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	11/14/2025

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. (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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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a physician after a significant change (COC- a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) in the mental or physical condition of a resident who had abnormal laboratory (lab) results for one of the three sampled residents (Resident 1)This deficient practice could have resulted in in the worsening of Resident 1's symptoms such as pain and sepsis (a life-threatening blood infection).During a review of the admission record for Resident 1indicated Resident 1was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic disturbance), hypertension (HTN-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of history and physical (H&P- is a thorough assessment a doctor does to understand a patient's health. It involves asking about the patient's past and current health problems [the history] and then examining the patient's body to look for signs of illness [the physical examination], dated 7/23/2025, indicated Resident 1 can make needs known but cannot make medical decisions. The same H&P listed Family Member (FM)1 as the responsible party (RP). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 8/25/2025, indicated Resident 1 had moderate cognitive impairment (Difficulty remembering recent events, Forgetting familiar names and faces, and Misplacing items frequently). The same MDS indicated Resident 1 was dependent on facility staff for her Activities of Daily Living such as: (ADLs- routine tasks/activities such as oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of the lab results dated 9/3/2025 5:13 pm for a urinalysis (a laboratory test that analyzes a urine sample to detect potential health issues). The urinalysis (UA) indicated the following lab results were flagged as abnormal: Result Reference rangeCharacterTurbid Clear Blood Moderate NegativeNitrate Protein Positive Negative100md/dl NegativeLeukoesterase Large NegativeWBC (white blood cells-fight infection) 3770 /HPF 0-5Bacteria Moderate None During a concurrent interview and record review of Resident 1's chart with the Registered Nurse Supervisor (RNS) 1 on 9/26/2055 at 2:03 pm, the RNS stated that a COC is based on resident assessment and/or resident reports that they are not doing well. RNS stated that some of the conditions that may trigger a COC included cough, abnormal labs, and pain. The RNS stated that the Medical Doctor (MD) must be notified right away to ensure that meds are ordered such as cough meds for a resident that is coughing. RNS 1 stated that a COC/SBAR is documented, progress notes which will include the MD informed in the resident's chart. RNS 1 stated that Labs such as UA, culture, Complete Blood Count are called in or faxed to the facility by the laboratory staff. RNS 1 stated that the UA must be reported right way by facility staff unless the MD requests to wait for the culture (results indicate exactly what type of bacteria in the UA). The potential effect is a safety risk in that the resident would experience symptoms which will adversely affect the resident such as experiencing continued pain upon urination when a resident had abnormal UA results. RNS 1 confirmed that there was no documented evidence that the MD or family were notified and that the SBAR progress notes were not documented even though RNS 1 confirmed that she (RNS 1) had received Resident 1's UA results. During an interview with the Director of Nursing (DON) on 9/26/2025 at 3:10 pm, the DON confirmed that abnormal UA results are considered a COC and should be followed by informing the MD, the resident's RP, documentations such as SBAR, and progress notes. The DON confirmed that there was no documented evidence that any of the above named actions were implemented. 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 consecutive times);- need to transfer the resident to a hospital/treatment center.- specific instruction to notify the Physician of changes in the resident's condition. During a review of a P&P titled, Lab and Diagnostic Test Results - Clinical Protocol, the

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility failed to meet professional standards of quality by failing to ensure that one of four sampled residents (Resident 1)'s medications were administered in accordance with the physician's orders, including any required time frame according to facility's policy and procedure (P&P), titled, Administering MedicationsThis deficient practice increased the risk for accidents and jeopardized resident's health and safety by failing to administer necessary medications in accordance with the physician order.Findings:During a review of the admission Record, Resident 1 was admitted to the facility on [DATE] with diagnosis including unspecified convulsions (sudden, involuntary muscle spasms that can affect the whole body or a part of it), sepsis (a life-threatening blood infection) and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 9/10/2025 indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were mildly impaired. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated, the physician ordered the following:i. Depakote (an anticonvulsant that works in the brain tissue to stop seizures - [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) tablet 125 milligram (mg - unit of measurement) - give three tablets by mouth in the afternoon.ii. Depakote tablet 250 mg - Give 1 tablet by mouth two times a day During a review of Resident 1's Care Plan for high risk for black box warning signs and symptoms related to the use of anti-convulsant Depakote, initiated on 9/8/2025, the CP had a goal of resident (1) will be free from black box warning signs and symptoms related to the use of anti-convulsant, with interventions including, Administer prescribed medication.During a review of Resident 1's Medication Administration Audit Record (MAAR) on 9/8/2025, the MAAR indicated that the Depakote 125 mg tablets were scheduled to be administered at 5 p.m., but the record indicated that the medications were administered at 9:42 p.m. The MAAR also indicated that on 9/12/2025, the Depakote 250 mg tablet was scheduled to be administered at 9 a.m., but the record indicated, the Depakote tablet was administered at 11:24 a.m.During an interview with Resident 1 on 9/22/2025 at 10:06 a.m., Resident 1 stated, she had a seizure while in the facility because her medications for anti-seizure were not being given on time.During a concurrent interview and record review with the Director of Nursing (DON) on 9/22/2025 at 1:29 p.m., DON reviewed Resident 1's MAAR with surveyor, DON stated and confirmed, on 9/8/2025 and on 9/12/2025, the Depakote medications were not administered on time. DON stated, medications are to be administered one hour before and after it was scheduled. DON further stated, if Depakote were not administered on time, residents may have convulsions. During a review of the facility's P&P titled, Administering Medications, reviewed on 1/30/2025, the P&P indicated, Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders.)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident received appropriate treatment and services to prevent urinary tract infection (UTI- an infection in the bladder/urinary tract) for one of three sampled residents (Resident 1) by failing to notify the physician when Resident 1 complained of pain and staff observed sediments in Resident 1's indwelling urinary catheter (foley catheter - a hollow tube inserted into the bladder to drain or collect urine).This deficient practice had the potential to result in urinary tract infections and urinary complications for Resident 1.Findings:During a review of the admission Record, Resident 1 was admitted to the facility on [DATE] with diagnosis including UTI, sepsis (a life-threatening blood infection) and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of the Minimum Data Set (MDS - resident assessment tool) dated 9/10/2025 indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were mildly impaired. The MDS also indicated, Resident 1 had an indwelling urinary catheter.During a review of Resident 1's Care Plan (CP) for high risk for developing complications including UTI due to use of foley catheter, initiated on 9/11/2025, the CP indicated a goal of, Resident (1) will not develop any complications associated with catheter usage and Resident (1) will be free from signs and symptoms of UTI. The CP indicated interventions including, (to) assess for and record any changes in bladder status and observed and notify MD (Medical Doctor) for signs and symptoms of UTI.During a review of Resident 1's Treatment Administration Record (TAR), dated 9/11/2025, the TAR indicated, Resident 1's foley catheter was changed by Treatment Nurse 1 (TXN 1). During an interview with TXN 1 on 9/11/2025, TXN 1 stated, he received an order from the physician to exchange the foley catheter due Resident 1's complained of pain. TXN 1 stated, he observed sediments at the tip of Resident 1's foley catheter after removing it but he did not notify the physician of what he observed, and he did not document the sediments in Resident 1's foley catheter. TXN 1 stated, maybe I should have documented it. TXN 1 stated, sediments may be a symptom of UTI, as well as fever, but he did not check Resident 1's vital signs (measure the basic functions of the body which include body temperature, blood pressure, pulse and respiratory [breathing] rate). TXN 1 further stated, he touched Resident 1 but did not take her temperature.During an interview with Director of Nursing (DON) on 9/22/2025 at 1:29 p.m., DON stated, Resident 1's complained and pain and sediments in foley catheter should have been documented after it was observed and assessed, and the physician should have been notified. DON stated, if the interventions were effective, they should have documented it as well.During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, reviewed on 1/2025, the P&P indicated, Observe the resident for complications associated with urinary catheters: If the resident indicates that his or her bladder is full or that he or she needs to void (urinate), notify the physician or supervisor; Check the urine for unusual appearance (i.e., color, blood, etc);. Report any complaints that resident may have of burning, tenderness, or pain in the urethral area; Observed for other sigs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately.