lbs. The TN stated that Resident 80's has LAL ordered for comfort and preventative measures, the TN stated that she changed the LAL mattress setting from 320 lbs to 180 closest setting to Resident 80's current weight of 187 lbs. The TN stated that the LAL is used to help residents that are not able to move on their own to prevent pressure injuries and if the LAL is too firm at 320lbs for resident whose weight is at 187lbs it may cause pressure injuries. During an interview, on 5/22/2026, at 4:57 P.M., with the Director of Nursing (DON), the DON stated that the LAL mattress setting is based on the resident's weight or within the range. The DON stated that, if the LAL mattress setting is not within the range of the resident's weight, it may not be effective for the resident's use. The DON stated that if the LAL mattress setting is higher than the resident's weight, over inflation may put resident at risk for developing pressure ulcers. A review of the facility's P&P, titled, Support Surface Guidelines dated 1/29/2026, indicated,PurposeThe purpose of this procedure is to provide information and guidelines for the assessment and care of a resident using support surfaces to assist in the prevent of pressure injury.PreparationReview the resident's care plan to assess for any special needs ofthe resident.Assemble the equipment and supplies as needed.General Guidelines1. Support surfaces are used for pressure redistribution, shearreduction, and in some cases temperature/moisture control for the resident at risk of pressure injury.2. Support surfaces can be active (powered support surface that can change pressure redistribution properties regardless of load), or reactive (powered or non-powered support surface that only changes its redistribution properties in response to an applied load).3. Types of support surfaces include:a. pressure redistribution foam (reactive);b. powered air surface (excluding low air loss) (reactive);c. non-powered air surface (reactive)d. air-fluidized surface (reactive)e. medical grade sheepskin (reactive);f. alternating pressure air surface (active); andg. low air loss surface with enhanced (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	microclimate management features (active) . A review of the manufactures guide, undated, indicated, Alternating Pressure Mattresses can help heal or prevent decubitus ulcers, commonly called 11bedsoresjf or1'pressure ulcers and provide comfort to patients.Adjust the pressure range based on the patient's weight and comfort needs. Start with a moderate setting and observe the patient's comfort and skin integrity. The digital control unit provides feedback to help optimize pressure redistribution.

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	555808	A. Building B. Wing	05/22/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide treatments and services to maintain or improve mobility (ability to move) and Range of Motion (ROM, full movement potential of a joint) for two of six sampled residents (Residents 50 and 105) with ROM and mobility concerns. ^ ^ 1. For Resident 105, the facility failed to: a. Objectively (evaluating or viewing something based solely on observable facts, measurements, and evidence) measure both of Resident 105's knees, shoulders, elbows, wrists, and hands during the Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday activities) evaluations, dated 2/18/2026. b. Assess both of Resident 105's legs during the Joint Mobility Assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 1/22/2026. 2. For Resident 50, the facility failed to: a. Apply Resident 50's right elbow splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) in accordance with physician's orders, dated 6/5/2025. b. Obtain a physician's order prior to applying Resident 50's right hand splint These deficient practices had the potential for Residents 50 and 105 to experience a decline in ROM resulting in contracturesˆ(loss of motion of a joint associated with stiffness and joint deformity) and have a further decline in physical functioning and activities of daily livingˆ(ADL, basic activities such as eating, dressing, toileting). Findings: During a review of Resident 105's admission Record, the admission Record indicated the facility originally admitted Resident 105 on 12/10/2024 and re-admitted Resident 105 on 6/18/2025 with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), aphasia (loss of ability to understand or express speech, caused by brain damage), and muscle weakness. During a review of Resident 105's Joint Mobility Assessment (JMA, is an evaluation by a healthcare professional, such as a physical therapist, to measure how freely a joint can move through its natural range of motion (ROM) and assess the quality of its surrounding tissue), dated 1/22/2026, Section I of the JMA, titled, Joint Mobility Screening (PT) was not signed or completed. During a review of Resident 105's OT Evaluation and Plan of Treatment (OT Eval), dated 2/18/2026, the OT Eval indicated Resident 105's ROM of both shoulders, elbows, forearms, wrists, hands, thumbs, index fingers (pointer fingers), middle fingers, ring fingers, and little fingers were impaired. During a review of Resident 105's PT Evaluation and Plan of Treatment (PT Eval), dated 2/18/2026, the PT Eval indicated Resident 105's ROM of both knees were impaired. During a review of Resident 105's Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 