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	03/15/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497 Based on interview and record review, the facility failed to initiate a change of condition (COC) for one of six sampled residents (Resident 13), who was readmitted from a general acute care hospital (GACH) with significant weight loss. As a result, a physician was not notified of Resident 13's weight loss, which placed Resident 13 at risk for further weight loss. Findings: A review of Resident 13's Admission Record, indicated Resident 13 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including thrombocytopenia (low platelet level), elevated white blood cell count (measures the number of white cells in the blood), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood), muscle weakness, dysphagia (inability to swallow), type 2 diabetes (body's inability to process blood sugar), depression (loss of pleasure or interest in activities for long periods of time), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (elevated blood pressure), chronic vascular disorders of intestine (narrowing of the arteries that supply blood to the intestines), hypothyroidism (low thyroid levels), and atherosclerosis (plaque buildup in artery walls). A review of Resident 13's Minimum Data Set (MDS-a standardized assessment and care-screening tool), dated 2/27/2024, indicated Resident 13's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making were severely impaired. MDS indicated Resident 13 was dependent on staff with activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 13's Nutritional Screen and assessment dated [DATE], indicated Resident's weight was 110 lbs (pounds) on 3/6/2024. The Nutritional Screen and Assessment indicated Resident 13's body mass index (a measure of body fat based on height and weight) was within normal limits and the weight loss (18. 5%) on readmission from acute care was likely related to aggressive hemodialysis treatment (normal a process of filtering the blood of a person whose kidneys are not functioning) with fluid removal in hospital. The Nutritional Screen and Assessment indicated dietary recommendations plan of care met estimated needs, and to continue to monitor and adjust diet for Resident 13. Supplements as indicated. During an interview with the Dietician on 3/14/2024 at 1:33 PM, the Dietician stated, Resident 13 was readmitted from GACH with a significant weight loss. The Dietician stated Resident 13 weighed 135 pounds on 2/8/2024 when the resident was transferred to GACH. The Dietician stated when Resident 13 was readmitted to the facility on [DATE], the resident's weight was 110 pounds (20 lbs weight loss). The Dietician further stated, she was not responsible to notify the physician of the resident's significant weight loss (when a patient loses 5 percent of weight in a one-month period). The Dietician stated, she notifies the nursing department, and the nurses are responsible to initiate a COC including notifying the Medical Doctor and the resident's family. During an interview with the Infection Preventionist (IP) on 3/14/2024 at 1:40 PM, IP stated, he was aware of Resident 13's significant weight loss after being readmitted to the facility. IP stated, because the weight loss happened in the GACH, the facility was not required to initiate a COC including notifying the Medical Doctor. The IP confirmed and stated there was no documentation that Resident 13's doctor was notified of the resident's significant weight loss. A review of the facility's policy and procedures (P&P) titled, Charting and Documentation dated 7/2017, indicated, 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. A review of the facility's P&P titled, Weight Monitoring and Management dated 1/2019, indicated, the Attending Physician and Responsible Party will be notified by the licensed nurse regarding significant weight loss and weight gain. Such notifications will be documented in medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46843 Based on observation and interview, the facility failed to ensure a safe homelike environment for eight ambulatory residents. This deficient practice had the potential to result in residents falling in the hallway due to uneven surfaces in the facility hallways and resident rooms. The area of the floor was slightly raised potentially leading to a tripping hazard for the residents in the facility. Cross Reference F919 Findings: During an observation on 11/6/2023 at 8 AM., the hallway floor in front of Resident rooms 9, 10, 11, 14, 15, and 16, and in Nurses' Station 2, had bulged up area. During an interview on 3/13/2024 at 12:06 PM., Maintenance Supervisor (MS) stated that MS had spoken to the Administrator concerning the bulges floor outside rooms Resident rooms 9, 10, 11, 14, 15, and 16. MS stated the Administrator (ADM) was aware the floor had uneven surface with air bubbles, causing the floor to bulge. MS stated MS attempted to take out the bubble by cutting the tiles and allowing the air to escape; however, that did not work, and the floor remained uneven with small to medium sized bubbles. During an interview on 3/13/2024 at 12:06 PM., ADM stated the floor tiles were installed about four years ago and slight waves and bubbles in the surface appeared later. ADM stated ADM informed the company that there were problems with the tiles getting bubbles in the surface and having waves throughout the entire building. ADM stated the company came out to the facility several times and attempted to reheat the tile and flatten the surface in that manner. ADM stated the company attempted to press down the tile, however, the surfaces could not be repaired and remained slightly uneven with bubbles and waves. ADM stated that he spoke with the MS concerning the issue and there was no solution that MS could find. A review of the facility's policy and procedures (P&P) titled, Floors revised 12/2009, indicated, Floors shall be maintained in a clean, safe and sanitary manner. A review of the facility's P&P titled, Maintenance Service, revised 12/2009, indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment . Functions of maintenance personnel include, but not limited to: maintaining the building in good repair and free from hazards. A review of the facility's P&P titled, Homelike Environment revised 2/2021, indicated, Residents are provided with a safe, clean, comfortable and homelike environment .

