STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Point Care Center	1430 West 6th Street San Pedro, CA 90732

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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 a Registered Nurse (RN) was designated to serve as the Director of Nursing (DON) on a full-time basis.This deficient practice had the potential to negatively affect all 78 residents in the facility by impacting the overall clinical oversight, management, and quality of nursing care provided.Findings:During a review of the Facility Assessment (a facility-wide evaluation conducted and documented to indicate the resources, and staffing the facility needs to provide the necessary care for their residents daily) dated 5/29/26, the facility assessment indicated, there should be a DON full time five days (40 hours) a week. The facility assessment indicated, there were two Registered Nurse Supervisors (RNS).During a review of the DON's Terminated w2, dated 6/4/26, the terminated w2 indicated, the last day of employment for the DON was 6/4/26.During an interview on 6/24/26 at 9:34 a.m. with the Director of Staff Development (DSD), the DSD stated the DON quit on 6/4/26. The DSD stated the DON was responsible for overseeing the nursing department. The DSD stated with the facility not having a DON there is a potential for the residents' quality of care to be compromised.During an interview on 6/25/26 at 2:01 p.m. with the Administrator (ADM), the ADM stated the DON was necessary to coordinate the care between the staff and the residents. The ADM stated there was a potential for a negative outcome to occur when the facility does not have a DON.During a review of the facility's policy and procedure (P&P) titled Director of Nursing Services dated 8/2022, the P&P indicated, the nursing services department is managed by the director of nursing services (DNS). The director is a registered nurse (RN), licensed by this state, and has experience in nursing service administration, rehabilitative and geriatric nursing. The director is employed full-time (40 hours per week) and is responsible for, but is not necessarily limited to a. developing and periodically updating the nursing service objectives and statements of philosophy;b. overseeing standards of nursing practice;c. developing and maintaining nursing policy and procedure manuals;d. developing and maintaining written job descriptions for each level of nursing personnel;e. providing direct resident care when needed;f. coordinating nursing services with other resident services;g. recruiting and retaining the number and skill levels of nursing personnel necessary to meet the nursing care needs of each resident;h. ensuring sufficient and competent staffing levels to meet the needs of the residents as indicated by the facility assessment and resident care plans;1. developing staff training programs for nursing service personnel;j. participating in the planning and budgeting for nursing services;k. ensuring complete and accurate documentation;L. participating in the completion of the resident assessment instruments (MOS) and care area assessments;m. assisting the interdisciplinary team in assessing, planning, implementing and monitoring resident care; andn. assuring that nursing care personnel are administering care and services in accordance with the resident's assessment and care plan.The P&P indicated, the DNS may serve as charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food in a safe and sanitary manner. The facility had (78) residents receiving oral diet. The facility failed to:1.Ensure prepared cups of orange juice, apple juice and cranberry juice were stored at the required 40 degrees Fahrenheit (F-unit of measure) while the breakfast was being plated (scooped on plates) prior to serving it to the residents.2.Ensure a container of ice cream had a use-by date (the final day a product is guaranteed to be at top quality for consumption) after it was opened. This failure had the potential to place residents at risk for developing food borne illnesses (any illness resulting from eating contaminated/spoiled foods) and reduce the quality of food served in the facility.Findings:1.During an observation on 6/23/26 at 6:44 a.m. in the kitchen, the meal trays were observed to be set up with different types of juices. The temperature of the apple juice, cranberry juice and orange juice was observed to be 69.9 degrees Fahrenheit.During an interview on 6/25/26 at 8:44 a.m. with the cook, the cook stated the temperature of the juices should have been between 37 and 40 degrees and not at 69 degrees Fahrenheit. The cook stated 69 degrees Fahrenheit was too warm for juice. The cook stated the residents may get sick and the juice wont taste good.During an interview on 6/25/26 at 8:25 a.m. with the Dietary Supervisor (DS), the DS stated juice should be stored in the refrigerator or stored on ice prior to serving. The DS stated juice should be kept at 40 degrees Fahrenheit or below. The DS stated juice could spoil and cause a food borne illness.During a review of the facility's policy and procedure (P&P) titled Meal Service dated 2023, the P&P indicated, cold food items will be placed on the trays as close to serving time as possible to assure the temperature is below 41 F. To accomplish this, all cold foods will be pre-poured and kept in the refrigerator or freezer and pulled out in small quantities at a time. The cold beverages can be stored up to 1 - 2 hours prior to service in a freezer and pulled out in quantities sufficient to maintain proper temperature. 2. During an observation on 6/22/2026 at 8:08 a.m. in the kitchen, Freezer 1 had an open box of ice cream stored in it with no use-by date labeled on the open box of ice cream.During an interview on 6/25/2026 at 8:18 a.m. with the Cook, the [NAME] stated all of the kitchen staff were responsible for putting use-by dates on food opened and stored in the freezer. The [NAME] stated the ice cream should have a used-by date, so we know it has not expired.During an interview on 6/25/2026 at 8:28 a.m. with the Dietary Supervisor (DS), the DS stated indicating the use-by date on the ice cream was important, so we know when the ice cream is expired and we know when not to use it.During a review of the facility's policy and procedure (P&P) titled, Refrigerator and Freezers, date revised 11/2022, the P&P indicated .Expiration dates on unopened food are observed and use by dates are indicated once food is opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 infection control measures were implemented for three of six sampled residents (Residents 6, 68 and 99). The facility failed to ensure:Personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for Enhanced Barrier Precautions (EBP- infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug-resistant organisms {microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents) was disposed of correctly in a closed container after providing care to Resident 68.2. Certified Nursing Assistant (CNA) 4 wore the required personal PPE before entering and washed her hands with soap and water after exiting Resident 6's room. Resident 6 was in contact precautions (are set of safety measures used when a resident has a disease that can be spread through contact with the patient or patient's environment) due to active diarrhea and history of Clostridium difficile (C. diff- a highly contagious bacterial infection causing diarrhea and colitis [inflammation of the colon]).3.Staff implemented transmission-based precautions (contact precautions) ([TBP]- are extra infection control steps added to basic safety measures) by requiring appropriate PPE during direct resident care for two of two sampled residents (Resident 99). This deficient practice had the potential to result in the transmission of infectious organisms (germs) between residents, staff, and visitors, leading to cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) with the facility, and potential outbreak situations among a vulnerable population. Findings:1.During an observation on 6/23/26 at 8:45 a.m. in Resident 68's room an uncovered trashcan was observed over flowing with discarded PPE (gowns).During a review of Resident 68's admission Record (face sheet) dated 5/25/26, the admission record indicated, Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including anemia (a condition in which there is lack of enough red blood cells), type 2 diabetes (a condition in which the body fails to process glucose (sugar) correctly) and hypertension (HTN-high blood pressure).During a review of Resident 68's History and Physical (H&P) dated 5/22/26, the H&P indicated Resident 68 had the capacity to understand and make decisions.During a review of Resident 68's Minimum Data Set (MDS - a resident assessment tool) dated 5/19/26, the MDS indicated Resident 68's cognition (memory) was intact. The MDS indicated, Resident 68 was partial to moderate assist (helper does less than half the work with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 68 had a stage three reopened pressure injury (PI-full-thickness loss of skin. Dead and black tissue may be visible).During a review of Resident 68's Order Summary Report dated 6/25/26, the order summary report indicated Resident 68 was on EBP for the sacrococcyx (tailbone) PI . The order summary report indicated, Resident 68 was prescribed [NAME]- Vite (supplement) two times a day (BID), vitamin C (supplement) 500 milligrams (mg- unit of measure) give twice a day, and zinc sulfate (supplement) 220 mg give one time a day. The order summary indicated Resident 68 had a sacrococcyx PI and was being treated with Santyl (wound debridement) use one time a day.During a review of Resident 68's care plan titled Enhanced Barrier Precautions dated 4/23/26, revised on 5/26/26, the care plan indicated Resident 68 was on EBP for chronic wounds. The care plan indicated, Resident 68 was at high risk for developing a multi-drug-resistant organism (bacteria that is resistant to multiple antibiotics). The care plan indicated, staff were to wear PPE (gown & gloves) when rendering care.During an interview on 6/24/2026 at 4:19 p.