105 had severe cognitive (the mental ability to make decisions of daily living) impairment for daily decision making. The MDS indicated Resident 105 was dependent (helper does all the effort) on facility staff for eating, hygiene, bathing, dressing, rolling to both sides and transfers. During a concurrent observation and interview on 5/20/2026 at 9:30 am, in Resident 105's room, Resident 105 was observed lying in bed with both arms straight and resting at the sides of the body with a slight bend in the right elbow and both knees bent. Family member (FM) 1 stated Resident 105 was paralyzed in the right arm and the right leg, could not move the left leg independently, and minimally moved the left arm. FM 1 stated Resident 105's both knees were stuck and could not be straightened. During the same observation and interview, Certified Occupational Therapy Assistant (COTA) 1 entered Resident 105's room to provide therapy services. COTA 1 was observed providing passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to Resident 105's both arms and both legs. COTA 1 moved Resident 105's right shoulder to less than shoulder height and minimally moved the right elbow and wrist. COTA 1 stated both of Resident 105's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knees and right elbow were contracted. COTA 1 stated Resident 105 did not move the left arm functionally and had no active movement in the right arm. During a concurrent interview and record review on 5/21/2026 at 2:59 pm with the Director of Rehabilitation (DOR), Resident 105's PT Eval dated 2/18/2026 and JMA dated 1/22/2026 were reviewed. The DOR stated the facility monitors the residents for changes in joint (where two bones meet) ROM through staff report and through JMAs conducted by the Rehabilitation Department (Rehab-a unit that helps individuals regain, improve, or maintain the physical, mental, or cognitive abilities they have lost due to disease, injury, or surgery) upon admission, quarterly, annually, and upon a change of condition (COC, a deviation from the most recent evaluation that may affect multiple areas of functioning or health that is not). The DOR stated the physical therapists (PT) and occupational therapists (OTs) use goniometers (an instrument used to precisely measure the angle and ROM of a joint) to measure joint mobility to objectively determine a resident's baseline ROM and to detect changes in joint ROM. The DOR stated any limitations in joint ROM observed in an OT or PT evaluation must be measured with a goniometer and documented in the resident's evaluation because it was an objective way of establishing a resident's ROM baseline and monitoring for changes in ROM. The DOR stated and confirmed that Resident 105's PT Eval dated 2/18/2026, indicated that Resident 105's ROM of both knees were impaired. The DOR reviewed Resident 105's OT Eval, 2/18/2026, the ROM of both shoulders, elbows, forearms, wrists were impaired, and that all the resident's fingers of both hands were impaired. The DOR stated Resident 105's ROM of both knees, shoulders, elbows, forearms, wrists, and all the fingers of both hands should have been measured with a goniometer since they were impaired but were not. The DOR stated Resident 105's baseline ROM of both arms and both knees were not determined due to lack of objective measurements in the OT and PT evaluations which in turn affected staff's ability to monitor and detect any changes in ROM. The DOR stated Rehab performed a detailed JMA which included a ROM assessment of each resident's arms and both legs upon admission, quarterly, annually, and upon a change of condition. The DOR stated Section I of the JMA, titled JMA (PT), included a detailed ROM assessment of a resident's both legs and was completed and signed by the PT or OT after completion. The DOR confirmed and stated that Resident 105's JMA, dated 1/22/2026 did not include an assessment of Resident 105's ROM of both legs because Section I of Resident 105's JMA was not completed or signed by a PT or OT. The DOR stated that incomplete JMAs can lead to a potential decline in a resident's ROM due to the inability to detect changes in ROM. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated the facility monitors the residents for changes in ROM through staff report, weekly RNA meetings, and JMAs done quarterly and annually by Rehab. The DON stated that it is important for staff to objectively measure ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected facility staff's ability to effectively monitor changes and provide appropriate services to address any declines. The DON stated that it is important that JMAs ROM are assessed on all resident's joints to ensure the facility promptly identified any ROM changes and provide the appropriate services to address any declines and prevent contractures. 