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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** 43497 Based on interview and record review, the facility failed to develop a comprehensive care plan for one of five residents (Resident 49), who was placed on a psychotropic medication (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). This deficient practice had a potential for Resident 49 to not receive appropriate care and treatment related to the specific use of psychotropic medication. Findings: A review of Resident 49's Admission Record, indicated Resident 49 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes (elevated blood sugar), lack of coordination, hyperlipidemia (elevated cholesterol), anxiety disorder (a mental health disorder characterized by feelings of worry), hemiplegia (paralysis of one side of the body), hypertension (elevated blood pressure), retention of urine (inability to urinate), transient ischemic attack (a short period of symptoms similar to a stroke), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply. A review of Resident 49's Minimum Data Set (a standardized assessment and care screening tool) dated 2/15/2024, indicated Resident 49 was cognitively (relating to mental ability to make decisions of daily living) intact. Resident 49 required moderate assistance with oral hygiene, eating, and personal hygiene. A review of Resident 49's Physician Orders dated 5/26/2023, indicated an order for Diazepam (a medication used to treat anxiety) tablet 5 milligram (mg, unit of measurement) give 1 tablet by mouth at bedtime for anxiety disorder manifested by verbalization of anxiety. During an interview and concurrent record review with the Minimum Data Set Nurse (MDSN), on 3/13/2024 at 4:11 PM, Resident 49's care plans were reviewed. MDSN stated, MDSN could not locate a care plan for Resident 49's medication Diazepam. MDSN stated, there needs to be a care plan in place that indicates the appropriate treatment and interventions for Resident 49. A review of the facility's policy and procedures (P&P) titled, Care Plan, Comprehensive Person-Centered dated March 2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497 Based on observation, interview, and record review, the facility failed to follow the physicians order for oxygen supplementation for one of six sampled residents (Resident 119). This deficient practice had the potential to result in inappropriate treatment of oxygen delivery, placing Resident 118 at risk to experience shortness of breath and/or hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis) Findings: A review of Resident 118's Admission Record, indicated Resident 118 was initially admitted on [DATE], and readmitted on [DATE] with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder (persistent worry), depression (a mood disorder characterized by feelings sadness), anemia (low blood red blood cells), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure (not enough oxygen), pressure ulcer of sacral region (bed sores), psoriasis (a condition in which cells build up and form scales and itchy patches), epilepsy (a seizure disorder), emphysema (a type of lung disease that causes breathlessness), thrombocytopenia (low platelets), hypercalcemia (elevated calcium levels), and dysphagia (inability to swallow). A review of Resident 118's Minimum Data Set (MDS-a standardized assessment and care-screening tool), dated 12/14/2023, indicated Resident 118's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making were severely impaired. The MDS indicated Resident 118 was dependent on staff with activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene). A review of Resident 118's Physician Orders dated 3/7/2024, indicated an order for oxygen at 2 liters/minute (measures amount of fluid passes through cross-sectional area) via nasal cannula (used to deliver supplemental oxygen or increased airflow to a patient in need of respiratory help) as needed to maintain oxygen saturation (a measure of how much hemoglobin is bound to oxygen) at 95%. During an observation and a concurrent interview with Licensed Vocational Nurse 5 (LVN 5) in Resident 118's room, on 3/13/2024 at 9:25 AM, Resident 118 was observed on oxygen via nasal cannula at 1 liter per minute. LVN 5 confirmed and stated, the physician's order was for Resident 118 to receive 2 liters. LVN 5 stated Resident 118 was not receiving the correct oxygen treatment. LVN 5 further stated, not following the physician's order can lead to the resident to experience increased shortness of breath. A review of the facility's policy and procedures (P & P) titled, Oxygen Administration dated October 2010, indicated, the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation includes to verify that there is a physician's order for the procedure and review the physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P & P titled, Physician Orders Policy undated, indicated, medications and treatments will be administered as ordered, recorded timely and monitored for accuracy.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46843 Based on interview and record review, the facility failed to administer pain medication in accordance with physician's orders and care plans for one out of eight sampled residents (Residents 58). As a result, Resident 58 suffered burning pain level 9 out of 10 (9/10 - numerical pain assessment tool where zero is no pain and 10 is severe pain) to the left leg for two hours. Cross reference to F919 Findings: A review of Resident 58's Admission Record dated 3/13/2024, indicated the facility initially admitted Resident 58 on 10/18/2022 with diagnoses that included toxic encephalopathy, (a brain dysfunction caused by toxic (poisonous substances) exposure), muscle weakness (a lack of physical or muscle strength, throughout the body, essential hypertension (high blood pressure), and hemiplegia, (paralysis (is when you are not able to move some or all your body) that affects only one side of your body) affecting the left side of the body. A review of Resident 58's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 