STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION CENTER OF SANTA MONICA	**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 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility nursing staff failed to implement their abuse and incident reporting policy and procedures for two of two sampled residents (Resident 1 and Resident 2). The facility failed to: 1.Report an abuse allegation to the Administrator immediately. 2.Complete the Incident/Accident Report form prior to completing the shift. 3.Forward the Incident/Accident Report to the Administrator for review within 24 hours of the event. This deficient practice resulted in a delayed in investigation and placed Resident 1 at risk for unrecognized abuse or neglect. Findings: On 6/15/20, at 2:45 p.m., an unannounced visit was made to the facility to investigate an entity-reported incident regarding resident to resident abuse. A review of Resident 1's face sheet (a facility document containing demographic information of the resident) indicated the resident was admitted to the facility on [DATE], and readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's History and Physical (H&P), dated 12/1/19, indicated Resident 1 does not have the capacity to understand and to make decisions. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 5/19/20, indicated Resident 1 has severe cognitive impairment, requires extensive assistance from staff for bed mobility, transfers, eating, and personal hygiene, and total dependence with dressing, toileting, and bathing. A review of Resident 2's face sheet (a facility document containing demographic information of the resident) indicated the resident was admitted to the facility on [DATE], and readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's History and Physical, dated 12/22/19, indicated Resident 2 has the capacity to understand and to make decisions. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 5/19/20, indicated Resident 2's cognition is intact, and requires extensive assistance from staff for bed mobility, transfers, dressing and bathing, limited assistance with locomotion and personal hygiene and independent with eating. A review of Resident 1's Incident/Accident Report, dated 6/1/20 and 6/2/20, unknown time, indicated alleged incident that Resident 2 threw water on Resident 1. A review of Resident 2's Incident/Accident Report, dated 6/1/20 and 6/2/20, unknown time, indicated alleged incident that Resident 2 threw water on her roommate, Resident 1. A review of Resident 1 and Resident 2's clinical record indicated no documentation reporting to the Administrator upon discovering the abuse allegation. During an interview and a concurrent record review of Resident 1 and Resident 2's clinical records with Administrator, on 06/25/20, at 04:35 p.m., the Administrator stated and confirmed nursing staff did not immediately inform him of the abuse allegation and the Incident/Accident Report was not completed until 6/1/20. The Administrator further stated and confirmed the nursing staff should have immediately reported the abuse allegation to him, and the Incident/Accident Report should have been completed timely by the nursing staff and forwarded to him within 24 hours of the abuse allegation, to inform the appropriate regulatory agencies in a timely manner. During a telephone interview and a concurrent record review with Registered Nurse (RN 1) Supervisor, on 7/28/20, at 4:21 p.m., RN 1 stated and confirmed the facility policy is to notify the Administrator immediately and to complete the Incident/Accident Report upon discovery of the abuse allegation. RN 1 stated the nursing staff is educated to do so right away. RN 1 further stated that the nursing staff should have reported the allegation of abuse immediately and completed all required documentation timely to ensure Resident 1's safety and to conduct timely investigation. A review of the facility's policy and procedure titled Incident Reporting for Residents or Visitors, dated 10/2008, and revised 5/2011, indicated, all incidents involving a resident will be documented and reported so as to meet all regulatory requirements. Definitions: any event reportable to federal and state agencies as defined by those agencies. Procedure: 1. When an event is discovered, if the event requires immediate action form the Administrator (resident safety or state regulatory requirements), he or she will be notified immediately. 7. If an event involves abuse of any nature, file a complete report in accordance with the state statutes. 8. The person discovering the event must complete the Incident/Accident Report form prior to completing the shift. 12. All completed incident reports must be forwarded to the Director of Nursing and Administrator for review within 24 hours of the event. A review of the facility's policy and procedure titled Abuse & Neglect Prohibition, dated (Release/Revision date 10/2004) indicated Policy: each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Procedure; Reporting: 2. The facility will report to company management in accordance with company reporting procedures.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely report an abuse allegation to the regulatory agency (Department of Public Health) for one of two sampled residents (Resident 1). This deficient practice resulted in a delayed investigation and placed Resident 1 at risk for unrecognized abuse or neglect. Findings: On 6/15/20, at 2:45 p.m., an unannounced visit was made to the facility to investigate an entity-reported incident regarding resident to resident abuse. A review of Resident 1's face sheet (a facility document containing demographic information of the resident) indicated the resident was admitted to the facility on [DATE], and readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's History and Physical (H&P), dated 12/1/19, indicated Resident 1 does not have the capacity to understand and to make decisions. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 5/19/20, indicated Resident 1 has severe cognitive impairment, requires extensive assistance from staff for bed mobility, transfers, eating, and personal hygiene, and total dependence with dressing, toileting, and bathing. During an interview and a concurrent record review of the SOC 341 (a report template for reporting suspected dependent adult/elder abuse) form with the Administrator, on 06/25/20, at 4:35 p.m., the SOC 341 indicated an abuse allegation for Resident 1 occurred on 05/30/20, at unknown time. The SOC 341 further indicated the allegation of abuse was completed and faxed to the Department of Public Health on 6/1/20, at unknown time. The SOC 341's fax confirmation indicated transmission completed on 6/1/20, at 5:38 p.m. The Administrator stated and confirmed the facility did not report the abuse allegation for Resident 1 in a timely manner. He further stated the facility should have notified the regulatory agency within 24 hours of the abuse allegation to ensure Resident 1's safety. During a telephone interview and record review with Registered Nurse (RN 1) Supervisor, on 7/28/20, at 4:21 p.m., RN 1 stated and confirmed the facility policy is to notify the regulatory agencies as per state regulation. RN 1 further stated that the facility should have reported the allegation of abuse timely to ensure

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

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident 1's safety and to conduct timely investigation. A review of the facility's policy and procedure titled Incident Reporting for Residents or Visitors, with revised date of 5/2011, indicated, All incidents involving a resident will be documented and reported so as to meet all regulatory requirements. Definitions: any event reportable to federal and state agencies as defined by those agencies. Procedure: 4. The Administrator or Director of Nursing must notify the appropriate state agency as required by state regulations. A review of the facility's policy and procedure titled Abuse & Neglect Prohibition, dated (Release/Revision date 10/2004) indicated, Policy: each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Procedure; Investigation: 2. The facility will report such allegations to the state, as per state regulation.