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	06/05/2026

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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(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. Based on observation, interview, and record review, the facility failed to prepare, store, and serve food in a sanitary manner and environment. This failure had the potential to increase the risk of foodborne illness for the residents who consumed food from the facility's kitchen.Findings: During a concurrent observation and interview in the facility's kitchen on 6/1/2026 at 7:37 A.M. with the Food Services Director (FSD), a metal pot filled with white liquid was in the refrigerator with a use by date of 5/29/2026. The FSD stated the white liquid was a prepared protein shake mixture. The FSD stated that the current date was 6/1/26, therefore the shake mixture should be thrown away. During an observation on 6/1/2026 at 7:55 A.M. in the kitchen, Dietary Aide (DA) 1 was serving food onto a plate while holding the plate's surface with a bandaged thumb. During an interview with the FSD on 6/1/26 at 7:55 A.M., the FSD stated that DA1 should wear a glove on the injured hand when serving food minimize the risk of food contamination (transfer of bacteria, viruses, or chemicals into food). During a concurrent observation and interview on 6/1/2026 1:31 P.M. with FSD in the kitchen:The floor drain near the entrance to the kitchen had collected a pool of standing water. The FSD stated that the floor drain was closed off below the floor level and did not drain. The FSD stated that standing water in a kitchen is not sanitary.Small serving dishes were stored on a low shelf behind a trash can. The FSD stated that storing dishes close to a trash can increase the risk of contamination.Small serving cups were stacked on a shelf above the dish drying station with moisture trapped between each cup. The FSD stated that the moisture between the cups and dishes should not be stacked wet to avoid bacteria growth.A stored food prep container had adhesive residue on its outer surface. The FSD stated that a container with adhesive is not clean.Multiple plastic pitchers had chips and cracks on their surfaces. The FSD stated that chipped or cracked pitchers should be thrown away.A large metal bowl with a plastic pitcher inside was stored under kitchen sink with moisture both in the bowl and the plastic pitcher. The FSD stated that dishes should be stored dry.Plates stored in the plate warmer were stored wet. The FSD stated that the plate warmer should have dry plates only.A large plastic container of Ken's Bleu Cheese Dressing was found in the dry storage with a bulging lid and the label indicated, Keep Refrigerated. A large plastic container of Ken's [NAME] Caesar dressing was also found in the dry storage area with a label indicating Keep Refrigerated. Two plastic containers of lemon juice were found in the dry storage area with a label indicating Keep Refrigerated. The FSD stated that these products were not stored properly. The FSD stated that if these products were served to residents, it could cause illness. The FSD stated that it is important to read the labels to know how to properly store products. During an interview on 6/2/2026 at 1:09 P.M. with the Registered Dietician (RD), the RD stated that kitchen prepared foods are good for 72 hours after they are prepared and should be thrown away after the 72-hour use by date. The RD stated that a cut on the hand should be covered with a glove before handling or serving food. The RD stated that a bandage that contacts food can contaminate the food. The RD stated that standing water in the kitchen is not acceptable and can cause insects, bacteria, or mold. The RD stated that dishware must be air dried and stored in a clean area. The RD stated that stacked wet dishware stays wet and can cause bacteria or mold growth. The RD stated that refrigerated food should be placed in the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerator no later than 2 hours after receiving the product. The RD stated that eating expired dressing may cause stomach issues, diarrhea, or food poisoning. During a concurrent observation and interview on 6/3/2026 at 10:02 A.M. with the FSD, the food processor bowl attachment had black residue in the clear handle and cracks on the bottom of the bowl. The FSD stated that the attachment is not clean and should have been replaced.During a review of the facility's policy and procedures (P&P) titled, Food Receiving and Storage, dated 10/2017, the P&P indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. The P&P also indicated, Refrigerated foods must be stored below 41(degrees)F unless otherwise specified by law.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, for one of one sampled resident (Resident 77), the facility failed to ensure that Giver (CG) 1 provided and maintained Resident 77's privacy and dignity (basic right to be valued, respected, and treated as a human being) by failing to close the door and close dignity (privacy) curtains door to the room during activities of daily living care (ADL - activities such as bathing, dressing and toileting a person performs daily) according to the facility's policy and procedure (P&P) tiled Quality of Life -Dignity, revised 1/2026 for one of one sampled resident. This deficient practice resulted in violating Resident 77's rights to be treated with privacy and dignity and also had the potential for the resident not to feel dignified and suffer lowered self-esteem.Findings: A review of Resident 77's admission Record indicated the facility admitted Resident 77 on 10/23/2024 and readmitted Resident 77 on 5/26/2026 with diagnoses including dementia (progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hypertension (HTN - high blood pressure). A review of Resident 77's Minimum Data Set (MDS - resident assessment tool) dated 5/30/2026, indicated Resident 77 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 77 is dependent on staff with ADL care. During an observation on 6/1/2026, at 9:41 A.M., in the hallway Resident 77's door room was open and the dignity curtain/s was open and Resident 77 was observed in bed. Resident 77's private area was visible from the hallway and CG 1 was observed provided care to Resident 77. Upon noticing the writer, CG 1 attempted to close the dignity curtain/s. During an interview on 6/1/2026, at 9:42 A.M., with CG 1, CG 1 stated that she was closing the curtain to provide Resident 77 with privacy while she was changing the resident's incontinent brief. CG 1 stated that dignity curtains should be closed during incontinent care to give the resident privacy. During an interview on 6/4/2026, at 11:41 A.M., with the Director of Nursing (DON), the DON stated that resident's dignity curtains should be completely closed during ADL care to provide residents with privacy. The DON stated that leaving the dignity curtain open during incontinent care may cause the residents to feel due to lack of privacy and is not dignifying A review of the Facility P&P titled Quality of Life -Dignity, revised 1/2026 indicated the following: Policy StatementEach resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect andIndividualityPolicy Interpretation and Implementation1. Residents shall be treated with dignity and respect at all times.2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteemand self-worth.10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance withpersonal care and during treatment procedures.