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated she was not aware that after removing PPE it should be disposed of in a closed container. CNA 6 stated that's why she threw the PPE in the regular trashcan after providing care to Resident 68. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA 6 stated she should have disposed of her PPE in the closed container that was in Resident 68's room to protect Resident 68 from infection due to cross contamination.During an interview on 6/25/26 at 11:28 a.m. with the Assistant Director of Nurses (ADON), the ADON stated Resident 68 was on EBP for her sacrococcyx PI and she was made aware that CNA 6 did not dispose of her PPE correctly in a closed container. The ADON stated PPE must always be disposed of in closed container to contain any germs that might be on the PPE it is an infection prevention measure.2. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses including enterocolitis (inflammation in the gut that affects the small intestine and colon) due to C. diff, muscle weakness and atrial fibrillation (irregular heartbeat).During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderately impaired cognitive skills (a person has noticeable difficulties with memory, thinking, making decisions and learning) and required partial/ moderate assistance (helper does less than half the effort) with toileting hygiene, bathing, and dressing.During a review of Resident 6's Order Summary Report dated 6/9/2026, the Order Summary Report indicated an order for Contact Isolation (contact precautions) for every shift due to active diarrhea.During a concurrent observation and interview on 6/22/2026 at 2:11 p.m. in Resident 6's room, signage indicating Resident 6 was on Contact Precautions was posted on the wall near the entrance of the room. Observed CNA 4 use alcohol- based hand rub (ABHR - liquid gel or foam sanitizer used to clean hands and kill germs) then wore an isolation gown but did not put on a pair of gloves before entering Resident 6's room to answer resident's call light. Observed CNA 4 dispose of her gown inside the room and used ABHR to clean hands after exiting the room. CNA 4 stated she was aware Resident had C. Diff and was on Contact Precautions. CNA 4 stated she was not sure if she should wear a pair of gloves because she did not touch the resident. CNA 4 stated she would only wear gloves with the gown if she were cleaning or touching the resident. CNA 4 stated using ABHR to clean hands before entering and after exiting Resident 6's room is sufficient to kill the bacteria in C.diff. CNA 4 stated it could spread infection to the residents and staff if she did not use the appropriate PPE before entering Resident 6's room and did not practice the proper hygiene intended for resident who had diarrhea and being treated for C.diff.During an interview on 6/24/2026 at 8:03 a.m. with the Infection Preventionist (IP), the IP stated Resident 6 was on contact isolation and had active diarrhea. The IP stated CNA 4 should have worn a gown and a pair of gloves before entering the room of a resident on contact precautions. The IP stated CNA 4 had to use water and soap for hand hygiene because alcohol-based hand rub did not kill the germs of C. diff. The IP stated the germs could still be present on the hands of CNA 4 because she did not wear gloves and used ABHR for hand hygiene. The IP stated not properly washing hands and using the proper PPE could cause an outbreak (a sudden, unexpected increase in the number of disease cases in a specific location or among a specific group of people).During an interview on 6/25/2026 at 2:08 p.m. with Quality Assurance (QA), QA stated staff should wear gloves and gown before entering Resident 6's room who was in Contact Precautions. QA stated there was a risk for cross contamination because the germs could still be present or alive on the surfaces of the resident's room. QA stated all staff should practice and observe the right isolation precautions to prevent cross contamination and spread of infection.3. During a review of Resident 99's admission Record, the admission Record indicated Resident 99 was admitted to the facility on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) affecting left dominant side and cerebral infarction (damage to the brain from interruption of its blood supply).During a review of Resident 99's Care Plan dated 6/16/2026, the Care Plan indicated, Focus: Enhanced Barrier Precautions; Resident with indwelling catheter (foley catheter [f/c: a hollow tube inserted into the bladder to drain or collect urine]).Interventions: Staff will perform hand hygiene, wear PPE (gown, and gloves) before and after high contact care activities.During a review of Resident 99's MDS dated [DATE], the MDS indicated Resident 99 was dependent (helper does all the work) with eating, oral hygiene, showering/bathing, toileting, lower body dressing, and putting on and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	taking off footwear. During a concurrent observation and interview on 6/25/2026 at 8:16 a.m. with Certified Nurse Assistant (CNA) 3, CNA 3 was observed entering a room identified as a transmission-based precaution (TBP) room. CNA 3 proceeded to provide feeding assistance to Resident 99. CNA 3 was not wearing the required personal protective equipment (PPE) indicated for transmission-based precautions. CNA 3 acknowledged the resident was on transmission-based precautions and stated that she did not wear PPE. CNA 3 stated she was aware of the facility education regarding PPE requirements. CNA 3 stated that failure to wear the proper PPE could cause the spread of germs to the resident, other residents, staff, and visitors. CNA 3 stated that wearing PPE helps prevent passing infections from one person to another, especially when providing direct care. During an interview on 6/25/2026 at 9:07 a.m. with the Infection Preventionist (IP), the IP stated she was responsible for overseeing infection prevention practices, and staff education. The IP stated she was aware Resident 99 was on transmission-based precautions (TBP). The IP stated staff entering a TBP room and providing direct care are required to wear the appropriate PPE, including gloves, gown, and mask. The IP stated staff are educated regarding transmission-based precautions through in-services and one-on-one education. The IP stated staff are notified of a resident's transmission-based precautions through signage posted outside the resident's room and through a blue dot placed next to the resident's name outside prior to entering the room. The IP stated PPE was available and located outside of the resident's room for staff use. The IP stated the expectation of staff entering a transmission-based precaution room is to don the required PPE prior to entering the room and providing resident care. The IP stated when staff are observed not following transmission-based precaution requirements, the staff member should receive immediate one-on-one education regarding the required infection prevention practices. The IP stated staff competency related to infection prevention practices is validated through rounding and observation of staff practices. The IP stated failure to wear appropriate PPE increases the risk of transmission of infectious organisms between residents, staff, and visitors. The IP stated that not following transmission-based precaution requirements may result in the spread of infection due to potential transfer of infectious organisms during direct resident care activities.During an interview on 6/25/2026 at 10:19 a.m. with Registered Nurse Supervisor (RNS), the RNS stated she was made aware that Resident 99 was on transmission-based precautions (TBP). The RNS stated that her role includes ensuring staff follow infection prevention protocols related to transmission-based precautions. The RNS stated that the required PPE for staff providing direct resident care includes gown, mask, gloves, and performance of hand hygiene before and after entering the resident's room. The RNS stated that staff are notified of transmission-based precautions through staff in-services, signage posted outside the resident's room, and discussion during daily huddles. The RNS stated PPE was available outside of the resident's room and signage indicating transmission-based precautions was posted. The RNS stated that her expectation of staff prior to entering a transmission-based precaution room is to perform hand hygiene and appropriately don and doff required PPE. The RNS stated that when staff are observed providing care without required PPE, they are immediately provided one-on-one in-service education. The RNS further stated that the Infection Preventionist (IP) and charge nurses provide staff education related to infection prevention practices. The RNS stated that staff compliance is monitored through routine rounding and observation of staff practices. The RNS stated PPE practices and infection prevention expectations are reinforced during shift huddles and unit rounds. The RNS stated competency is validated through return demonstration and observation of the staff practices. The RNS stated that she reports infection prevention concerns verbally to the Infection Preventionist. The RNS stated that failure to wear required PPE may result in the transmission of infectious organisms between residents, staff, and visitors. This may lead to cross-contamination within the facility, increased risk of healthcare-associated infections, potential