1/17/2024, indicated Resident 58 was cognitively (relating to mental able to make decisions concerning care, alert to situation and oriented to place and time) intact. Resident 58 needed maximal assistance (helper does more than half the effort needed to complete activities of daily living (ADL - shower, toileting hygiene, upper and lower body dressing). A review of Resident 58's Pain Assessment document dated 1/19/2023 at 12:51 p.m., indicated Resident 58 to receive Tylenol (pain medication) oral tablet 325 milligrams (mg - unit of measurement) every 6 hours as needed, Gabapentin (Neurontin - medication for nerve pain) capsule 300 mg two times a day, and Oxycodone HCL (controlled strong pain medication) oral tablet 5 mg by mouth every 6 hours as needed for pain. A review of Resident 58's Physician's Orders dated 3/13/2024 at 3 p.m., indicated to keep Resident 58 comfortable by administering Tylenol oral tablet 325 mg every 6 hours as needed, Gabapentin Capsule 300 mg two times a day and Oxycodone HCL oral tablet 5 mg by mouth every 6 hours as needed. A review of Resident 58's Medication Administration Record (MAR - a record of medications administered to a resident and refused by a resident) for the month of 3/2024, indicated Resident 58 was receiving Gabapentin capsules 300mg three times a day as scheduled for pain, Oxycodone tablet 5mg three times a day as needed. However, the MAR did not indicate Resident 58 either received or refused any pain medication on 3/10/2024. A review of Resident 58's care plan titled High risk for black box warning signs and symptoms of narcotic analgesic oxycodone, no initiation date, indicated, Administer prescribed medication. A review of Resident 58's care plan titled High risk for black box warning signs and symptoms of Gabapentin (Neurontin), no initiation date, indicated, Administer prescribed medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2024 at 9:40 a.m., Resident 58 stated the call lights system was not working for three days and had difficulty getting pain medication on time. Resident 58 stated the left leg pain would start at different times of the day and night. Resident 58 stated last weekend (3/9/2024 and 3/10/2024), the left leg pain level of pain level was 9/10. Resident 58 stated he was very upset because he had to wait and remained in severe pain for 2 hours for someone to respond to him calling for pain medication. During an interview with Director of Nursing (DON) on 3/15/2023 at 3:27 p.m., DON confirmed and stated Resident 58 had pain management care plan in place. A review of facility's policy and procedures titled Pain Assessment and Management, revised 10/2022, indicated, General Guidelines 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain. Based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48026 Based on observation, interviews, and records review, the facility failed to: 1) Ensure staffing information was posted in a prominent place readily accessible to residents and visitors. 2) Make nurse staffing information readily available in a readable format to residents and visitors at any given time. 3) Make daily staffing available to the public for review upon request. 4) Maintain the posted daily nurse staffing data for a minimum of 18 months. Findings: During an observation on 3/12/2024 at 12:50 PM, the nurse staffing data information was not posted anywhere in the facility visible to residents and visitors. During an observation on 3/13/2024 at 9:50 AM, the nurse staffing data information was not posted anywhere in the facility visible to residents and visitors. During an interview with Director of Nursing (DON) on 3/15/2024 at 4:22 PM, DON was asked why the required daily nurse staffing data was not posted at the Nurse's Station 1 where it would be visible to residents and visitors. DON stated the facility posted Census and Direct Care Service Hours Per Patient Day (DHPPD - the number that results from dividing the actual number of hours worked by direct caregivers per patient day) daily. DON stated DON did not know the daily nurse staffing data with the total number of Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and Certified Nursing Assistants (CNAs) plus the actual work hours for each licensed and unlicensed nursing staff with direct care to residents should be posted daily. During an interview with Administrator (ADM) on 3/15/2024 at 5:28 PM, ADM stated that DHPPD was posted daily. However, the surveyor informed ADM that DON was now aware the daily nurse staffing with total number of RNs, LVNs, and CNAs plus the actual work hours for each licensed and unlicensed nursing staff should be posted daily. ADM stated the facility has never maintained specific hours for the RNs), LVNs, and CNAs. A review of the facility's policy and procedures (P&P) dated 8/2022, indicated, our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents and records of staffing information for each shift are kept for a minimum of 18 months.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497 Based on interview and record review, the facility failed to follow up and communicate with a physician the consultant pharmacist's recommendation to perform blood tests for two of three sampled residents (Residents 49 and 51) in accordance with facility's policy titled Medication Regime Reviews. This deficient practice had the potential to result in missed opportunity to correct identified irregularities regarding prescribed medications for Residents 49 and 51. Findings: A review of Resident 49's Admission Record, indicated Resident 49 was admitted on [DATE] with diagnoses including type 2 diabetes (elevated blood sugar), lack of coordination, hyperlipidemia (elevated cholesterol), anxiety disorder (a mental health disorder characterized by feelings of worry), hemiplegia (paralysis of one side of the body), hypertension (elevated blood pressure), retention of urine (inability to urinate), transient ischemic attack (a short period of symptoms similar to a stroke), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply. A review of Resident 49s Minimum Data Set (a standardized assessment and care