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, for one of one resident (Resident 22) the facility failed to:1. Notify a physician that Resident 22 was self-administering medications and storing medications at the bedside.2. Obtain a physician's order for Resident 22 to self-administer medications and or supplements, and store medications and/or supplements at the bedside3. Conduct an assessment if Resident 22 can self-administer medications and/or supplements and store medications and/or supplements at the bedside. These failures had the potential to result in harm, hospitalization and death to Resident 22.Findings: During a review of Resident 22's admission Record (Face Sheet - includes a resident's identification, medical, and demographic information), the admission Record indicated, the facility initially admitted Resident 22 on 3/16/2021, and then readmitted Resident 22 on 3/19/2025 with medical diagnoses that included obstructive hypertrophic cardiomyopathy (a genetic heart condition where the heart wall becomes abnormally thick, reducing the flow of oxygen-rich blood from the heart to the rest of the body), type 2 diabetes mellitus (DM II, ongoing high blood sugar levels), depression (a serious mood disorder that causes a persistent feeling of sadness, emptiness, and a loss of interest in activities), and muscle weakness. During a review of Resident 22's Minimum Data Set (MDS - resident assessment tool), dated 4/14/2026, the MDS indicated the Resident 22's cognition (mental ability to make decisions of daily living) was intact (person able to comprehend concept and verbalize own needs). The MDS indicated Resident 22 required substantial assistance with activities of daily living (ADL-dressing, toileting, bed mobility and bed-to-chair transfers) and was dependent on staff (when helper does all the effort, resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with showering. During a concurrent observation and interview with Resident 22 on 6/1/2026 at 8:41 a.m., Resident 22 was in her room and sitting in bed. The writer observed the following ointment and supplements on the resident's bedside table.Lidocaine ointment (topical cream with local anesthetics that temporarily numbs the skin by blocking nerve signals to relief pain),Biotin 25000 microgram (mcg - unit of measurement in medications) per capsule,Vitamin B7 (supplement for skin, nails and hair),Collagen peptides (proteins that provide the building blocks for skin, hair, nails, joints, and bones),Ginger herbal tea with vitamin C (supplement for immune system [bodily function to fight infection]),Probiotics (supplement of healthy gut bacteria strains), and Sinus calm meltaway tablets (herbal remedy for sinus pain/congestion).During the same observation and interview, Resident 22 stated she takes ginger herbal tea due to nausea (to feel like wanting to vomit) caused by all the medication she is taking. Resident 22 stated she usually informs the facility staff what medications and/or supplements she is taking because the staff need to write the medications and/or supplements down and that a facility staff took pictures of the medications and/or supplements but was unable to recall the name of the staff member. During a concurrent observation and interview on 6/3/2026 at 1:37 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 reviewed Resident 22's supplements at her bedside. LVN 4 stated she was not aware of the following supplements at Resident 22's bedside table:Lidocaine ointmentBiotin 25000 mcg;Vitamin B7;Collagen peptides;Ginger herbal tea with vitamin C;Probiotics; Sinus calm meltaway tablets. During a concurrent interview and record review on 6/3/2026 at 1:46 p.m. with LVN 4, Resident 22's Order Summary Report, dated 6/3/2026 was reviewed. The Order Summary Report indicated Resident 22 did not have a physician's order for self-administration for the following supplements found at Resident 22's bedside:Biotin 25000 mcg;Vitamin B7;Collagen peptides;Ginger herbal tea with vitamin C;Probiotics; Sinus calm meltaway tablets.LVN 4 stated the usual process when staff noticed medications or supplements at the residents' bedside, they would notify the doctor and receive orders for the administration and storage of them locked in the medication cart. LVN 4 stated, if the resident is awake, alert, and oriented to person, date, time, and situation (person can make informed decision), the facility allows them to self-administer medications or supplements. LVN 4 stated, if residents (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refuse to surrender their own medications and/or supplements for the facility lock up in storage, then it is discussed in the interdisciplinary team (IDT, a group of multiple specialists, such as a nurse, a social worker, and a physician providing care to residents) meeting. During a review of Resident 22's Care Plan Report, dated 6/3/2026, the Care Plan Report did not include assessments nor care plan interventions for Resident 22 to self-administer medications and/or supplements. During a review of policies and procedures (P&P) titled, Self-Administration of Medications, dated 1/2016, the P&P indicated, The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room . Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party. Nursing staff will review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered. The staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an appropriately sized bed for one of one sampled resident (Resident 26). This failure resulted in Resident 26 feeling uncomfortable and had the potential for the resident to suffer physical discomfort, pain, and develop pressure ulcers (injuries that occur when sustained pressure cuts off blood and oxygen supply to the skin and underlying tissue leading to tissue death typically forming over bony prominences (like the tailbone, heels, hips, and elbows) or beneath tight medical devices), dissatisfaction, and psychosocial harm.Findings: During a review of Resident 26's admission record, dated 11/25/2025, the admission record indicated Resident 26 was admitted to the facility on [DATE] with diagnoses but not limited to hemiplegia (severe or complete loss of voluntary movement on one entire side of the body) affecting the right side, dysphagia (difficulty swallowing), dysarthria (muscles used to breathe or talk are weakened or paralyzed), and epilepsy (a brain disorder that causes repeated seizures). During a review of Resident 26's history and physical (H&P), dated 8/17/2025, the H&P indicated Resident 26, can make needs known but cannot make medical decisions. During a review of Resident 26's Minimum Data Set (MDS- a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 26 required total physical assistance with toileting, dressing below the waist, and putting on and removing socks and shoes. The MDS also indicated Resident 26's cognitive patterns were moderately impaired (a person's memory or thinking have started to weaken). During a concurrent observation and interview on 6/1/226 at 9:30 A.M. with Resident 26 in Resident 26's room, Resident 26's legs were bent with feet positioned against the footboard of the bed. Resident 26 stated they felt uncomfortable in bed. During an observation on 6/3/2026 at 8:45 A.M. in Resident 26's room, Resident 26's feet were positioned against the footboard of the bed. During a concurrent observation and interview on 6/3/2026 at 12:28 P.M. with Certified Nursing Assistant (CNA) 3 in Resident 26's room, CNA 3 stated Resident 26's bed was too small. CNA stated residents should be comfortable in bed to minimize pain and discomfort. CNA stated good positioning for residents is important to decrease risk of pressure ulcers (damage to the skin and/or tissue usually over a bony prominence). During an interview on 6/3/2026 at 1:01 P.M. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated longer beds are available for taller residents. RNS 1 stated bed positioning is important to reduce the resident's pain and discomfort and to decrease risk of pressure ulcers. RNS 1 stated if a bed was not appropriately sized for the resident, the resident will feel uncomfortable and dissatisfied. During an interview on 6/3/2026 at 4:12 P.M. with the Director of Nursing (DON), the DON stated that proper bed positioning is important for the residents to decrease risk of pressure ulcers and to minimize pain and discomfort. The DON stated it is important that residents are comfortable in bed to meet their physical and psychosocial needs. During a review of the facility's policy and procedures (P&P) titled, Quality of Life Homelike Environment, dated January 2026, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment.

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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. Based on observation, interview, and record review, the facility failed to ensure that for one of 20 sampled residents (Resident 6) was not provided with the bedside table was missing one of four wheels. This failure had the potential to result in accidents and injuries not limited to the bedside table tilting, collapsing, and falling on Resident 6, and hot liquids and food spilling on Resident 6. Findings: During a review of Resident 6's admission Record (Face sheet, which includes a resident's identification, medical, and demographic information), dated 6/4/2026, the admission Record indicated, the facility admitted Resident 6 on 5/11/2020 with medical diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (severe or complete loss of motor function on one side of the body, affecting the arm, leg, and sometimes facial muscles caused by lack of blood supply in the brain), dysphagia (difficulty in swallowing), essential hypertension (chronic high blood pressure), type 2 diabetes mellitus (DM II - chronic disorder of persistent high blood sugar levels), epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures, caused by sudden, abnormal electrical surges in the brain), muscle weakness, and presence of gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 6's Minimum Data Set (MDS - resident assessment tool), dated 4/27/2026, the MDS indicated, Resident 6's cognitive skill for daily decision making was severely impaired - resident never or rarely made decisions. The MDS indicated Resident 6's speech pattern as absence of spoken words, and Resident 6 was dependent on two or more staff for activities of daily living (ADL- like eating, dressing, walking, toileting eating, dressing, transfers, toileting and showering). During an observation on 6/1/2026 at 8:26 a.m. in Resident 6's room, Resident 6 was sitting in bed with bedside table and breakfast tray in front of her. Resident 6 then pushed the bedside table and the bedside table tilted. The breakfast tray almost slid off the bedside table. Upon further inspection, the bedside table was missing one of the four wheels meant to support/stabilize the bedside table. During a concurrent observation and interview on 6/1/2026 at 8:28 a.m. with Certified Nurse Assistant (CNA) 1 in Resident 6's room, CNA 1 noted that Resident 6's bedside table was missing a wheel. Observed CNA 1 removed Resident 6's bedside table with a missing wheel outside the room right away. CNA 1 stated, When we have broken table, we put it outside and call a maintenance guy, and we fill out the paper for repairs. During an interview on 6/3/2026 at 1:04 p.m. with CNA 1, CNA 1 stated that CNA 2 had placed the bedside table and a breakfast tray for Resident 6 on 6/1/2026. CNA 1 stated she told a maintenance personnel to fix the bedside table with a missing wheel. CNA 1 stated, We should remove broken equipment from the residents to prevent injuries and not to hurt them. During an interview on 6/3/2026 at 1:14 p.m. with CNA 2, CNA 2 stated, on 6/1/2026 he placed the bedside table and breakfast tray for Resident 6 and did not notice it was missing the wheel. CNA 2 stated that if he noticed that Resident 6's bedside table was missing a wheel, he would have filled out maintenance log or called the maintenance personnel; removed the bedside table for the maintenance, swapped the bedside table with a functional one, and would have placed a note on the broken bedside table so that no one would use it.ˆCNA 2 stated staff should check if the bedside table is clean, the lever on the side of the bedside table is working properly, and that the bedside tabletop can adjust up and down before giving it to a resident to use. During a review of the facility's Maintenance Log, dated June 2026, the Maintenance Log did not indicate that any bedside tables needed repairs between 6/1/2026 and 6/4/2026. During a review of the facility's policy and procedures (P&P) titled, Use of Supplies and Equipment, dated January 2026, the P&P indicated, the expectation to report all needed repairs to the Environmental Services or Maintenance Director. During a review of the facility's P&P titled, Reporting Equipment Malfunction, dated January 2026, the P&P indicated, if the malfunction continues to occur, complete a Service Request Form and remove the equipment from service. Send Service Request Form to the Maintenance Department.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an alleged incident of abuse (a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) to the California Department of Public Health (CDPH) within 24 hours for two of two sampled residents (Resident 79 and Resident 80). This failure resulted in delayed investigation by CDPH to ensure the safety and wellbeing of Residents 79 and 80, with the potential for continued resident to resident altercation, harm/injury and hospitalization.Findings: During a review of Resident's 79 admission Record (also known as a ?face sheet,' which includes a resident's identification, medical, and demographic information), dated 6/4/2026, the admission Record indicated the facility admitted Resident 79 on 12/27/2025 with medical diagnoses that included chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes breathing difficult by blocking airflow into and out of the lungs), mild cognitive impairment (a decline in memory or thinking skills that is noticeable but not severe enough to disrupt daily life), dementia (a progressive state of decline in mental abilities), and abnormalities of gait and mobility (irregular, unsteady, or inefficient walking patterns). During a review of Resident 79's Minimum Data Set (MDS - resident assessment tool), dated 4/3/2026, the MDS indicated, Resident 79's cognitive (mental ability to make decisions of daily living) skills were intact (person able to comprehend concept and verbalize own needs). The MDS indicated Resident 79 required supervision with activities of daily living (ADL- eating, dressing, walking, toileting), touch assistance with transfers to chair, toilet and walking, and partial/moderate assistance (a helper does less than half effort) with toileting and showering. During a review of Resident 80's admission Record, dated 6/4/2026, the admission Record indicated the facility admitted Resident 80 on 03/12/2026 for aftercare with diagnoses not limited to following joint replacement surgery (invasive procedure to replace damaged tissue, bone or joint with artificial metal, plastic prosthesis), presence of left artificial knee joint, abnormalities of gait and mobility (irregular, unsteady, or