2. During a review of Resident 50's admission Record, the admission Record indicated the facility originally admitted Resident 50 on 5/19/2021 and re-admitted Resident 50 on 3/29/2025 with diagnoses including right-sided hemiplegia and hemiparesis following a cerebral infarction and aphasia. During a review of Resident 50's Order Summary Report, the Order Summary Report indicated a physician's order dated 6/5/2025, for the RNA to apply a right arm splint for two hours, five times a week. During a review of Resident 50's Order Summary Report, the Order Summary Report indicated a physician's order, dated 6/13/2025, for the RNA to provide active range of motion (AROM, is the degree of movement a patient can voluntarily achieve at a joint using their own muscle power, without any outside assistance) exercises to Resident 50's right shoulder, elbow, and wrist for contracture management, five times a week. During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50 had severe cognitive impairment. The MDS indicated Resident 50 required set-up or clean-up assistance (helper sets up or (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleans up and resident completes the activity) with eating and rolling to both sides, partial/moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, sit to stand, and transfers, and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, bathing, and dressing. The MDS indicated Resident 50 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm and one leg. During an observation on 5/22/2026 at 1:43 pm of Resident 50 in Resident 50's room, Resident 50 was observed sitting in a wheelchair with the right elbow bent at a 90-degree angle and wearing a splint which included Resident 50's right hand and wrist bent downwards, and the fingers of the hand bent toward the palm. During an interview on 5/20/2026 at 11:55 am with RNA 1, RNA 1 stated she (RNA 1) applied a hand roll splint to Resident 50's right hand and wrist. RNA 1 reviewed Resident 50's RNA physician's order dated 6/5/2025 and confirmed Resident 50 had an RNA physician's order for RNA to apply a right elbow splint, not a right-hand roll splint. RNA 1 stated she (RNA 1) was not Resident 50's primary RNA but recalls only placing a right-hand roll splint on Resident 50's right hand and wrist, not a right elbow splint, every time she provided RNA services to Resident 50. RNA 1 stated she did not apply the right elbow splint as ordered by the physician. RNA 1 stated she should have applied a splint to Resident 50's right elbow as ordered by the physician and should not have applied the right-hand roll splint because she did not have physician's orders to do so. RNA 1 stated RNAs are not qualified to modify the RNA program and had to follow physician's orders when providing RNA services to residents. During a concurrent interview and record review on 5/22/2026 at 2:01 pm with the Director of Rehabilitation (DOR), Resident 50's physician's order, dated 6/5/2025, was reviewed. The DON stated and confirmed that Resident 50's RNA order indicated for RNA to apply a splint to Resident 50's right elbow, five times a week. The DOR was unaware RNA was applying to right hand roll splint to Resident 50's right hand and wrist. The DOR stated if an RNA order indicates to apply a right elbow splint to Resident 50's right arm, it is expected that the RNA will apply a right elbow splint as ordered. The DOR stated RNAs are not qualified to modify the RNA program and must follow the RNA order exactly as written as incorrect splint application and deviation from the RNA program as ordered can result in an injury/ies to the resident and result in an inappropriate and ineffective treatment for the resident. During an interview on 5/22/2026 at 5:09 pm with the DON, the DON stated the rehab department created and modified RNA programs, which included splint application. The DON stated RNAs cannot apply splints without a physician's order and had to follow the RNA program exactly as written in the physician's order. The DON stated if RNA applies a splint other than the splint indicated on the physician's order and without a physician's order, it could result in resident injury, pain, discomfort, and ineffective treatment. During a review of the facility's undated Job Description, titled Restorative Nursing Assistant, undated, the Job Description indicated RNA duties and responsibilities included administering restorative activities specific to resident's needs, assist patients with ROM exercises to improve or maintain the resident's mobility and independence, and provide residents with routine restorative care and services in accordance with the resident's assessment, care plan, and as established by physical and occupational therapy. During a review of the facility's Policy and Procedures (P&P), revised 1/26/2026, titled Restorative Nursing Services, the P/P indicated the residents are to receive restorative nursing care as needed to help promote optimal safety and independence. During a review of the facility's P&P titled, Splint Application, revised 1/29/2026, the P/P indicated a splint was a device placed on a resident's limb to help improve or correct performance or prevent further deformity. The P&P indicated therapy assessed the resident for appropriate splints and set up a program for application (donning and doffing), and all residents who wore splints for upper and lower extremities would be monitored by RNAs to ensure correct usage and optimal splint condition. During a review of the facility's P/P titled Resident Mobility and ROM, revised 1/29/2026, the P/P indicated resident will not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. Building B. Wing	05/22/2026

