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	01/24/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 1) was properly supervised and monitored for safety after the facility was notified of Resident 1's Family Member 2's (FM 2) had a case order with the Adult Protective Services (APS - a social services program focused on helping elderly adults and adults with disabilities live with dignity and respect by investigating allegations of abuse, neglect, self-neglect and exploitation). This deficient practice placed Resident 1 at risk of abuse and neglect. Cross reference to F656 Findings: A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including ESRD (End Stage Renal Disease-irreversible kidney failure), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/23/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was mildly impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 1's Progress Notes dated 7/6/2023 indicated, APS Supervisor 1 (APSS1) called to follow-up with Resident (1). A review of Resident 1's Social Worker Progress Notes (SWPN) from General Acute Care Hospital 1 (GACH 1) on 9/1/2024 indicated, Patient (Resident 1) has an active case with APS . APSS1 confirmed APS has been following case on/off for about 6 months and follow closely. Write also provided handoff to facility Social Services team upon most recent discharge to Skilled Nursing Facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Referral notes from GACH 1 on 10/7/2024 indicated, Patient (Resident 1) FM 2 who is the subject of multiple APS reports attempted to take patient (Resident 1) out of the facility without staff knowledge/approval. This was discussed with facility Social Worker (Social Services Assistant - SSA) and Social Services Director (SSD) who were aware of the previous APS reports. A review of Resident 1's electronic and paper clinical record as of 1/24/2025 indicated, there was no documentation that the facility followed up on GACH 1's referral and handoff report regarding the APS case report on Resident 1's FM 2. A review of Resident 1's electronic and paper clinical record as of 1/24/2025 indicated, there was no CP developed regarding FM2's APS allegation report. During an interview with APSS1 on 1/24/2025 at 11:33 a.m., APSS1 stated and confirmed, there are APS cases reported against FM 2 for about [AGE] years, and they have been closely monitoring FM 2. During an interview with Registered Nurse 1 (RN 1) on 1/24/2025 at 12:01 p.m., RN 1 stated, FM 2 often visits Resident 1 in the facility during admission. FM 2 stated, she is not aware of any APS report regarding FM 2 and there was no CP developed with interventions that they need to follow for Resident 1's safety. During an interview with SSA on 1/24/2024 at 3:06 p.m., SSA stated, she was aware of FM 2's APS case report from GACH 1. SSA stated, she mentioned it to the staff but did not document anything about it. SSA stated, they should have documented and developed a CP to monitor FM 2 to ensure Resident 1's safety. During an interview with Director of Nursing (DON) on 1/24/2025 at 2:13 p.m., DON stated, there should be a follow-up documented regarding monitoring Resident 1's FM2 regarding APS report case. DON stated, there was no CP developed regarding FM 2's APS case and they should have developed a CP so that all staff are in the same page in regarding Resident 1's safety. A review of the facility's policy and procedure (P&P), titled, Abuse Investigation and Reporting, reviewed on 4/2024, the P&P indicated that, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure safe and orderly discharge from the facility to home for one of four sampled residents (Resident 1) by failing to: 1. Properly discharge Resident 1's without completing a pre-dialysis and post-dialysis assessment after resident's dialysis treatment on 12/30/2024. 2. Complete a discharge plan summary upon Resident 1's discharge to home on 12/30/2024. 3. Complete an Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) meeting for Resident 1's discharge planning according to facility's policy and procedure (P&P). These deficient practices had the potential to result in incomplete or ineffective discharge planning and can lead to lack of necessary care for Resident 1 after discharge. Findings: A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including ESRD (End Stage Renal Disease-irreversible kidney failure), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/23/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was mildly impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and Resident 1 uses manual wheelchair and walker for device and aids used for mobility. A review of Resident 1's electronic and paper clinical record as of 1/24/2025 indicated, there was no pre-dialysis assessment, dialysis unit assessment and post-dialysis assessment on 12/30/2024 completed. The electronic and paper medical record also indicated, there was no IDT meeting done prior to Resident 1's discharge. A review of Resident 1's Progress Notes dated 12/30/2024 indicated, Social Services Assistant (SSA) documented, Resident (1) was discharge to home after her dialysis treatment. The Progress Notes did not indicate any Nurse's Notes regarding Resident 1's discharge on 12/30/2024. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 1 (RN 1) on 1/24/2025 at 12:01 p.m., RN 1 stated, after dialysis, residents must be assessed after dialysis, and they fill out a form where they document their assessment of the vital signs, any signs of bleeding, skin assessment and to monitor for any change of condition. RN 1 reviewed Resident 1's medical record and stated, Resident 1 was sent home after dialysis on 12/30/2024 and there was no documentation that they did a post-assessment dialysis. RN 1 further stated, there was no discharge assessment form completed and there was no discharge summary completed upon Resident 1's discharge to home. During an interview with SSA on 1/24/2024 at 3:06 p.m., SSA stated, Resident 1 was discharged to home on 12/30/2024 and she assisted with setting up home health agency. SSA stated, she discussed discharge planning with Resident 1, but did not document it. SSA stated and confirmed, there was not an IDT meeting for discharge planning for Resident 1. During an interview with Director of Nursing (DON) on 1/24/2025 at 1:12 p.m., DON stated, Resident 1's post dialysis assessment and discharge summary form assessment was not done upon Resident 1's discharge which placed her (Resident 1) at risk for harm due to unsafe discharge. A review of the facility's policy and procedure (P&P), titled, Discharge Summary and Plan, revised on 4/2024, the P&P indicated that, When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment . Every resident will be evaluated for his or her discharge needs and will have an individualized post discharge plan. The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family . A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43454 Based on interview and record review, the facility failed to implement a comprehensive care plan that met the care/services based on the resident's individual assessed needs for one of four sampled residents (Resident 1) by failing to ensure that a comprehensive (CP) was developed after the facility was notified that Resident 1's Family Member 2 (FM 2) have a case order with the Adult Protective Services (APS - a social services program focused on helping elderly adults and adults with disabilities live with dignity and respect by investigating allegations of abuse, neglect, self-neglect and exploitation). This deficient practice had the potential to result negative impact on residents' health and safety, as well as the quality of care and services received. Cross Reference F600. Findings: A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including ESRD (End Stage Renal Disease-irreversible kidney failure), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/23/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was mildly impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and Resident 1 uses manual wheelchair and walker for device and aids used for mobility. A review of Resident 1's Progress Notes dated 7/6/2023 indicated, APS Supervisor 1 (APSS1) called to follow-up with Resident (1). A review of Resident 1's Social Worker Progress Notes (SWPN) from General Acute Care Hospital 1 (GACH 1) on 9/1/2024 indicated, Patient (Resident 1) has an active case with APS . APSS1 confirmed APS has been following case on/off for about 6 months and follow closely. Writer also provided handoff to facility Social Services team upon most recent discharge to Skilled Nursing Facility. A review of Resident 1's Referral notes from GACH 1 on 10/7/2024 indicated, Patient (Resident 1) FM 2 who is the subject of multiple APS reports attempted to take patient (Resident 1) out of the facility without staff knowledge/approval. This was discussed with facility Social Worker (Social Services Assistant - SSA) and Social Services Director (SSD) who were aware of the previous APS reports. (continued on next page)

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