inefficient walking patterns), atrial fibrillation (irregular heart beat), and hypertension (HTN- high blood pressure). During a review of Resident 80's MDS), dated [DATE], the MDS indicated Resident 80's cognitive skills were intact. The MDS indicated Resident 80 required supervision/touching assistance with ADL (transfers to chair, toilet and walking), and substantial/moderate assistance with lower body dressing and showering. During a review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 3/23/2026, the SOC 341 indicated that, On 3/23/26 at approximately 1:30 a.m., (Resident 79) appeared to have a hallucination (is a false perception of objects or events involving a person's senses such as sight, sound, smell, touch and taste) and display hitting behavior towards (Resident 80). The SOC 341 did not indicate the incident was reported to the CDPH. During a concurrent interview and record review on 6/2/2026 at 9:47 a.m. with the Administrator (Admin), the Grievance Log, dated 3/23/2026 was reviewed. The Grievance Log indicated that on 3/23/2026, Resident 80 reported concerns about recent physical altercation with Resident 79 and as part of resolution, the local Police Department (PD) was called who filed a report on 3/23/26, a room change was initiated (not specified for which resident), and trauma screening was completed. The Admin stated the resident-to-resident altercation complaint of abuse was reported to PD on 3/23/26. The Admin stated he did not report the incident to the CDPH because a resident-to-resident altercation incident there was not considered abuse because one of the residents had dementia and did not cause harm, and therefore not sufficient reason to report the altercation complaint between Resident 79 and Resident 80 based on the facility's AFL (All Facilities Letter) interpretation. During a concurrent interview and record review on 06/03/2026 at 3:27 p.m. with the Admin, the facility's policy and procedures (P&P) titled, Alleged or Suspected Abuse and Crime Reporting, dated January 2026 was reviewed. The P&P indicated, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Covered Individuals, must report a reasonable suspicion of a crime to the Department within the designated time frame by e-mail, fax or telephone. The Admin stated he did not report the abuse incident between Resident 79 and Resident 80 to the CDPH.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan addressing supplemental oxygen therapy (a medical treatment that provides extra oxygen to people who cannot get enough through normal breathing) for one of three sampled residents (Resident 75) according to the facility's policy and procedures (P&P) titled Baseline Care plan dated 1/29/2026. This deficient practice resulted in failure to establish a guide for Resident 75s respiratory status that would allow nurses to safely titrate (to gradually adjust the dosage of a medication over time-upward or downward-to find the exact amount that achieves the best results while causing the fewest side effects) flow rates, prevent toxic hyperoxemia (an abnormally high concentration of oxygen in the blood), and detect respiratory deterioration early and had the potential for delayed provision of necessary care and services.Findings: A review of Resident 75's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included, sequelae of cerebral infarction (permanent residual effects, impairments, and complications that persist after someone suffers a stroke), encounter for gastrostomy (a medical device inserted through the abdominal wall directly into the stomach.), dysphagia following cerebral infarction (difficulty or discomfort in swallowing that occurs as a result of a stroke), atrial fibrillation (Afib-an irregular, rapid, and chaotic heart rhythm that begins in the heart's upper chambers), presences of heart assist device (a surgically implanted mechanical pump), depression (a serious mood disorder characterized by persistent feelings of sadness, emptiness, and a loss of interest in activities) and, malignant neoplasm of the prostate (an uncontrolled growth of abnormal cells in the prostate (a walnut-sized gland in the male reproductive system). A review of Resident 75s Minimum Data Set (MDS - a resident assessment tool) dated 6/2/2026, indicated Resident 75's cognition was moderately impaired. The MDS also indicated Resident 75 required partial to moderate assistance with eating and, oral hygiene, substantial maximal assistance for upper body dressing, Resident 75 is dependent on staff for toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear. The MDS also indicated that the Resident is non-ambulatory. A review of Resident 75's Order Summary Report dated 6/4/2026 indicated a physician's order to administer oxygen at two (2) (dose) liters (unit of measure) per minute (duration) via nasal cannula (a thin, flexible medical device used to deliver supplemental oxygen directly into the nostrils) continuously every shift for desaturation (low blood oxygen saturation). During an initial tour on 6/2/2026 at 8:28am, Resident 75 was lying in bed on his right lateral side, an oxygen concentrator machine (a medical device that concentrates oxygen from environmental air and delivers it to the resident in need of supplemental oxygen) was observed at bedside flowing at 3.5-4 liters per (L/min) via nasal cannula. During an interview on 6/2/3036 at 8:35 am, Registered Nurse Supervisor (RNS) 1 stated Resident 75's supplemental oxygen physician order was 2L/min. A review of Resident 75' care plan dated 6/3/2026 indicated a person-centered care plan addressing Resident 75 supplemental oxygen need with clear measurable goals and time of recovery or improvement and, interventions to safely correct hypoxemia (low blood oxygen) was not addressed. During an interview on 6/4/2026 at 1:47pm, the Director of Nursing (DON) stated a base line care plan should be initiated within 24hrs of patient admission. The DON stated Resident 75's needs may not be met if a base line care plan is not initiated. A review of the facility's policy and procedures (P&P) titled Baseline Care plan dated 1/29/2026, indicated that, Nursing facilities are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. The baseline care plan shall: include the minimum healthcare information necessary to properly care for a Resident including, but not limited to: Initial goals based on admission orders Physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the environment was free from accidents and hazards by failing to ensure that staff did not leave unidentified white creamy substance in a medication cup at the bedside of one