

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Ocean Pointe Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's call light (a device used to notify the nurse that the resident needs assistance) were answered promptly for two of three sampled residents (Resident 2 and Resident 3). This deficient practice had the potential to result in the residents not being able to summon staff for assistance for care and services as needed, which could lead to accidents such as falls with injuries. During a review of the admission Record, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including history of falling, muscle weakness (weakening, shrinking, and loss of muscle), fibromyalgia (a condition that causes pain all over the body, sleep problems, fatigue, and often emotional and mental distress) and difficulty in walking. During a review of the Minimum Data Set (MDS - resident assessment tool) dated 12/9/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately intact. The MDS indicated Resident 2 required moderate 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). During a review of Resident 2's care plan (CP) for high risk for falls and injury, the CP included interventions such as, have things needed by the resident within reach including call light and other common personal items. During an observation of the facility on 12/30/2025 at 12/30/2025 at 9:40 a.m., a buzzing sound can be heard at Nursing Station 1 and a light bulb was lit. Three staff in the nursing station were observed sitting and looking at a computer monitor. The buzzing sound and light was observed from 9:40 a.m. to 9:47 a.m. During an interview with Resident 2 on 12/30/2025 at 10:03 a.m., Resident 2 stated, she uses the call light especially in the morning where staff sometimes answer the call light immediately, or sometimes, not at all. Resident 2 stated, she pressed the call light about 20 minutes ago because she needed her morning medications.2. During a review of the admission Record, the record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain) and history of falling. During a review of the MDS dated [DATE], the MDS indicated, Resident 3's skills for daily decisions were severely impaired. The MDS indicated Resident 3 were totally dependent on staff for ADLs. During a review of Resident 3's CP for communication deficit related to hearing impaired, and high risk for falls and injury related to metabolic encephalopathy, the CP included interventions such as, keep call light within reach. During an observation of the facility on 12/30/2025 at 10:59 a.m., a buzzing sound can be heard at Nursing Station 1 and a light bulb was lit on. Two staff in the nursing station were observed sitting and looking at a computer monitor. The buzzing sound and light was observed from 10:59 a.m. to 11:07 a.m. During an interview with Certified Nursing Assistant 2 (CNA 2) on 12/30/2025 at 1:13 p.m., CNA 2 stated, she was assigned to Resident 3 and she was aware that Resident 3 used the call light to request assistance from staff. CNA 2 stated, she was helping another resident when she called and she couldn't answer the call light right away. During a concurrent observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 12/30/2025 at 1:29 p.m., LVN 2 were observed sitting on Nursing Station 1. LVN 2 stated, she heard the buzzing sound while she was sitting in the nursing station, LVN 2 stated, I don't work here, I'm from the registry. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 12/30/2025 at 1:30 p.m., LVN 1 was observed sitting on Nursing Station 1 and was working on a computer. LVN 1 stated, there are buzzing sound and call lights on for two rooms. LVN 1 stated, she is going through paperwork for new admissions and new orders today. LVN 1 further stated, I can use the overhead page system for staff to respond on call lights request. During an interview with Registered Nurse 1 (RN 1) on 12/30/2025 at 2:20 p.m., RN 1 stated, the call lights should be answered immediately, and any staff can answer the call light, and if the call lights were not attended right away, resident may be in harm. RN 1 further stated, all staff is responsible for answering call light, even if they are under registry, and even if they are working on something currently, they are able to use the overheard page to ask for help from staff who are working on the floor. During a review of the facility's policy and procedures titled, Call Lights: Accessibility and Timely Response, reviewed on 1/2025, the P&P indicated that, Staff members who see or hear an activated call light are responsible for promptly responding. If staff member cannot provide what Resident desires, appropriate personnel should be notified. During a review of the facility's P&P titled, Quality of Life - Accommodation of Needs, revised on 1/2025, the P&P indicated that, The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that staff follow infection prevention when Treatment Nurse 1 (TXN 1) and Certified Nurse Assistant (CNA) 3 did not wear personal protective equipment (PPE- protective items or garments worn which includes the use of gloves, gown, mask, face shield, when anticipating coming in contact with blood, body fluids or other communicable toxins or agents) when providing suprapubic catheter change for one of four sampled residents (Resident 1) who was on Enhanced Barrier Precaution (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs - bacteria that are resistant to more than one antibiotic and can cause serious infections in nursing facilities).This deficient practice has a potential for Resident 1 risk for acquiring and transmitting infection to other residents, staff and visitors in the facility.Findings:During a review of Resident 1's admission Record , the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including hypertension (HTN-high blood pressure), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and obstructive uropathy (a condition in which the flow of urine is blocked and urine flows backward from your bladder into your kidneys).During a review of the Minimum Data Set (MDS - resident assessment tool) dated 12/2/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills suggests that the individual has a severe level of cognitive impairment. The MDS indicated Resident 1 requires moderate to maximum assistance from the staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS also indicated that Resident 1 had a suprapubic catheter. During a review of Resident 1's Order summary report dated 12/31/2025, the order summary indicated a physician's order was initiated on 08/05/2025 stated Enhanced Barrier Precaution (EBP) related to suprapubic catheter- Apply enhanced barrier to prevent the spread of infections for specific care activities such as: morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave the room, cleaning and disinfecting the environment every shift for monitoring.During an observation on 12/30/2025 at 10:46 a.m., a signage of Enhanced Barrier Precaution was posted outside of Resident 1's room. Treatment Nurse 1 (TXN 1) was observed changing Resident 1's suprapubic catheter with Certified Nursing Assistant 3 (CNA 3) at Resident 1's bedside. Neither TXN 1 and CNA 3 wore complete PPE. During an interview with TXN 1 on 12/30/2025 at 12:02 p.m., TXN 1 stated that he forgot to observe the EBP while changing Resident 1's suprapubic catheter change. TXN 1 stated that CNA 3 should have worn PPE while assisting. TXN 1 explained the facility follows EBP protocol to reduce the risk of spreading multidrug-resistant organisms (MDROs). TXN 1 acknowledged that failing to follow EBP could result in staff transmitting bacteria or viruses to other residents. During an interview with Infection Preventionist (IP 1) on 12/30/2025 at 1:27 p.m., IP 1 stated that residents that have suprapubic catheter are placed on EBP. IP 1 added that staff are expected to wash hands and wear proper PPE. IP 1 further stated that if EBP is not followed, there is a high risk of transmitting bacteria to another resident if staff are not wearing proper PPE. During a review of the facility's P&P titled, Suprapubic Catheter Care, revised on 01/2025 indicated the P&P indicated that equipment and supplies listed for suprapubic catheter care procedure included wash basin; soap and water; washcloth; towel; bed protector; drainage sponge (if ordered by physician); and Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).During a review of the facility's P&P titled, Enhanced Barrier Precautions, reviewed on 01/2025, the P&P indicated that, Facility staff shall perform hand hygiene and will don gown and gloves before performing the following high-contact resident care activities: (may not need to don gowns and gloves prior to entering the resident's room) dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care on chronic wounds requiring a dressing.</p>		