STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055155	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Pointe Healthcare Center	1330 17th 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 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** 43261 Based on interview and record review, the facility failed to provide reasonable accommodation of resident needs and preferences for one of four sampled residents (Resident 3) by failing to ensure Resident 3 felt safe and comfortable inside Resident 3's room. Resident 3's roommate (Resident 2) was constantly screaming and cursing. This deficient practice had the potential to negatively impact the psychosocial well-being of Resident 3 and had the potential to delay necessary care for Resident 3. Findings: A review of Resident 2's Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis that included sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), anxiety, depression (a mood disorder that causes persistent feeling of sadness and loss of interest) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 2's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 6/1/2024, indicated Resident 2 had a severe impairment in cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure), generalized weakness and dysphagia (difficulty swallowing food or liquid). A review of Resident 3's MDS dated [DATE], indicated Resident 3 had a severe impairment in cognition for daily decision-making and required maximal assistance from staff for ADLs. During an interview with Resident 3 on 6/21/2024 at 11:21 a.m., Resident 3 stated she has been feeling unsafe, uncomfortable, and feeling tired due to lack of sleep since Resident 2 (Roommate) has been screaming and cursing throughout the day and night. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with Licensed Vocational Nurse 1 (LVN 1) near the hallway, on 6/21/2024 at 11:26 a.m., Resident 2 was heard screaming, yelling, and cursing. LVN 1 stated Resident 2 was constantly screaming and cursing whenever she (Resident 2) needed something. LVN 1 also stated she (LVN 1) was made aware regarding Resident 3's concerns when she (LVN 1) started the shift. LVN 1 stated she (LVN 1) had not notified the Director of Social Services (DSS) and Facility Administrator (FA) regarding Resident 2's issue and added she (LVN1) was required to report it right away. During an interview with the FA on 6/21/2024 at 12:32 p.m., FA stated he (FA) was not made aware regarding Resident 3's concern with Resident 2. FA also stated that staff should report such issues or concerns to him (FA) immediately. A review of the facility's policy and procedures (P&P), titled, Accommodation of Needs, reviewed on 4/25/2024, indicated that the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. A review of the facility's P&P, titled, Quality of Life, reviewed on 4/25/2024, indicated it is the facility's policy to specify the responsibility to create and sustain an environment that humanizes and individualized each resident's quality of life by ensuring all staff, understand the principles of quality of life, honor and support these principles for each resident; and the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. A review of facility's P&P, titled, Resident Rights, reviewed on 4/25/2024, indicated that facility staff shall treat all residents with kindness, respect and dignity.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview and record review, the facility failed to ensure a grievance involving one of two sampled residents (Resident 1) was completed per the facility policy by failing to: 1. Ensure a prompt effort to resolve Resident 1's family members (R1FM) grievance when R1FM expressed issues against Resident 1's roommate (Resident 2). 2. Ensure facility staff report all alleged violations (neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property). These deficient practices violated R1FM's right to have grievance addressed and had a potential to delay any necessary care and services for Resident 1. Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included lack of coordination, diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (a chronic or persistent disorder of the mental processes caused by brain disease). A review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 4/13/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 2's Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis that included sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), anxiety, depression (a mood disorder that causes persistent feeling of sadness and loss of interest) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 2's MDS dated [DATE], indicated Resident 2 has a severe impairment in cognition for daily decision-making and required maximal assistance from staff for ADLs. A review of Resident 2's SBAR (situation, background, appearance and review/notify- structured tool for healthcare provider that provides communication between members. Also, being used as documentation for any changes of condition) form dated 6/15/2024, indicated that Resident 2 was screaming, cursing and threw filled cups to the roommate and staff member. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's grievance/concern form by R1FM dated 6/19/2024, indicated R1FM expressed frustration regarding Resident 2, claiming that Resident 2 was shouting racist slurs toward her and allegedly threw coffee at Resident 1. The Grievance/concern form also indicated the Director of Social Services (DSS) called the police for intervention and there were no other things which can be done. During an interview with R1FM on 6/21/2024 at 9 a.m., R1FM stated she (R1FM) notified the DSS regarding her concerns against Resident 2. R1FM stated Resident 2 was constantly yelling, screaming, and cursing. R1FM also stated she (R1FM) found out that Resident 2 threw a cup of coffee at Resident 1. R1FM stated she fears for her mother's (Resident 1) safety. R1FM stated that rather than assisting her, the DSS called the police for intervention. During an observation and interview with Licensed Vocational Nurse 1 (LVN 1) near the hallway, on 6/21/2024 at 11:26 a.m., Resident 2 was heard screaming/yelling and cursing. LVN 1 stated Resident 2 was constantly screaming and cursing whenever she (Resident 2) needed something. LVN 1 stated that Resident 2 also had an episode when Resident 2 threw cups to both staff and resident. During an interview with the DSS, on 6/24/2024 at 10:55 a.m., the DSS stated she (DSS) was made aware of R1FM's issues and unable to do anything else since R1FM was the one that complained against Resident 2. The DSS stated there was no witness or documentation that she (DSS) found that R1FM's statement really happened and calling the police for assistance was necessary due to R1FM's agitation toward the facility staff. The DSS stated that for any possible abuse, they must report it and conduct an investigation. During a concurrent interview and record review with the Facility Administrator (FA) on 6/24/2024 at 11:25 a.m., Resident 2's SBAR form was reviewed. FA stated the issue with Resident 2's screaming, cursing and throwing cups to both resident and staff was not reported to him (FA) and added that for any possible abuse/neglect, they have to conduct an investigation and provide reporting to the ombudsman (an affiliated organization who serves as an advocate for patients), police and state agency. During a concurrent interview and record review with the FA on 6/24/2024 at 11:59 a.m., facility grievance/concern form, dated 6/19/2024 was reviewed. The FA stated the result of the grievance report was not acceptable since there was no specific resolution on R1FM's concern. FA also stated that they should have done more investigation of the issue. A review of facility's policy and procedures (P&P), titled, Grievances/Complaints, Filing, reviewed on 4/25/2024, indicated the administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. The P&P also indicated the Grievance Officer (DSS) will coordinate actions with the appropriate state and federal agencies and all alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law.

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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** 43261 Based on interview and record review, the facility failed to implement its policy and procedure for ensuring the reporting of a reasonable suspicion of an abuse in accordance with state and federal law involving one of one sampled resident (Resident 1). This resulted in a delay of an onsite inspection by the State Agency (SA) to ensure the safety of the residents and had the potential to result in unidentified abuse in the facility as well as failure to protect residents from any possible abuse. Cross Reference F610. Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including lack of coordination, diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (a chronic or persistent disorder of the mental processes caused by brain disease). A review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 4/13/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 2's Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), anxiety, depression (a mood disorder that causes persistent feeling of sadness and loss of interest) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 2's MDS dated [DATE], MDS indicated Resident 2 has a severe impairment in cognition for daily decision-making and requiring maximal assistance from staff for ADLs. A review of Resident 2's SBAR (situation, background, appearance and review/notify- structured tool for healthcare provider that provides communication between members. Also, being used as documentation for any changes of condition) form dated 6/15/2024, indicated Resident 2 was screaming, cursing and threw filled cups at the roommate and staff member. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1's Family member (R1FM) on 6/21/2024 at 9 a.m., R1FM stated she (R1FM) notified the Director of Social Services (DSS) regarding her concerns against Resident 2. R1FM stated that Resident 2 was constantly yelling, screaming, and cursing. R1FM also stated she (R1FM) found out that Resident 2 threw a cup of coffee at Resident 1. R1FM stated that she fears for her mother's (Resident 1) safety. R1FM stated that rather than assisting her (R1FM), the DSS called the police for intervention. During an observation and interview with Licensed Vocational Nurse 1 (LVN 1) near the hallway, on 6/21/2024 at 11:26 a.m., Resident 2 was heard screaming, yelling and cursing. LVN 1 stated that Resident 2 was constantly screaming and cursing whenever she (Resident 2) needed something. LVN 1 stated that Resident 2 also had an episode when Resident 2 threw cups at both staff and a resident. During an interview with the DSS, on 6/24/2024 at 10:55 a.m., the DSS stated that she (DSS) was made aware regarding R1FM's issues and was unable to do anything else since R1FM was the one that complained against Resident 2. The DSS stated that there was no witness or documentation that she (DSS) found that R1FM's statement really happened and calling the police for assistance was necessary due to R1FM's agitation toward the facility staff. The DSS stated for any allegations of possible abuse, they must report it and conduct an investigation. During a concurrent interview and record review with the Facility Administrator (FA) on 6/24/2024 at 11:25 a.m., Resident 2's SBAR form was reviewed. FA stated that the issue with Resident 2's screaming, cursing, and throwing cups to a resident and staff was not reported to him (FA); and he was unable to do the reporting. FA stated and added that for any possible abuse/neglect, they have to conduct an investigation and provide reports to the ombudsman (an affiliated organization who serves as an advocate for patients), police and state agency. A review of the facility's policy and procedures (P&P), titled, Abuse Reporting and Investigation reviewed on 4/25/2024, indicated to promptly report ALL allegations of abuse as required by law and regulations to the appropriate agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to implement its abuse policies and procedures to ensure an investigation was completed for any reasonable suspicion of an abuse in accordance with state and federal law for one of one sampled resident (Resident 1). This resulted in a delay of an onsite inspection by the State Agency (SA) to ensure the safety of the residents and had the potential to result in unidentified abuse in the facility as well as failure to protect residents from any possible abuse. Cross Reference F609. Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including lack of coordination, diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and dementia (a chronic or persistent disorder of the mental processes caused by brain disease). A review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 4/13/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and requiring moderate to maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 2's Admission Record indicated that Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), anxiety, depression (a mood disorder that causes persistent feeling of sadness and loss of interest) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 2's MDS dated [DATE], MDS indicated Resident 2 had a severe impairment in cognition for daily decision-making and required maximal assistance from staff for ADLs. A review of Resident 2's SBAR (situation, background, appearance and review/notify- structured tool for healthcare provider that provides communication between members. Also, being used as documentation for any changes of condition) form dated 6/15/2024, indicated Resident 2 was screaming, cursing and threw filled cups at the roommate and staff member. During an interview with Resident 1's Family member (R1FM) on 6/21/2024 at 9 a.m., R1FM stated that she (R1FM) notified the Director of Social Services (DSS) regarding her concerns against Resident 2. R1FM stated that Resident 2 was constantly yelling, screaming, and cursing. R1FM also stated that she (R1FM) found out that Resident 2 threw a cup of coffee to Resident 1. R1FM stated that she fears for her mother's (Resident 1) safety. R1FM stated that rather than assisting her (R1FM), the DSS called police for intervention. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with Licensed Vocational Nurse 1 (LVN 1) by the hallway, on 6/21/2024 at 11:26 a.m., Resident 2 was heard screaming, yelling, and cursing. LVN 1 stated Resident 2 was constantly screaming and cursing whenever she (Resident 2) needed something. LVN 1 stated Resident 2 also had an episode when Resident 2 threw cups at both staff and a resident. During an interview with the DSS, on 6/24/2024 at 10:55 a.m., the DSS stated she (DSS) was made aware regarding R1FM's issues and was unable to do anything else since R1FM was the one that complained against Resident 2. The DSS stated that there was no witness or documentation that she (DSS) found that R1FM's statement really happened and calling the police for assistance was necessary due to R1FM's agitation toward the facility staff. The DSS stated that for any allegations of possible abuse, they must report it and do an investigation. During a concurrent interview and record review with the Facility Administrator (FA) on 6/24/2024 at 11:25 a.m., Resident 2's SBAR form was reviewed. FA stated that the issue with Resident 2's screaming, cursing, and throwing cups to a resident and staff was not reported to him (FA); and he was unable to do the reporting. The FA stated and added that for any possible abuse/neglect, they must conduct an investigation and provide reports to the ombudsman (an affiliated organization who serves as an advocate for patients), police and state agency. A review of the facility's policy and procedure (P&P), titled, Abuse Reporting and Investigation reviewed on 4/25/2024, indicated to thoroughly investigate reports of ALL allegations of abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of an unknown source.