outbreaks, and exposure of vulnerable residents, staff, and visitors to communicable pathogens during direct resident care activities.During a review of the facility's policy and procedure (P&P) titled, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Standard Precautions, Enhanced Barrier Precautions and Transmission Based Precautions dated 6/2026, the P&P indicated, the purpose was to provide guidelines for infection control practices to reduce the potential for transmission of pathogens including COVD-19 and multi-drug-resistant organisms and viruses. The P&P indicated, enhanced Barrier Precautions (EBP)- primarily is the use of gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO colonization and transmission. The P&P indicated, staff Education is essential in reducing the transmission of infectious agents including COVID-19 and [NAME]. Facility staff including those who have direct resident contact and those in administrative positions should be educated during new employee orientation, annually concerning the epidemiology of specific infectious agents and the role they play in reducing the potential for transmission of these as well as other micro-organisms; proper use of PPE; resident hygiene; their responsibilities in cleaning and disinfecting medical equipment and environmental surfaces, and when observations indicate that employees are not in compliance with the facility infection control procedures including hand hygiene

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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 ensure one of one sampled resident (Resident 21), had a call light within reach. This failure had the potential to result in Resident 21 not being able to call for assistance.Findings:During a review of Resident 21 admission Record (Face Sheet-front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 21 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to spinal stenosis (narrowing of spaces within the spine), muscle weakness, dementia (a progressive state of decline in mental abilities) and difficulty walking.During a review of Resident 21's Physician Progress Note, dated 5/5/2025, the Physician Progress Note indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Care Plan titled, Alteration In Physical Functioning, date revised 10/7/2025, the Care Plan interventions indicated the call light be placed within easy reach and answered promptly.During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2026, the MDS indicated Resident 21 needed substantial to maximal assistance (helper does more than half the effort) with toileting, showering, dressing, and transferring.During an observation on 6/22/2026 at 2:18 p.m. in Resident 21's room, Resident 21 was resting quietly in bed and Resident 21's call light was on the floor. Certified Nursing Assistant (CNA)10 came to Resident 21 room to give Resident 21 tissues (soft absorbent paper used for blowing the nose or wiping the face). CNA 10 left Resident 21's room without placing Resident 21's call light within reach.During an interview on 6/25/2026 at 1:28 p.m. with Certified Nursing Assistant (CNA) 11, CNS 11 stated when Resident 21's call light was on the floor, we were to ask the resident if they needed something to clip the call light onto the Resident's blanket. CNA 11 stated Resident 21 could have a risk for falling if he tried to help himself because he could not reach his call light to summon help.During an interview on 6/25/2026 at 3:09 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the call light not in the resident's reach will cause a delay of care, the resident cannot call for help, and the resident could have an emergency (a sudden, urgent, usually unexpected occurrence or occasion requiring immediate action) .During a review of the Policy and Procedure (P&P), titled, Answering the Call Light, dated 6/2026, the P&P indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) for two of three sampled residents (Resident 86 and Resident 92).This failure had the potential to prevent residents or their representatives from making informed decisions about whether to receive services that may require out-of-pocket payment.Findings: During a concurrent interview and record review on 6/24/2026 at 1:40 p.m. with the Business Office Manager (BOM), the BOM stated that Resident 86's last covered day for Medicare Part A was 4/16/2026 and Resident 92's was 6/11/2026. The BOM stated she failed to provide SNF ABNs in writing to Residents 86 and 92 or their representatives thus failing to notify them of potential financial liability. The BOM stated she was responsible for notifying residents or their representatives of changes in Medicare to inform them when coverage was ending and possible share of cost. The BOM stated residents or their representatives could face financial difficulties if they were not informed of changes in benefits and allowed to appeal those