screening tool) dated 2/15/2024, indicated Resident 49 was cognitively (relating to mental ability to make decisions of daily living) intact. The same MDS indicated Resident 49 required moderate assistance with oral hygiene, eating, and personal hygiene. A review of Resident 49's Physician Orders dated 1/5/2024, indicated the resident was on Depakote (medication that treats seizures and bipolar disorder) oral tablet delayed release 125 milligrams (mg, unit of measurement) by mouth two times a day for mood disorder manifested by verbalization of racing thoughts. A review of facility's Pharmacy Consultation Report dated 2/28/2024, indicated Resident 49 had an order for Depakote (medication that treats seizures and bipolar disorder), which may cause blood dyscrasias (a blood disorder affecting blood cells, plasma, and proteins) and impaired liver function, especially early in therapy. The facility's Pharmacy Consultation Report, indicated to consider ordering a complete blood count (CBC - full blood count test which test for wide range of disorders), liver panel (a group of blood test that provide information about the state of a person's liver), ammonia (measures the amount of ammonia in the blood), and serum valproic acid level on the next lab draw. The Pharmacy Consultation Report was not signed or dated by a physician. During an interview with Director of Nurses (DON), on 3/15/2024 at 2 PM, DON stated, the pharmacy recommendation to order labs for Resident 49 was not done. DON stated, she could not provide any documentation indicating the laboratory (lab) tests were ordered. DON stated, it was important to follow pharmacy recommendations to ensure residents receive correct medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 51's Admission Record, indicated Resident 51 was admitted on [DATE] and readmitted on [DATE] with diagnoses including toxic encephalopathy (acute cerebral dysfunction due to different metabolic disturbances), history of falling, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), muscle weakness, dysphagia (inability to swallow), chronic obstructive pulmonary disease with acute exacerbation (a group of lung diseases that block airflow and make it difficult to breathe), acute and chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), malignant neoplasm of bladder (bladder cancer), cardiomegaly (an enlarged heart), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow of the limbs), cellulitis of right lower limb (bacterial skin infection), adult failure to thrive (when an older adult has a loss of appetite, leading to weight loss), dorsalgia (back pain), and hyperlipidemia. A review of Resident 51's MDS dated [DATE], indicated the resident's cognition was moderately impaired. Resident 51 required moderate assistance with oral hygiene and eating, and maximal assistance with upper body dressing. A review of Resident 51's Drug Regimen Review dated 3/6/2024, indicated, an issue with administering parameters for the medication Midodrine (medication to treat low blood pressure that causes severe dizziness and fainting) with recommendation per order this medication is to be given as needed in addition to routinely. Consult with Medical Doctor and clarify administration parameters in what situation should it be given and frequency. A review of Resident 51's Physicians Orders dated 3/6/2024, indicated the resident continued to receive Midodrine HCL oral tablet 5 mg give 1 tab by mouth as needed for hypotension (low blood pressure). The order did not indicate the parameters and frequency for Midodrine administration. During an interview with DON, on 3/15/2024 at 2:30 PM, DON stated, the Drug Regimen Review for Resident 51, was not signed or dated, and therefore it was not done. A review of facility's policy and procedures titled, Medication Regimen Reviews dated May 2019, indicated, the consultant pharmacist reviews the medication regimen of each resident at least monthly. The consultant pharmacist provides the director of nursing services and medical director with a written, signed, and dated copy of all medication regimen reports. Copies of medication regimen reports, including physician responses, are maintained as part of the permanent medical record. The attending physician documents in the medical record that the irregularities have been reviewed and what action was taken to address it.

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Ocean Pointe Healthcare Center	1330 17th Street Santa Monica, CA 90404

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497 Based on observation, interview, and record review, the facility failed to ensure the safety of storing, preparing, distributing, and serving food in accordance with professional standards and its policies for food service when: 1) Multiple food items in the kitchen did not bear a label indicating a use-by date in accordance with the policy. 2) Multiple food items were expired or did not have an open date. These deficiencies had the potential to result in food-borne illness in medically vulnerable residents who consumed the food prepared by the facility kitchen. Findings: During an observation and a concurrent interview with Dietary Supervisor (DS), on [DATE] at 8:30 AM, the following were observed: 1. A container of dill weed had an expiration date of [DATE]. 2. A container containing beans did not have a use by label. 3. A bag of green lentils did not have a used by label. 4. A gallon of milk did not have an open date or expiration date. 5. A container containing prunes did not indicate a use by date. 6. A container containing peaches did not have any labels indicating use by date. 7. A container with apple sauce did not have use by date. 8. A container with tofu did not have use by date. 9. A container of strawberry sauce was expired on [DATE]. 10. A tuna salad container had an expiration date of [DATE]. 11. An open container containing hamburger dill chips did not have expiration date or used by date. 12. A box containing bananas had a paper with a black substance. 