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	03/24/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure one of four sample resident (Resident 1) was provided with immediate interventions such as monitoring and assessment to assure the safety of the resident after Resident 1 reported an allegation of physical altercation between another resident (Resident 2) according to facility's policy and procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting and Charting and Documentation.This deficient practice placed residents being subject to neglect, verbal, mental and physical abuse.Findings:During a review of Resident 1's admission Record, it indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), difficulty in walking, Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and depression (a mood disorder that causes persistent feeling of sadness and loss of interest).During a review of the Minimum Data Set (MDS - resident assessment tool) dated 1/26/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate assistance to supervision 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 admission Record, it indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure) and dementia (a progressive state of decline in mental abilities).During a review of the MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 2 required moderate to maximal assistance from staff for ADLs.During a review of Resident 2's Progress Notes (PN) indicated the following:dated 3/24/2026, the PN indicated, (Resident 2) continues on monitoring for repeated physical and verbal aggression toward others.Dated 3/15/2026, the PN indicated, At around 6 a.m., resident noted with physical aggression towards others in the hallway, attempted to hit with his walker.During an interview with Resident 1 on 3/24/2026 at 12:34 p.m., Resident 1 stated, there had been physical altercations between him and another resident in the facility (Resident 2). Resident 1 stated, he was hit and swung on the mouth and on his head by Resident 2 which happened four to five days ago. Resident 1 further stated, it also happened yesterday (3/23/2026) and he called the Police.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 3/24/2026 at 12:52 p.m., LVN 1 stated, Resident 1 and Resident 2 had history of arguments and both residents don't get along. LVN 1 stated, it had happened few days ago.During an interview with Director of Nursing (DON) on 3/24/2026 at 1:27 p.m., DON stated, Resident 1 had called the Police on 3/23/2026 due to Resident 1's complaint of physical aggression with Resident 2. DON stated, she documented an Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) notes regarding Resident 1's complaint. DON stated, the IDT notes were written only by her, and no other team of the IDT (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented how the meeting went. DON stated, it is the license nurses who do the nursing assessment. DON stated, she did not do any nursing assessments such as skin assessment after Resident 1's complaint of physical aggression with Resident 2. DON stated, when a resident reports any type of abuse, they need to assess and monitor the residents, do a change of condition documentation, report to the physician and responsible party, and all their assessment has to be documented.During a concurrent interview and record review of Resident 1's medical record with Medical Record Director (MRD) on 3/24/2026 at 1:55 p.m., there was no nursing documentation completed regarding Resident 1's allegation of physical altercation with Resident 2. MRD reviewed Resident 1's medical record and stated and confirmed, there are no change of condition or SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) documentation if there was any nursing assessment completed such as skin assessment that was conducted after Resident 1 reported the allegation to the nursing staff.During an interview with Administrator (ADM) on 3/24/2026 at 2:19 p.m., ADM stated, they need to do complete documentation with nursing assessment such as change of condition and/or SBAR when a resident reports any type of abuse and physical aggression between another residents and/or staff.During a review of the facility's P&P titled, Alleged or Suspected Abuse and Crime Reporting, revised on 10/2026, the P&P indicated that, Each resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation. Facility will implement policies and procedures to prevent and prohibit abuse neglect, misappropriation of resident property, and exploitation, for example: assessment and care planning appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Identification: The facility will monitor the adequacy of assessment, care planning and monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse, neglect, exploitation and misappropriation and mistreatment such as: physically aggressive or self-injurious behaviors, verbally abusive towards others. The facility will take necessary actions that are appropriate based on the nature of allegation and results of investigation.During a review of the facility's P&P titled, Change in a Resident's Condition or Status, dated 1/2025, the P&P indicated that, the nurse will notify the resident's Attending Physician or physician on call when there has been a. accident or incident involving the resident. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.During a review of the facility's P&P titled, Charting and Documentation, revised on 1/2026, the P&P indicated that, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.