out of one sampled resident (Resident 7). This deficient practice had the potential to result in harm through ingestion of the unidentified white creamy substance, leading to poisoning and/or allergic reactions, unnecessary hospitalizations and even death for residents who are confused and or with wandering behaviors.Findings: A review of Resident 7's admission record indicated Resident 7 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included diabetes mellitus (high sugar in the blood), chronic obstruction pulmonary disease (COPD- is a common lung disease causing restricted airflow and breathing problems), dysphagia (difficulty swallowing) and congestive heart failure (CHF- a condition that develops when your heart doesn't pump enough blood for your body's needs). A review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 5/16/2026, indicated Resident 7's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 7 required setup or cleanup assistance with eating and oral hygiene, partial moderate assistance with toileting hygiene and upper body dressing and, substantial/maximal assistance with lower body dressing, putting on/taking off footwear and shower/bathes. Resident 7 required partial moderate assistance walking 10 feet. During a facility tour on 6/2/2026, at 9:27 am, a medication cup with a white creamy substance was observed placed on a wall caddy within view and easy reach inside Resident 7's room. During an interview on 6/2/2026 at 9:30 am, Certified Nurse Assistance (CNA) 4 stated the white creamy substance in the medication cup looked like Zinc (medication) used to treat skin rashes on residents. During an interview on 6/2/2026 at 9:40 am, Licensed Vocational Nurse (LVN) 5 stated that the white creamy substance in the medication cup is Zinc barrier cream/Skin protectant. LVN 5 stated the medication (white creamy substance) should be discarded after use and not left at bedside, LVN 5 stated a confused/wandering resident can ingest (eat/swallow) the white creamy substance because the white creamy substance looks like ice-cream or cream cheese which could lead to upset stomach or an allergic reaction. During an interview on 6/4/2026 at 1:47pm, Director of Nursing (DON) stated residents are only allowed to have medication at bedside once the resident has been assessed and the resident is able demonstrate to safely self-administer the medication. The DON stated that a doctor's order/approval is required before for a resident to self administer medication. The DON stated medications left unattended at bedside could lead to unintended consequences if consumed/ingested by a Resident such as upset stomach, allergic reactions, unnecessary hospitalizations and possible poor outcomes. A review of facility policy and procedure titled Discarding and Destroying Medication dated, revised 2014 indicated, Medications will be disposed of in accordance with federal, state and local regulations governing management of . pharmaceuticals, ointments, creams, may be discarded into the trash receptacle in the medications room.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility failed to ensure one out one sampled Resident (Resident 75) received the sufficient enteral feeding (a medical method of delivering specialized liquid food and nutrients directly into the gastrointestinal (GI) tract.), as per physician order summary dated 6/4/2026 . This deficient practice placed Residents 75 at risk for altered nutritional status such as delayed wound healing and muscle wasting to chronic (ongoing) diseases and increased susceptibility to infections, weight loss, altered hydration status and complications associated with fluid imbalance.Findings: A review of Resident 75's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included, sequelae of cerebral infarction (permanent residual effects, impairments, and complications that persist after someone suffers a stroke), encounter for gastrostomy (a medical device inserted through the abdominal wall directly into the stomach.), dysphagia following cerebral infarction (difficulty or discomfort in swallowing that occurs as a result of a stroke), atrial fibrillation (an irregular, rapid, and chaotic heart rhythm that begins in the heart's upper chambers), presences of heart assist device (a surgically implanted mechanical pump), depression (a serious mood disorder characterized by persistent feelings of sadness, emptiness, and a loss of interest in activities) and, malignant neoplasm of the prostate (an uncontrolled growth of abnormal cells in the prostate (a walnut-sized gland in the male reproductive system). A review of Resident 75s Minimum Data Set (MDS - a resident assessment tool) dated 6/2/2026, indicated Resident 75's cognition (mental ability to make decisions of daily living) was moderately impaired. The MDS also indicated Resident 75 required partial to moderate assistance with eating and, oral hygiene, substantial maximal assistance for upper body dressing, Resident 75 is dependent on staff for toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear. The MDS also indicated that the Resident is non-ambulatory. During facility tour on 6/2/2026 at 8:28am, Resident 75's enteral feeding pump was observed to be turned off at the bedside. The enteral feeding was labeled as initiated on 6/1/2026 at 12:30pm at a rate of 80mls/hr. A residual (remaining) of 900 milliliters (mls - unit of measuring volume) was observed left in an enteral feeding bottle that was labeled 1500ml indicating, that Resident 75had received 400mls less of the enteral feeding than as ordered by the physician. A review of Resident 75's physician order summary dated 6/4/2026 indicated, every shift GT Feeding of Jevity1.5 @ 50ml/hr. x 20hrs. to provide, 1000ml/1500Kcal/24 hrs. via enteral from 2 pm to 10 am or until dose limit is met. During an interview on 6/2/2026 at 8:35 am, Registered Nurse Supervisor (RNS) 1 stated that failure to provide adequate enteral feeding to Resident 75 as per physician's orders can lead to malnutrition, skin breakdown and poor patient outcomes. During an interview on 6/4/2026 at 1:47pm the Director of Nursing (DON) stated, providing inadequate enteral feeding to a Resident could lead to significant weight loss, skin breakdown and open wounds. A review of facility Policy and Procedure (P&P) titled Nutrition & Weight Management, dated 1/29/2026 indicated, The facility provides care and services to each Resident to ensure the Resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Tube feeding or parenteral fluids shall be provided if indicated and in the context of the Resident's overall clinical condition and desired goals.