13. A bag of corn tortillas did not have an open date or used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. A container with lemons had an expiration date of [DATE]. 15. A container with tomatoes did not have used by label date. During an observation and a concurrent interview with Dietary Supervisor (DS), on [DATE] at 8:30 AM, DS confirmed and stated, food items in the refrigerator and dry food storage area must have a label indicating when the food should be used by. DS stated when food items are opened, there should also be an open date. DS stated it is important to prevent food borne illnesses (are infections or irritations of the stomach caused by food or beverages that contain harmful bacteria, parasites). A review of facility's policy and procedures titled, Food Service Management dated 2017, indicated, practices to maintain safe refrigerated storage include labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen where applicable or discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43497 Based on interview and record review, the facility failed to implement a safe water management program to prevent water borne diseases including legionnaire's disease (a serious type of pneumonia, can occur in persons who inhale water droplets contaminated with the bacterium Legionella). This deficient practice had the potential to spread water borne illnesses including legionnaire's disease in the facility. Findings: 46843 During an interview on 11/7/23 at 2:18 AM with Maintenance Supervisor (MS). MS stated MS was not aware of any water management program. However, MS stated MS had tested the water temperatures and kept a log of his activity. The MS stated MS did not know about any water testing program. During an interview on 3/14/2024 at 9:20 AM, Infection Preventionist (IP) stated, currently maintenance increases water temperature to kill bacteria such as legionella. MS stated all the shower heads are changed every three months and IP tests the water twice a month. MS stated MS checks/tests daily water temperatures daily and completes water testing monthly. IP stated water tests are completed by collecting samples of water from various sources throughout the facility using a mini-lab water testing kit. During an interview on 3/14/2024 at 11:06 AM, MS stated MS watches YouTube videos to figure out how to use the reusable water testing kits and to guide MS on water treatment and disinfection program. MS stated I use four ounces of bleaching solution to disinfect the water and wash the shower heads in resident showers. MS stated MS heats the hot water in the boiler to a very high temperature to kill any germs. MS stated once the water has reached, a high temperature, then I cool it down before it goes into the pipes. MS stated the facility does not have any outside laboratory company that comes into the facility to test the water. MS stated water testing in the facility is conducted by MS, IP, and Administrator (ADM). During an interview with ADM, IP, and MS on 3/14/2024 at 11:44 AM, ADM stated the water was tested by IP. ADM stated, as far as the water treatment, MS, does the cleaning and disinfecting of the shower and water faucets. ADM further stated, at the beginning of 2024 we started testing the water twice monthly for legionella. ADM stated IP collects water samples from various areas in the facility and uses a mini-lab test kit to test the water. A review of the facility's P&P titled, Legionella Water Management Program dated revised 7/2017 indicated, 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team will consist of at least the following personnel: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Infection Preventionist b. Administrator c. Medical Director d. Director of Maintenance and e. Environmental Services 5. The water management program includes the following elements: e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants);

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497 Based on interview and record review, the facility failed to ensure Pneumonia (PNA-infection of one or both lungs) vaccines was offered and/or re-offered to one of six sampled residents (Resident 29) per facility policy titled Pneumococcal Vaccination. This deficient practice had the potential to place Resident 29 at risk of acquiring and transmitting pneumonia infection. Findings: A review of Resident 29's Admission Record, indicated Resident 29 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including elevated white blood cell count (a white blood cell count measures the number of white cells in the blood), retention of urine, difficulty walking, muscle weakness, bipolar disorder (a disorder associated with episodes of mood swings), neuroleptic induced parkinsonism (drug induced parkinsonism), mild cognitive impairment (problems with a person's ability to think), tremors (a condition that affects the nervous system), hyperlipidemia (elevated cholesterol), hypertension (elevated blood pressure), allergic rhinitis (seasonal allergies), edema (swelling caused by too much fluid), and polyneuropathy (many nerves in different parts of the body are involved). A review of Resident 29's Minimum Data Set (MDS-a standardized assessment and care-screening tool), dated 5/11/2024, indicated Resident 29's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making were severely impaired. The MDS indicated Resident 29 required maximal staff assistance for activities of daily livings (ADLs-bed mobility, dressing, toilet use and personal hygiene). During an interview and a concurrent record review with Infection Preventionist (IP), on 3/15/2024 at 4:00PM, IP stated IP could not locate any records that indicated Resident 29 had received pneumonia vaccine. IP stated IP must have missed offering pneumonia vaccine to Resident 29. A review of the facility's policy and procedures titled, Pneumococcal Vaccination dated 2/2022, indicated, to minimize the risk of residents acquiring pneumococcal diseases by assuring each resident is informed about the benefits and risks of immunizations, and has the opportunity to receive, unless medically contraindicated or refused or already immunized, the influenza and pneumococcal vaccine.