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decrease in ROM. The P/P indicated the care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The P/P indicated the care plan will include the type, frequency, and duration of interventions as well as measurable 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. Based on observation, interview, and record review, for one of six sampled residents (Resident 126) identified as a high fall risk, was supervised and wore a helmet when walking in the hallway in accordance with physician's orders dated 5/2/2026. These deficient practices placed Resident 126 at risk for repeated falls and injury, pain, and a decline in overall physical functioning. Findings: During a review of Resident 126's admission Record, the admission Record indicated the facility originally admitted Resident 126 on 2/7/2025 and re-admitted Resident 126 on 1/6/2026 with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), muscle weakness, and Alzheimer's disease (a type of disease that affects memory, thinking, and behavior). During a review of Resident 126's Fall Risk Assessment, dated 1/4/2026, the Fall Risk Assessment indicated that Resident 126 had a history of three of more falls in the last three months. The same fall risk assessment indicated Resident 126 scored 18, indicating Resident 126 was a high fall risk. During a review of Resident 126's Order Summary Report, indicated a physician's order, dated 5/2/2026, for Resident 126 to wear a helmet (a specialized, rigid, or hard covering worn on the head to protect it from impacts, penetrations, and various hazards.) at all times when walking with the merry walker (is a walker/chair combination, allowing a independent and safe walking). During a review of Resident 126's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 126 had severe cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 126 was independent with eating and oral hygiene and required set-up or clean up assistance (helper sets up or cleans up) for rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance as individual completes the activity) for upper body dressing, and partial/moderate assistance (helper does less than half the effort) for sit to stand and bed to chair transfers. The MDS indicated walking was not attempted during the assessment period due to medical condition or safety concerns. During a review of Resident 126's comprehensive care plan (CP), the CP indicated Resident 126 was at risk for subsequent falls related to cognitive impairment, impaired safety awareness, limited ability to recognize hazards, impaired judgement, and need for assistive device (merry walker). The CP indicated a goal for Resident 126 to maintain the highest practicable level of safety during mobility and daily activities with implementation of individualized fall prevention interventions which included ensuring Resident 126's merry walker was used appropriately with staff monitoring and supervision. During an observation on 5/19/2026 at 2:35 pm, in the hallway, Resident 126 was in a merry walker and walking without a helmet, unattended. Resident 126 took a few steps with the merry walker, closed her eyes, put her hand on her forehead, and sat down repeatedly. Resident 126 walked for a total distance of about 400 feet without a helmet, unattended and without supervision. No staff member observed in or near the hallway providing supervision or monitoring while Resident 126 walked in the hallway. During a concurrent observation and interview on 5/19/2026 at 2:42 pm with the Director of Rehabilitation (DOR), Resident 126 was observed walking in the hallway unsupervised without wearing a helmet. The DOR stated and confirmed that Resident 126 was walking in the hallway unsupervised without wearing a helmet. The DOR stated DOR was unaware that Resident 126 was required to wear a helmet when walking. The DOR stated Resident 126 was a high fall risk because the resident was very confused and had suffered multiple falls in the past. During a concurrent observation, interview, and record review on 5/19/2026 at 2:48 pm with Licensed Vocational Nurse (LVN) 10, LVN 10 observed, stated and confirmedthat Resident 126 was walking in the hallway unsupervised without wearing a helmet. LVN 10 stated Resident 126 required supervision and a helmet when walking because Resident 126 was a high fall risk and had multiple falls in the past. LVN 10 reviewed Resident 126's physician's orders and confirmed Resident 126 was to always wear a helmet when walking. LVN 10 reviewed Resident 126's care plan and confirmed Resident 126 (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was high risk for falls and required supervision and staff monitoring while walking with a merry walker to prevent falls or injury. LVN 10 stated Resident 126 should be supervised and wearing a helmet while walking but was not. LVN 10 stated if Resident 126 walked with a merry walker unsupervised without wearing a helmet, it could result in injury and falls. During an observation and interview on 5/19/2026 at 3:15 pm with the Assistant Director of Nursing (ADON), the ADON observed Resident 126 walking unattended in the hallway and confirmed Resident 126 was walking unsupervised without a helmet. The ADON stated nursing staff was aware Resident 126 had a physician's order for Resident 126 to always wear a helmet when walking but did not enforce it because Resident 126 constantly refused. The ADON stated Resident 126 required supervision and was supposed to always wear a helmet when walking with the merry walker but was not. The ADON stated Resident 126 required supervision and a helmet when walking because Resident 126 was a high