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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** Based on observation, interview and record review, the facility failed to ensure the resident received the correct oxygen (a colorless, odorless gas that is essential for life and the proper functioning of the body) therapy as prescribed (ordered) by the physician for one (1) out of the three residents (Resident 75). This deficient practice had the potential to cause oxygen toxicity (excess oxygen supply in tissues and organs, typically caused by breathing higher concentrations of supplemental oxygen) resulting in damage to the lungs, coughing, difficulty breathing and even death in severe cases for Resident 75. Findings: A review of Resident 75's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included, sequelae of cerebral infarction (permanent residual effects, impairments, and complications that persist after someone suffers a stroke), encounter for gastrostomy (a medical device inserted through the abdominal wall directly into the stomach.), dysphagia (difficulty or discomfort in swallowing that occurs as a result of a stroke) following cerebral infarction (stroke), atrial fibrillation (Afib-an irregular, rapid, and chaotic heart rhythm that begins in the heart's upper chambers) following cerebral infarction, presences of heart assist device (a surgically implanted mechanical pump), depression (a serious mood disorder characterized by persistent feelings of sadness, emptiness, and a loss of interest in activities) and, malignant neoplasm of the prostate (cancer-an uncontrolled growth of abnormal cells in the prostate (a walnut-sized gland in the male reproductive system). A review of Resident 75s Minimum Data Set (MDS - a resident assessment tool) dated 6/2/2026, indicated Resident 75's cognition (mental ability to make decisions of daily living) was moderately impaired. The MDS also indicated Resident 75 required partial to moderate assistance with eating and, oral hygiene, substantial maximal assistance for upper body dressing, Resident 75 is dependent on staff for toileting hygiene, shower/bathing self, lower body dressing and putting on/taking off footwear. The MDS also indicated that the Resident is non-ambulatory. A review of Resident 75's Order Summary Report dated 6/4/2026 indicated a physician's order to administer oxygen to Resident 75 at two (2) (dose) liters (unit of measure) per minute (duration) via nasal cannula (a thin, flexible medical device used to deliver supplemental oxygen directly into the nostrils) continuously every shift for desaturation (low blood oxygen saturation). During an initial tour on 6/2/2026 at 8:28am, Resident 75 was lying in bed on his right lateral side, an oxygen concentrator machine (a medical device that concentrates oxygen from environmental air and delivers it to the resident in need of supplemental oxygen) was observed at bedside flowing at 3.5-4 liters per (L/min) via nasal cannula. During an interview on 6/2/3036 at 8:35 am, Registered Nurse Supervisor (RNS) 1 stated Resident 75's supplemental oxygen physician order was 2L/min. During an interview with the Director of Nursing (DON) Resident 75 prolonged use of oxygen could cause oxygen toxicity and cell damage (structural or functional changes that occur when cells are stressed beyond their ability to maintain normal balance). A review of the facility's policy and procedures (P&P) titled, Oxygen Administration, dated 1/2026 indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Review the physician's orders for oxygen administration. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. A review of facility P&P titled Medication Administration dated 1/2026 indicated, Medications are administered.as ordered by the physician and in accordance with professional standards of practice .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation and interview, the facility failed to ensure that a private caregiver did not provide incontinent care direct care to one of one resident (Resident 77) according to the facility's policy and procedures (P&P) tiled Private Duty Sitter, revised 1/2026. This deficient practice had the potential to result in infection, injury and/or hospitalization for Resident 77.Findings: A review of Resident 77's admission Record indicated the facility admitted Resident 77 on 10/23/2024 and readmitted Resident 77 on 5/26/2026 with diagnoses including dementia (progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hypertension (HTN - high blood pressure). A review of Resident 77's Minimum Data Set (MDS - resident assessment tool) dated 5/30/2026, indicated Resident 77 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 77 is dependent on staff with activities of daily living care (ADL - activities such as bathing, dressing and toileting a person performs daily) care. During an observation on 6/1/2026, at 9:41 A.M., in the hallway Resident 77's door room was open and the dignity curtain/s was open and Resident 77 was observed in bed. Resident 77's private area was visible from the hallway and CG 1 was observed provided care to Resident 77. Upon noticing the writer, CG 1 attempted to close the dignity curtain/s. During an interview on 6/1/2026, at 9:42 A.M., with caregiver (CG 1), CG 1 stated that she was closing the curtain to provide Resident 77 with privacy while she was changing Resident 77 incontinent brief. There was no facility staff assisting with Resident 77's incontinent care. During an interview on 6/4/2026, at 11:41 A.M., with the Director of Nursing (DON), the DON stated that private duty sitters (caregivers) should not provide direct care to residents because they are not trained. The DON stated that the provision of incontinent care by a private duty sitter may potentially lead to a urinary tract infection (UTI - an infection in the bladder/urinary tract) as they have not been given the proper training for incontinent care. A review of the Facility P&P titled Private Duty Sitter, revised 1/2026 indicated,Policy StatementThe use of private duty sitters will be permitted when approved by the residents attending physician and the facility's Director of Nursing Services.3. Private duty nursing personnel must follow the facility's established nursing care policies and procedures, instructions issued by the Nurse Supervisor/Charge Nurse, and may not administer direct care to the resident unless authorized in writing by the attending Physician.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure that a Registered Nurse (RN) was on duty on the 7am-3pm, 3pm-11pm, and 11pm-7am shifts on 7/20/2026. The facility had 64 residents in house. This failure had the potential for the residents' clinical needs not to be met and delayed assessments and interventions when needed. Findings: During a review of the facility's Licensed Nursing Schedule, dated July 2025, the Licensed Nursing Schedule indicated that there was no RN on duty for 7/20/2025. During a concurrent interview and record review on 6/4/2026 at 11:50 A.M. with the Director of Staff Development (DSD), the facility nursing assignment sheet, dated 7/20/2025 was reviewed. The nursing assignment sheet indicated that on 7/20/2025, there was no RN on-duty for 8 consecutive hours on all three shifts (7am-3pm, 3pm-11pm, and 11pm-7am). The DSD confirmed and stated that there was no RN on duty for 8 consecutive hours on 7/20/2025. The DSD stated that if there is no RN is on duty, the facility cannot perform assessments on the residents and certain medication will not be administered. The DSD stated this can potentially cause physical and psychosocial harm to the residents. During an interview on 6/4/2026 at 2:45 P.M. with the Director of Nursing (DON), the DON stated if no RN is on-duty at the facility, the residents' clinical needs will not be met such as receiving antibiotic medication and total parental nutrition (TPN- is a medical therapy that delivers essential nutrients-including proteins, carbohydrates, fats, vitamins, and minerals-directly into the bloodstream through an intravenous (IV-inside a vein) line. The DON stated the lack of an RN on duty can potentially cause physical and psychosocial harm to the residents. The DON also stated that the facility did not have a policy and procedure on RN staffing. During a review of the facility's job description titled, Nurse Supervisor, dated 2023, indicated, Ensure that a sufficient number of licensed practical and/or registered nurses are available for your tour of duty to ensure that quality care is maintained.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure that lids of two of three sampled outside garbage bins were closed. This failure had the potential to attract pests that could create a health and safety risk to the residents, visitors, and staff in the facility.Findings: During a concurrent observation and interview on 6/1/2026 at 1:31 P.M. with the Food Services Director (FSD) in the alley behind the facility, two outside garbage and recycling bin lids were left open. The FSD stated that garbage bins must be covered to prevent pests. During a review of The U.S. Food and Drug Administration's Food Code, dated 2022, the regulation indicated, Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff completed documentation on dental ancillary (supportive medical) services for one of one sampled resident (Resident 63) according to facility's job description titled, Social Service Designee, dated 2003, and the facility's policy and procedures (P&P) titled, Dental Services, dated 1/2026. This failure had the potential to not meet the physical and psychosocial needs of Resident 63. Findings: During a review of Resident 63's admission record, dated 3/31/2026, the admission record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses but not limited to fracture of the left mandible (lower jawbone), dementia (a state of decline in mental abilities), hypertension (high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool), dated 4/4/2026, the MDS indicated Resident 63 was cognitively (mental ability to make decisions of daily living) intact. During a review of Resident 63's Dental Records, dated 4/18/2026, indicated a dentist evaluated Resident 63, and the resident was awaiting approval for dentures. During an interview on 6/1/2026 at 9:22 A.M. with Resident 63, Resident 63 stated he recently had tooth pain while eating a banana. During a concurrent interview and record review on 6/3/2026 at 2:45 P.M. with the Social Services Director (SSD), Resident 63's Social Services Progress Notes were reviewed in PointClickCare (PCC- facility electronic medical record) between the date of admission 3/31/2026 until 6/3/2026. The SSD confirmed and stated that SSD did not document social service progress notes from 3/31/2026 to 6/3/2026 and did not document the dental services that was provided to Resident 63 on 4/18/2026. The SSD stated, incomplete documentation will have the potential to not meet the needs of the resident. During an interview on 6/3/2026 at 4:12 P.M with the Director of Nursing (DON), the DON stated, if the SSD has not documented dental services provided to (Resident 63), this will have the potential to not meet the needs of the resident. During a review of the facility's job description titled, Social Service Designee, dated 2003, the job description indicated, Record and maintain regular Social Service progress notes indicating response to the treatment plan. During a review of the facility's policy and procedures (P&P) titled, Dental Services, dated 1/2026, the P&P indicated, All dental services provided are recorded in the resident's medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the complete implementation of infection control practices in the facility, when Licensed Vocational Nurse (LVN) 2 did not clean and disinfect (use of chemical agents to destroy germs) shared resident care equipment before and after use for two of 20 sampled residents (Resident 35 and Resident 30).This failure had the potential for resident harm, as not cleaning and disinfecting shared resident care equipment before and after use can spread pathogens (disease causing germs) between residents throughout the facility, leading to transmission of infection to multiple residents in the facilityFindings: During a review of Resident 35's admission Record (Face sheet, which includes a resident's identification, medical, and demographic information), dated 6/4/2026, the admission Record indicated, the facility initially admitted Resident 35 on 6/10/2024, and then readmitted on [DATE], with medical diagnoses that included metabolic encephalopathy (brain dysfunction caused by chemical imbalances, systemic illnesses, or organ failure), decreased white blood cell count (immune system has fewer infection-fighting cells than normal), paraplegia (partial or complete paralysis [lack of strength and movement] of the lower half of the body, which typically affects both legs and feet), dysphagia (difficulty in swallowing), and essential hypertension (chronic high blood pressure). During a review of Resident 35's Minimum Data Set (MDS - resident assessment tool), dated 2/23/2026, the MDS indicated, Resident 35's cognitive skill for daily decision making was severely impaired (Resident never or rarely made decisions). The MDS indicated Resident 35 was dependent for activities of daily living (ADL- like eating, dressing, walking, toileting) and required two or more helpers with eating, dressing, transfers, toileting and showering. During a review of Resident 30's admission Record, dated 6/4/2026, the admission Record indicated, the facility initially admitted Resident 30 on 4/5/2023, and then readmitted on [DATE], with medical diagnoses that included fracture around other internal prosthetic joint (fracture of the bone near artificial joint), osteoarthritis (stiffness and pain in joints), type 2 diabetes mellitus (DM II, a ongoing disorder of persistent high blood sugar levels) dysphagia (difficulty in swallowing) , heart failure (heart muscle is too weak or too stiff to pump enough blood and oxygen to meet the body's needs) and thyrotoxicosis (a clinical syndrome caused by an excess of circulating thyroid hormones in the bloodstream, which speeds up your metabolism). During a review of Resident 30's MDS) dated [DATE], the MDS indicated, Resident 30 was cognitively intact. The MDS indicated Resident 30 needed moderate assistance with dressing, and personal hygiene, and maximal assistance with transfers to chair, toileting and showering. During an observation on 6/3/2026 at 8:11 a.m. by Resident 35's room, Licensed Vocational Nurse (LVN) 2 was preparing to administer medication to Resident 35 and the following was observed:- LVN 2 took a portable blood pressure (BP) reading machine, an electronic temporal thermometer (machine to measure body temperature), and a portable pulse oximetry machine (device to measure oxygen saturation at a fingertip) to Resident 35 to check their vital signs (measurements of blood pressure, pulse, temperature, breathing, pain level).- LVN 2 then dropped the BP machine on the floor, picked up the BP machine from the floor, and went to a medication cart (med cart - a locked medication storage cabinet) to clean it. LVN 2 used germicidal disposable wipe, wiped it for about 20 seconds, and put the cleaned BP machine back on the top of the med cart without first wiping the top of the med cart surface where the soiled BP machine came in contact prior. - LVN 2 then changed gloves and proceeded with checking the BP of Resident 35. LVN 2 then placed the used BP machine on top of the med cart. LVN 2 did not clean the equipment before moving on with medication administration. During an observation on 6/3/2026 at 8:50 a.m. by Resident 30's room, LVN 2 moved on to check vital signs for Resident 30. Between providing care for Resident 35 and moving on to Resident 30, LVN 2 did not clean nor sanitize the shared patient care equipment in use, which included a BP machine, pulse oximeter, and a thermometer.During a concurrent interview and records review on 6/3/2026 at 11:09 a.m. with LVN 2 manufacturer's (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	06/05/2026