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026 Based on interview and record review, the facility failed to provide alternate call system for nine of 62 residents from 3/9/2024 to 3/12/2024 when the facility's call system was nonfunctional. As a result: 1. Resident 58 continued to suffer burning pain to his left leg at a level 9 out of 10 (9/10 - zero is no pain and 10 is severe pain) because the call light system was not working, and staff were not responding to the Resident 58 calling for help/pain medication. 2. Residents 26, 49, 51, 58, 64, 119, 120, and 219 banged on the tables, yelled, and screamed for staff to get help. Residents 49, 64, 119, and 120 waited for 30 minutes to 1 hour for staff assistance. Residents 119 needed help to go to the rest room. Resident 120 needed to be turned and repositioned. Resident 51 felt distressed. 3. Resident 26 stated she was petrified and uncomfortable and that in case of emergency, she would not be able to get help because the facility's call light was not working 4. Residents 49 and 64 needed help for activities of daily living (ADL) and incontinence (inability to voluntarily control the bowels and bladder) care and the call light was not functional and had no means to alert staff for assistance. 5. Resident 64 used her personal phone to call the staff for assistance. 6. On 3/11/2024, Resident 218 fell and Resident 219 (Resident 218's roommate), found Resident 218 on the floor. Resident 219 called for help and wished the facility's the call light system was functional. The facility call light had been nonfunctional/not working (no light or sounding to alert staff) since 3/9/2024 at 3:15 AM. On 3/12/2024 at 7:20 AM, the survey team entered the facility and identified through observation, interview, and record review the facility failed to provide the residents with alternate call system(s) from 3/9/2024 at 3:15 AM to 3/12/2024 to 9:45 AM. On 3/12/2024 at 6 PM, an Immediate Jeopardy (IJ - a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM) and the Director of Nursing (DON) regarding the facility's call light has been nonfunctional/not working (no light or sounding to alert staff) since 3/9/2024 at 3:15 AM. On 3/14/2024 at 7:51 PM, while onsite at the facility, the IJ was removed in the presence of the ADM and the DON, after the ADM submitted an acceptable IJ Removal Plan (interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview, and record review. The acceptable IJ removal plan included the following: (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Effective 3/9/2024, residents able to utilize manual call bell when the call system was nonfunctional, were provided with manual call bells. Two direct care/clinical staff to complete the rounding log after making (hunger, thirst, repositioning, toileting, ADL, and medications) and interventions evaluated every shift until the call system was repaired. The ADM, DON and/or Director of Staff Development (DSD) will monitor compliance twice a shift. 2. Effective 3/9/2024, two direct care/clinical staff residents will make rounds on residents unable to utilize a manual call bell (residents who were cognitively impaired, confused, visually/hearing impaired, nonverbal, and/or comatose [prolonged unconsciousness brought on by illness or injury]). The two direct care/clinical staff will complete the rounding log after making rounds on residents every 15 minutes to ensure resident needs were met (hunger, thirst, repositioning, toileting, ADL, and medications) and interventions evaluated every shift until the call system was repaired. The ADM, DON and/or DSD will monitor compliance twice a shift. 3. On 3/9/2024, all 62 residents were identified and affected by the non-functioning call system. 4. On 3/12/2024, the Medical Director was notified immediately of the non-functioning call system. 5. The DON, DSD, RN Supervisors/Unit Managers and/or Nurse Consultant in-serviced/educated direct care/clinical and/or registry staff immediately on 03/09/2024. The in-service included: a. The importance of the expectations (keeping residents safe and ensure their needs are met) when the call light system fails. b. Encouraging and reminding residents to utilize manual call bell. c. Rounding on residents every 15 minutes to ensure resident needs were met. d. In-services addressed residents who were cognitively impaired, confused, visually/hearing impaired, nonverbal, comatose, etc. 6. Effective 3/9/2024, the Medical Records Director (MRD), notified the residents and/or family/resident representatives of the non-functioning call system, and interventions in place until call system was repaired. 7. Repair company was scheduled to fix/repair the call light system on 3/12/2024. 8. After the call system was repaired, the facility would continue to monitor of the call light twice per shift for 24 hours by a direct care/clinical staff from 3/12/2024 at 7 PM until 3/13/2024 at 7 PM. The facility will activate the call light system and the direct care/clinical staff would check to ensure the call light was on. The MRD would monitor for compliance and report any findings/trends to the monthly Quality Assurance Performance Improvement (QAPI, a systematic, data-driven approach to improving the quality of care and services provided to residents in long-term care facilities) meeting. 9. Maintenance Supervisor (MS) will monitor call light system every Friday for the next three months and correct identified issues. The ADM will monitor for compliance and report any findings/trends to the monthly QAPI meeting. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	10. On 3/21/2024, the IJ Removal Plan to be reviewed during QAPI committee Meeting. Cross Reference F697 Findings: On 3/12/2024 at 7:20 AM, the surveyor team entered the facility to conduct recertification survey and heard several residents, yelling, screaming, shouting, and banging asking for help. a. A review of Resident 218's (Resident 219's roommate) Admission Record indicated Resident 218 was admitted to the facility on [DATE] had diagnoses including memory loss, left eye vision loss, anxiety (a condition of excessive worry about daily issues and situations), and depression (a common but serious mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 218's history and physical (H&P - a physician's first complete patient examination) dated 3/11/2024, indicated, Resident 218 underwent a left total hip arthroplasty (a surgical removal of the diseased parts of the hip joint and replaced them with new, artificial parts) on 3/06/2024. A review of Resident 218's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/13/2024, indicated, Resident 218 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). A review of Resident 218's Morse Fall Risk Screen (a rapid and simple method of assessing a patient's likelihood of falling) dated 3/10/2024, indicated, Resident 218 had a weak gait (pattern of walking/balance function) and had a moderate fall risk. A review of Resident 218's Occupational Therapy Evaluation and Plan of Treatment dated 3/11/2024, indicated, Resident 218 was at risk for fall. A review of Resident 218's Morse Fall Risk Screen (a rapid and simple assessment tool of a patient's likelihood of falling) dated 3/11/2024, indicated, Resident 218 had an impaired gait and was a high risk for fall. A review of Resident 218's Situation-Background-Assessment-Recommendation/Change of Condition (SBAR/COC - a technique that provides a framework for communication between members of the health care team and used as a tool to foster patient safety) dated 3/11/2024 at 8:02 PM, indicated, Resident 218 had an unwitnessed fall. During an interview with Resident 219 (Resident 218's roommate) on 3/12/2024 at 2:09 PM, Resident 219 stated Resident 218, wouldn't use the call light anyway because she (Resident 218) will get out when she wants to. Resident 219 stated that on 3/11/2024, Resident 219 ran out of the room because the call light system was not working and had no other means of calling the staff, and yelled, she [Resident 218] fell , she fell to get the staff's attention when Resident 218 fell on the floor. Resident 219 stated I had to shout to have them [staff] hear me. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	b. A record review of Resident 219's Admission Record, indicated, Resident 219 was admitted to the facility on [DATE] with a diagnoses of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung diseases that causes obstructed airflow from the lungs), acute and chronic respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body leading to insufficient amount of oxygen at the tissue level), hypertensive heart disease with heart failure (heart problems that occur because of high blood pressure that is present over a long time with heart muscle not able to pump enough blood for the body's needs). A review of Resident 219's H&P dated 12/18/2023, indicated Resident 219 was alert and oriented to person and place. During an interview with Resident 219 (Resident 218's roommate) on 3/12/2024 at 2:09 PM, Resident 219 stated Resident 218, wouldn't use the call light anyway because she (Resident 218) will get out when she wants to. Resident 219 stated that on 3/11/2024, Resident 219 ran out of the room because the call light system was not working and had no other means of calling the staff, and yelled, she [Resident 218] fell , she fell to get the staff's attention when Resident 218 fell on the floor. Resident 219 stated I had to shout to have them [staff] hear me. During an observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 3/12/2024 at 3:35 PM, LVN 3 was observed rounding the south hallway with a clipboard, going into resident's room asking residents if they needed assistance. LVN 3 stated his shift started at 7AM but was asked by the Director of Nursing (DON) to work overtime until 11:30 PM tonight. LVN 3 stated LVN 3 checked each resident every 15 minutes but if a resident called for help while he was assisting another resident with nursing care, I would not be able to help the other resident at all. When asked when the cow bell or ring bell were made available to the residents, LVN 3 stated, I don't remember. 43497 c. A review of Resident 120's Admission Record, indicated Resident 120 was admitted on [DATE] with diagnoses including unspecified intracapsular fracture (a break along the length of the bone) of left femur (thigh bone) history of falling, atherosclerotic heart disease (damage or disease in the heart's major blood vessels), muscle weakness, dysphagia (inability to swallow), low back pain, intervertebral disc degeneration in the lumbosacral region (wear and tear of lumbar intervertebral disc), hyperlipidemia (elevated cholesterol), hypothyroidism (low thyroid levels), thrombocytopenia (low platelet level), and anorexia (an eating disorder characterized by restriction of food). A record review of Resident 120's MDS dated [DATE], indicated Resident 120 was cognitively intact (able to make needs known) and required moderate staff assistance with upper body dressing, and personal hygiene. During an observation and interview with Resident 120 on 3/12/2024 at 10:07 AM, Resident 120 was observed in bed and yelling for help. Resident 120 stated, he needed to be repositioned and that the call light had not been working since Saturday (3/2/2024). Resident 120 stated, he had to wait for 30 minutes to one hour to get help from staff. Resident 120 was observed to be visibly distressed and uncomfortable. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 64's MDS dated [DATE], indicated Resident 64 was cognitively intact. Resident 64 required moderate staff assistance with oral hygiene and eating, and maximal assistance with upper body dressing. During an observation and interview with Resident 64 on 3/12/2024 at 10:58 AM, Resident 64 was in bed in bed awake, alert and verbally responsive. Resident 64 stated, she had not had a functioning call light for three days (3/9/2024, 3/10/2024, and 3/11/2024). Resident 64 stated she used her cell phone to call the facility whenever she needed help. Resident 64 stated, she would call the nurses to change her because she was incontinent. Resident 64 stated, she would be in trouble if she did not have her cell phone because there is no other way to get help from a nurse. g. A review of Resident 49's Admission Record, indicated Resident 49 was admitted on [DATE] and was readmitted on [DATE] with diagnoses including type 2 diabetes (elevated blood sugar), lack of coordination, hyperlipidemia, anxiety disorder, hemiplegia (paralysis of one side of the body), HTN, urine retention (inability to urinate), transient ischemic attack (TIA - a short period of symptoms similar to a stroke), cerebral infarction (stroke - occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply). A review of Resident 49's MDS dated [DATE], indicated Resident 49 was cognitively intact. Resident 64 required moderate staff assistance with oral hygiene, eating, and personal hygiene. During an observation and interview with Resident 49 on 3/12/2024 at 11:40 AM, Resident 49 was in bed awake, alert and verbally responsive. Resident 49 stated, she has not had a functioning call light since the weekend. Resident 49 stated she has to yell out for help, and this makes her anxious. Resident 49 stated, she was not provided with any other options to call for help. 46843 h. A review of Resident 58' s Admission Record dated 3/13/2024, indicated the facility initially admitted Resident 58 on 10/18/2022 with diagnoses that included, toxic encephalopathy, muscle weakness, HTN, hemiplegia, and slurred speech (a motor speech disorder in which muscles used to produce speech are damaged, paralyzed, or weakened), and anarthria (complete loss of speech). A review of Resident 58's MDS dated [DATE], indicated Resident 58 was cognitively intact (able to make decisions concerning care, alert to situation and oriented to place and time). The MDS indicated Resident 58 needed maximal assistance (helper does more than half the effort needed to complete ADL (shower, toileting hygiene, upper and lower body dressing). A review of Resident 58's care plan titled Call lights Malfunctioning/not working (No initiation date), indicated, Resident 58 will be checked at least every 15 minutes. (continued on next page)

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	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Pointe Healthcare Center	1330 17th Street Santa Monica, CA 90404

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with Resident 58 on 3/12/2024 at 9:40 am, Resident 58 stated the facility call lights need to be fixed because the call lights had not been working for about three days. Resident 58 stated Resident 58 had difficulty getting pain medication on time due to the call light system not working. Resident 58 stated he really needed the call light, because his left leg pain would start at different times of the day and night. Resident 58 stated that on 3/9/2024 and 3/10/2024 his left leg pain level was nine out of 10 (numerical pain assessment tool where zero is no pain and 10 is severe pain). Resident 58 stated he had to yell for help and for pain medication because the facility's call lights was not working. Resident 58 stated he waited for about two hours for someone to respond to him calling for help. Resident 58 stated he was very upset that no one was there to help him when he needed help. Resident 58 stated he remained in severe pain for at least two hours on 3/10/2024 night. During an interview on with MS 3/12/24 at 12:02 PM, MS stated that on 3/9/2024 at 3:15am, MS notified the Director of Nursing (DON) that the call lights system was not working. MS stated that the next day, on 3/10/2024, MS contacted the company that performs maintenance and repairs on the facility call lights system and the company informed MS that a maintenance person could not be sent out until Tuesday 3/12/2024 after 5 pm to repair the call light system. MS stated MS called another company who too was unable to assist the facility any sooner. MS stated MS tried several times to fix the call light system but needed a part that MS was unable to purchase and had to wait until 3/12/2024 for the repair company to repair the call light system. During an interview with DSD on 3/12/24 at 3:13 PM, after the surveyor team identified nonfunctioning call light system, DSD stated, the facility will designate floaters for each shift until the call light system is repaired. The person assigned as floater will be responsible to check if residents need help. The floater will make rounds every 15 minutes to check if residents need assistance. The person that is assigned as floater will not have any residents assigned to them throughout the shift. The floaters only responsibility will be to check the residents and make sure their needs are met. During an interview with LVN 1 on 3/12/24 at 3:32 PM, LVN 1 stated, recently the facility assigned Restorative Nurse Assistant 1 (RNA 1 - a person trained to assist a patient/resident with performing transfers, bed mobility, positioning and range of motion) as a floater to make rounds to assist other staff when residents need help, such as putting residents back to bed, cleaning and provide incontinence care to residents, and help other staff members with various tasks. During an interview with RNA 1 on 3/12/24 at 3:43 PM, RNA 1 stated that during the weekend (3/9/2024 and 3/10/2024), and Monday (3/11/2024) the facility's administration called RNA 1 in to work overtime as a floater for 16 hours. RNA 1 stated, starting Saturday, 3/9/2024, RNA 1 was to come in at noon to help with the call light situation. RNA 1 stated he was assigned to assist nursing or certified nurse assistants (CNAs) put residents back in bed, or help cleaning residents and continued to perform RNA duties for residents assigned to RNA 1 from physical therapy department. During an interview with LVN 2 on 3/12/24 at 3:52 PM, LVN 2 stated LVN 2 came in to work on Saturday 3/9/2024, and that the facility's call light system was not working. LVN 2 stated the floater was supposed to make rounds (check on residents) hourly. LVN 2 stated sometimes the residents would call the main desk and ask the front desk staff to send someone to the residents' rooms. (continued on next page)

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