fall risk due to cognitive impairment, history of non-compliance, and multiple falls in the past. The ADON stated if Resident 126 walked unsupervised without a helmet, it could result in falls and accidents. During an interview on 5/22/2026 at 5:09 pm with the Director of Nursing (DON), the DON stated Resident 126 required supervision and a helmet when walking because Resident 126 was a high fall risk and had multiple falls in the past. The DON stated Resident 126 was very confused, had poor safety awareness, walked a few steps, closed eyes, tilted the merry walker, and shifted her body to either side causing her to miss the seat when sitting down and required supervision or assistance to prevent falls. The DON stated supervision meant ensuring Resident 126 was always in a staff member's direct line of sight. The DON stated that staff did not supervise Resident 126 when Resident 126 walked alone in the hallway since no staff were present. The DON stated if Resident 126 walked unsupervised without a helmet, it could result in falls, injury, or harm. During a review of the facility's Policy and Procedures (P/P) titled, Safety of Residents, revised 1/29/2026, the P/P indicated resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P/P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.

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	555808	A. Building B. Wing	05/22/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one out of one sampled Residents (Residents 147) received lidocaine external patch (a topical, medicated adhesive patch that delivers the local anesthetic lidocaine directly through the skin to the nerves) 5 percent (%-unit of measurement) according to physician's orders and the facility's policy and procedures (P&P) titled Administering Medications dated 1/29/2026. These deficient practices resulted in the Lidocaine External Patch 5% patches left on Resident 147 right elbow and outer left ankle in excess of 12 hours (hrs) with the potential for undesired complications not limited to Lidocaine External Patch 5% dose buildup, skin irritation, dizziness, confusion, or serious health complications, hospitalization, and death. Findings: A review of Resident 147's admission record indicated Resident147 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included, Parkinson's (a progressive, neurodegenerative disorder primarily affecting movement), Multiple sclerosis (a disorder in which body's immune system attacks the protective covering of the nerve cells in the brain, optic nerve), protein calorie malnutrition (an inadequate intake or absorption of protein, calories, or both), depression (mood disorder that causes persistent, intense feelings of sadness, emptiness, and a loss of interest in activities), and osteoarthritis (degenerative joint disease). A review of Resident 147's Minimum Data Set (MDS-a resident assessment tool), dated, 5/18/2026 indicated Resident 147's cognitive (mental ability to make decisions for daily living) was intact, Resident 147 required setup or clean up assistance with eating, supervision or touching assistance with oral hygiene Resident 147 required substantial maximum assistance with toileting hygiene, personal hygiene, shower bathing and upper body dressing, is dependent for lower body dressing and putting on and taking off foot wear and is non-ambulatory/uses a motorized wheelchair. During a facility tour on 5/18/2026 at 10:13 am, Resident 147 was observed to have undated lidocaine patches on the left upper arm. During an interview and concurrent record review on 5/18/2026 licensed vocational nurse (LVN) 1, Resident 147 electronic medication administration record (Emar) dated 5/21/2026 was reviewed. The Emar indicated the following physician order:Lidocaine External Patch 5%, apply to right elbow topically one time a day for pain management 12hrs on (9am-9pm), 12 hours (hrs), off (9pm-9am) and removed per schedule.Lidocaine External Patch 5%, apply to left ankle topically one time a day for pain management 12hrs on (9am-9pm), 12 hrs. off (9pm-9am) and removed per schedule.During the same interview and record review, LVN1 stated LVN1 did not administer and/or apply lidocaine patches on Resident 147's right elbow and/or the resident's outer left ankle. LVN1 stated the Lidocaine Patches on Resident 147's right elbow and outer left ankle were last applied on 5/17/2026 at 11:48 am. The Emar also indicated that LVN 3 documented that LVN 3 removed the undated Lidocaine patches on Resident 147 right elbow and outer left ankle. LVN1 stated that Resident 147 physician's order indicated to apply to right elbow and left ankle one time a day 12 hours on (9am-9pm) and 12 hours off remove per schedule. LVN1 stated that failing to remove lidocaine patches per physician's orders could result in lidocaine 5% overdose, respiratory distress, and tolerance of medication rendering medication non-therapeutic. During an interview on 5/21/2026 at 4:20 pm, Director of Nursing (DON) stated the Lidocaine Patch- is supposed to be changed every 12 hrs., application is 12 hrs. on 12 hrs. off, the space distribution of the day and off at night, prevents possible overdosing, risk of altered mental status, respiratory depression, unnecessary hospitalization, death. A review of the facility's policy and procedures (P&P) titled Administering Medications dated 1/29/2026, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.