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructions for germicidal disposable wipes were reviewed and LVN 2 stated the following:- LVN 2 stated the staff used the germicidal disposable wipe for equipment cleaning and sanitizing for non-disposable items like a BP machine. LVN 2 stated that alcohol-based (solution that destroys germs) wipes should be used for 20 seconds or until dry.- LVN 2 reviewed the manufactures' instructions of germicidal disposable wipe and stated that one of the ingredients was 55% isopropyl alcohol, and it disinfected (use of chemical agents to destroy germs) after three minutes disinfect time (contact time of chemical solution with surface). The manufacturer's instruction indicated disinfects in two (2) minutes.- LVN 2 stated he wiped and disinfected the med cart after all resident medications were administered.- LVN 2 stated the contact time for the germicidal product meant that he needed to wipe it and leave it to air dry, for three minutes, and there was no need to keep it wet in solution for two or three minutes.- LVN 2 stated that he did not recall wiping the equipment between the residents.- LVN 2 stated that it was important to properly sanitize between residents to prevent opportunities for cross contamination (transferring germs from one person or object to another). During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, dated January 2026, the P&P indicated, Non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical resident-care items include blood pressure cuffs. Reusable items are cleaned and disinfected or sterilized between residents. Intermediate and low-level disinfectants for non-critical items include ethyl or isopropyl alcohol. Manufacturers' instructions will be followed for proper use of disinfecting products including recommended use-dilution.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation and interview, the facility failed to ensure that the resident's call button (a button or remote on a cord that a patient in a hospital or nursing home presses to get help) was within reach for three of seven residents (Residents 8, 47, and 58) when residents 47's according to the facility's policy and procedure (P&P) tiled Call Lights: Accessibility and Timely Response, with revision date 10/2025. This deficient practice had the potential to result in delayed care, falls, accidents and/or hospitalization for Residents 8, 47, and 58. Findings: 1. During a review of Resident 8's admission Record, the record indicated that Resident 8 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (a type of irregular heart beat), Alzheimer's disease (a brain disease that affects memory, thinking skills, and the ability to carry out simple daily tasks), and care following a surgery on the digestive system. During a review of Resident 8's Minimum Data Set (MDS, an assessment tool), dated 4/16/2026, the record indicated that Resident 8 has impaired hearing, speech, vision, decision making skills, and memory. The record also indicated that Resident 8 uses a wheelchair and is dependent on others to perform all daily activities, such as bathing, toileting, dressing, and transferring from the bed to the wheelchair. During a review of Resident 8's Care Plan for communication deficit, initiated on 1/26/2026, the care plan indicated the intervention to address Resident 8's communication deficit is to keep the call light within reach. During a review of Resident 58's admission Record, the record indicated that Resident 58 was admitted to the facility on [DATE], with diagnoses including epilepsy (a disorder that causes an electrical surge in the brain, resulting in brief disruption of brain activity and often uncontrolled spasms of muscles), muscle weakness, and Alzheimer's disease. During a review of Resident 58's MDS, dated [DATE], the MDS indicated that Resident 58 has impaired memory and impaired decision making skills. The MDS indicated Resident 58 uses a wheelchair, and is dependent on others to perform all daily activities. During a review of Resident 58's Care Plan for communication deficit, initiated on 5/14/2025, the record indicated the intervention to address Resident 58's communication deficit is to keep the call light within reach. During an observation on 6/1/2026 at 8:31 A.M. in Resident 8 and Resident 58's room, both Resident8 and 58 were seated in reclining wheelchairs beside their own beds. The residents call light buttons were in the center of each of the residents beds and were not within reach of either resident. During an interview on 6/3/2026 at 9:33 A.M. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that all call lights need to be within reach of the residents and are usually clipped to the resident's clothing or bedding. During an interview on 6/4/2026 at 1:25 P.M. with the Director of Nursing (DON), the DON stated that (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call lights should be within reach for all residents. During a review of the facility's policy and procedures (P&P), titled Call Lights: Accessibility and Timely Response, dated 1/2026, the P&P indicated, Call system should be accessible to Residents while in bed or other sleeping accommodations in room and staff should facilitate call light placement within reach of resident and secure it as needed. 2. A review of Resident 47's admission Record indicated the facility admitted Resident 47 on 5/16/2026 with diagnoses including dementia (progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD -a chronic lung disease causing difficulty in breathing), and hypertension (HTN - high blood pressure). A review of Resident 47's MDS dated [DATE], indicated Resident 47 is cognitively (mental ability to make decisions of daily living) impaired. The MDS indicated Resident 47 is dependent on staff with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care. During an observation on 6/1/2026, at 10:24 A.M., Resident 47's call button was seen on his nightstand that was at the head of his bed, against the wall and not within reach of the resident. During a concurrent observation and interview on 6/1/2026, at 10:25 A.M., with LVN 1 in Resident 47's room, Resident 47's call button was seen on his nightstand that was at the head of his bed, against the wall and not within reach of the resident. LVN 1 stated that Resident 47's call button was on Resident 47's nightstand. LVN 1 stated resident call buttons need to be within reach of the resident so the residents can call us when they need help. LVN 1 stated that if the call button is not within the reach of the resident may try to get up on their own without assistance and end up falling or having an injury. During an interview on 6/4/2026, at 11:37 A.M., with the DON, the DON stated that the resident call buttons should be within the reach of the resident so that the residents may call for assistance. If the residents call buttons are not within their reach they may end up soiling themselves or potentially fall. A review of the Facility P&P titled Call Lights: Accessibility and Timely Response, with revision date 10/2025 indicated the following, Policy The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to facilitate appropriate response. Policy Explanation and Compliance Guidelines: . 5. Staff should facilitate call light placement within reach of resident and secure it as needed. 6. Call system should be accessible to Residents while in bed or other sleeping accommodations in room.