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	09/30/2025

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 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. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 72543(b) Based on observation, interview and record review, the facility failed to maintain medical records for one out of three residents (Resident 1) in accordance with accepted professional standards and practices by ensuring accurate documentation. This failure resulted in the facility's failure to reflect Resident 1's condition and care services provided across all disciplines when Resident 1 had a Change of Condition (COC- a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) as transferred to General Acute Care Hospital (GACH) on 8/3/2025.During a review of the admission record for Resident 3 indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including left and right rim of pubis (bone located in the front part of the pelvis [bony structure inside your hips, buttocks and pubic region]) fractures (break in bone), cerebral infarction (ischemic stroke - is the death of brain tissue due to a blocked artery that cuts off blood supply), and dysphagia (difficulty swallowing). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 8/16/2025, indicated Resident 1 had severe cognitive impairment (a person has great difficulty with thinking, learning, remembering, and making decisions, to the point where they can't live independently). The same MDS indicated Resident 1 required between partial/moderate substantial/maximal assistance for his Activities of Daily Living such as: (ADLs- routine tasks/activities such as toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of the 911 (universal phone number in the U.S. and Canada to connect you to a trained dispatcher who can send police, fire, or medical help to your location) run sheet dated 8/3/2025 indicated, the paramedics arrived at the facility at 12:13 am and were notified by the nursing staff that Resident 1's oxygen saturation (the amount of oxygen carried by red blood cells) had dipped below her (Resident 1) normal (normal levels between 92% to 100%) and was also complaining of pain throughout her (Resident 1) body. During a review of the GACH Emergency Department (ED) report with a service date of 8/3/2025 indicated, Resident 1's chief complaint was shortness of breath and generalized body aches. The same report indicated that Resident 1's oxygen saturation was at 86% while at the facility. During a review of the hospitalist progress notes dated 8/4/2025 indicated, Patient (Resident 1) got very hypoxic (a condition or situation where there is an inadequate supply of oxygen reaching the body's tissues and cells) and came into the hospital which shows bilateral extensive pulmonary embolism (a large, high-risk blockage of one or more pulmonary arteries in the lungs, usually caused by a blood clot that traveled from the deep veins of the legs or pelvis). Patient (Resident 1) now being admitted for treatment of pulmonary embolism. During an interview with Licensed Vocational Nurse (LVN) 3 on 9/29/2025 at 1:08 pm, LVN 3 stated that when there is a COC, a COC form must be completed within an hour in the resident's chart. LVN 3 stated that it was very important to document because it helped people such as the healthcare team understand what was going on with the resident. LVN 3 stated that that on 8/3/2025 around 11:30 pm, Resident 1 was observed to be crying and complained that she had pain in her chest. LVN 3 stated that Resident 1 was noted to have an oxygen saturation of 82% and 911 was called. During a concurrent interview and record review of Resident 1's chart with the Registered Nurse Supervisor (RNS) 2 on 9/30/2025 at 2:47 pm, RNS 2 stated that whenever there was a COC with a resident, the following actions must be taken: assess the resident, notify the physician, notify the resident's family, documentation such as inter act transfer form, progress notes, and/or physician orders to transfer resident to GACH if applicable . RNS 2 confirmed that there was no documented evidence of Resident 1's COC, no progress notes, and no orders for Resident 1 for transfer to GACH. RNS 2 stated that the importance of documentation is to ensure that there is documented evidence that implementations for life safety and preservation of the residents' health were carried out. During a review of the Policy and Procedure (P&P) titled Change in a Resident's Condition or Status, revised 1/30/2025, indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). the same P&P indicated under policy interpretation and implementation the followingThe nurse will notify the resident's Attending Physician or physician on call when there has been a(an):- accident or incident involving the resident.- discovery of injuries of an unknown source.- adverse reaction to medication.- significant change in the resident's physical/emotional/mental condition.- need to alter the resident's medical treatment significantly - refusal of treatment or medications two (2) or more