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	555808	A. Building B. Wing	05/22/2026

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observation, interview, and record review, the facility failed to ensure staff provide specialized rehabilitative services (Rehab, services that require specialized training and experience of a licensed therapist or therapy assistant), Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function), and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluations for one of six sampled residents (Residents 17) in accordance with physician's orders, dated 4/4/2026. These deficient practices prevented Residents 17 from receiving skilled Rehab services to maintain, improve, and achieve his highest practicable level of function.Findings: During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 5/23/2025 and re-admitted Resident 17 on 6/20/2025 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue), osteoarthritis (loss of protective cartilage that cushions the ends of your bones), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 17 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half the effort) for eating, substantial/maximal assistance (helper does more than half the effort) for upper body dressing, and was dependent (helper does all the effort or requires the assistance of two or more helpers for the resident to complete the activity) for hygiene, bathing, lower body dressing, rolling to both sides, sit to stand, and bed to chair transfers (moving from one place to another). During a review of Resident 17's comprehensive care plan (CP), the care plan indicated Resident 17 had Activities of Daily Living (ADL, basic activities such as eating, dressing, toileting) performance deficit. The CP goal indicated Resident 17 would improve ADL function. The CP interventions included for Resident 17 to have PT and OT evaluations and treatment per physician's orders. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/4/2026, for PT to evaluate Resident 17 as indicated. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/4/2026, for OT to evaluate Resident 17 as indicated. During a concurrent observation and interview on 5/18/2026 at 12:29 pm with Resident 17, in Resident 17's room, Resident 17 was lying in bed. Resident 17 moved both shoulders, elbows, wrists, hands, hips, knees, and ankles fully. Resident 17 stated he did not have concerns about his range of motion (ROM, full movement potential of a joint) but stated he was unable to sit, walk, or care for himself and needed PT and OT services, not RNA for ROM exercises. Resident 17 stated he had been in the facility for about one year and had not received PT and OT services. During a concurrent interview and record review on 5/21/2026 at 2:59 pm with the Director of Rehabilitation (DOR), the DOR stated the facility provided skilled PT, OT, and ST services to the residents in the facility per physician's orders. The DOR stated the purpose of PT was to improve a resident's mobility (ability to move) and overall functioning. The DOR stated the purpose of OT was to improve a resident's activities of daily living (ADL, basic activities such as eating, dressing, toileting) and overall functioning. The DOR reviewed Resident 17's medical record and confirmed Resident 17 had physician's orders for Resident 17 to be evaluated by PT and OT on 4/4/2026. The DOR reviewed Resident 17's clinical record and confirmed PT and OT evaluations were not conducted as ordered by the physician. The DOR stated PT and OT evaluations should have been completed since they were ordered by the physician but were not done because he was unaware Resident 17 had PT and OT evaluation orders from the physician. The DOR stated it is important physician's orders were followed and the residents received rehab evaluations as ordered to ensure the residents received a comprehensive (complete, including all or nearly all elements or aspects of something) assessment to determine the appropriate type of care and services needed to maintain and improve their level of (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function. During an interview on 5/22/2025 at 5:09 pm with the Director of Nursing (DON), the DON stated the facility provided rehab services which included PT, OT, and ST per physician's orders. The DON stated it is important residents received skilled rehab evaluations as ordered by the physician to ensure the residents received the appropriate care and services they needed while in the facility. During a review of the facility's policy and procedures (P&P) titled, Specialized Rehabilitative Services, revised 1/29/2026, the P&P indicated the facility provides specialized rehabilitative services, which includes PT, ST, and OT. The P&P indicated therapy services are provided upon the written order of the resident's attending physician. During a review of facility's P&P titled, Resident Mobility and Range of Motion, revised 1/29/2026, the P&P indicated residents with limited mobility will receive the appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility was unavoidable. During a review of facility's P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 1/29/2026, the P&P indicated residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs.

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	555808	A. Building B. Wing	05/22/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure all Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) therapy records prior to 2/2026 were systematically organized and readily accessible for three of six sampled residents (Residents 17, 50, and 105). This deficient practice had the potential to delay and negatively affect the delivery of necessary care and services.Findings: During a review of Resident 17's admission Record, the admission Record indicated the facility initially admitted Resident 17 on 5/23/2025 and re-admitted Resident 17 on 6/20/2025 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue), osteoarthritis (loss of protective cartilage that cushions the ends of your bones), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 50's admission Record, the admission Record indicated the facility initially admitted Resident 50 on 5/19/2021 and re-admitted Resident 50 on 3/29/2025 with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death) and aphasia (loss of ability to understand or express speech, caused by brain damage). During a review of Resident 105's admission Record, the admission Record indicated the facility initially admitted Resident 105 on 12/10/2024 and re-admitted Resident 105 on 6/18/2025 with diagnoses including right-sided hemiplegia and hemiparesis following cerebral infarction, aphasia, and muscle weakness. During an interview on 5/21/2026 at 8:45 am with the Medical Records Director (MRD), the MRD stated the facility has a new Rehabilitation (Rehab) company which started at the end of 2025. The MRD stated she did not have access to therapy records prior to 11/2025 when the new Rehab company began their contract. The MRD stated she did not know why she did not have access and stated the Administrator (ADM) may have therapy records stored elsewhere for Residents 17, 50, and 105. The MRD stated it is important that medical records were readily available to staff because it enabled the staff to review a resident's background, determine which services had or had not been delivered, and ensured the residents received proper care. During an interview on 5/21/2026 at 9:00 am with the ADM, Resident 17, Resident 50, and Resident 105's PT and OT Evaluations, re-certifications, and discharge summaries from 2025 to 2026 were requested. The ADM stated the facility did not have therapy records readily accessible and needed to request therapy records for Resident 17, Resident 50, and Resident 105's from the previous Rehab company. The ADM stated that the facility only had access to therapy records for Resident 17, Resident 50, and Resident 105's from the current Rehab company which began their contract in 11/2025. During a concurrent interview and record review on 5/21/2026 at 2:59 pm with the Director of Rehabilitation (DOR), the DOR stated the facility did not have access to any therapy records for Resident 17, Resident 50, and Resident 105's prior to 2/2026 because all therapy documentation was done on a different electronic charting system and did not officially switch over to the current electronic system until 2/2026. The DOR stated he contacted the previous Rehab company and requested Resident 17, Resident 50, and Resident 105's therapy records prior to 2/2026 but had not received them. The DOR stated that to obtain therapy records prior to 2/2026, the facility had to contact the previous Rehab company who then in turn contacted a representative from the electronic charting system before any progress could be made in accessing therapy records. The DOR stated it was difficult to obtain a resident's therapy records prior to 2/2026 and often took several days to obtain. The DOR stated it was important that all therapy records were readily accessible to staff to ensure the facility had information regarding a resident's baseline level of function, allowed staff to understand a resident's history, and ensured the residents received the appropriate care and services. (continued on next page)

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	555808	A. Building B. Wing	05/22/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/21/2026 at 4:46 pm with the ADM, the ADM stated staff could not readily access Resident 17, Resident 50, and Resident 105's therapy records. The ADM stated it was important all resident's therapy records were readily accessible to staff because they were a part of a resident's medical record and ensured continuity of care. During an interview on 5/22/2026 at 5:09 PM with the Director of Nursing (DON), the DON stated staff must have immediate access to all therapy records because it allowed staff to track each resident's progress, understand their baseline level of function, and review their medical history to ensure the proper treatment and services were provided. During a review of the facility's policy and procedures (P&P) titled, Location and Storage of Medical Records, revised 1/29/2026, the P/P indicated that, All current medical records were filed in the Medical Records Department and were maintained by the Medical Records Clerk. During a review of the facility's P&P titled, Retention of Medical Records, revised 1/29/2026, the P&P indicated that, medical records shall be retrained by the facility in accordance with current applicable laws.