decisions.During a review of Resident 86's admission Record, dated 6/25/2026, admission record indicated the facility admitted the resident on 2/6/2026 with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), generalized muscle weakness and abnormalities of gait and mobility.During a review of Resident 86's MDS dated [DATE], MDS indicated the resident was unable to make decisions for self. During an interview on 6/24/2026 at 2:22 p.m. with Resident 86's representative (RP), the RP stated they were not given any written notification of changes in Resident 86's Medicare coverage and were receiving bills from the facility.During an interview on 6/24/2026 at 3:03 p.m. with the Administrator (ADM), the ADM stated she was not clear of Advanced Beneficiary Notice policies and regulations and will discuss further with the business office to get clarification. The ADM stated that if residents were not told their Medicare coverage was ending, they may be unaware of their potential financial responsibilities and share of costs. During a review of facility's Policy and Procedure (P&P) titled Medicare Advanced Beneficiary Notice not dated, the P&P indicated If the director of admission or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one sampled residents (Resident 92)'s assessment entries on the Minimum Data Set (MDS- a resident assessment tool) related to hearing status and use of hearing aids was accurately documented to reflect the resident's ability to hear. This failure had the potential to negatively affect Resident 92's's plan of care and delivery of necessary care and services.Findings:During a review of Resident 92's admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 92 was admitted to the facility on [DATE] with diagnoses of but not limited to encephalopathy (damage or disease that affects the brain), dementia (a progressive state of decline in mental abilities), anxiety (emotion characterized by feelings of tension, worried thoughts), and generalized muscle weakness.During a review of Resident 92's Order Summary, dated 3/20/2026, the Order Summary indicated Resident 92 may have a ENT (ear, nose and throat) and an Audiology (the study of hearing, balance, and related disorders) consultation (a formal meeting with a professional or expert to seek advice, evaluate, a specific situation or make a collaborative decision), and treatment as needed.During a review of Resident 92's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2026, the MDS indicated Resident 92 had minimal difficulty hearing. The MDS indicated Resident 92 did not use a hearing aid or other hearing appliance. The MDS indicated Resident 92 sometimes had the ability to express wants and ideas. The MDS indicated Resident 92 sometimes had the ability to understand others. The MDS indicated Resident 92 was dependent (helper does all of the effort) on nursing staff for toileting, showering, dressing, sitting and standing.During a concurrent interview and record review on 6/22/2026 at 4:04 p.m. with the Minimum Data Set Nurse (MDSC), Resident 92's MDS, dated [DATE], was reviewed. The MDS indicated Resident 92 had minimal difficulty with hearing and did not use hearing aids. The MDSC stated she just found out today Resident 92 used hearing aids. The MDSC stated Resident 92's MDS was not coded correctly, and Resident 92 could have a decline in communication.During an interview on 6/25/2026 at 3:00 p.m. with the Assistant Director of Nursing (ADON), the ADON stated none of the nursing staff were aware of Resident 92 having or using hearing aids. During a review of the facility's policy and procedure (P&P) titled, Position Title: MDS Coordinator/MDS Nurse, undated, the P&P indicated, a position summary, To conduct, collect data, and coordinate the development and completion of the resident assessment in accordance with the federal, state, and local laws, guidelines, and regulations governing the facility. The MDS Coordinator/MDS Nurse collaborates with all levels of nursing personnel as well as with facility consultants, physicians, department managers and other department employees. The MDS Coordinator/MDS Nurse coordinates resident assessment instrument implementation and provides resident assessment related education. Ensure that all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions and that they are aware of the penalties, including civil money penalties, for false certification.

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	055527	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Point Care Center	1430 West 6th Street San Pedro, CA 90732

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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** Based on interview and record review the facility failed to ensure one of one sampled resident (Resident 92) had a care plan initiated and implemented for hearing loss.This failure to provide Resident 92 with her hearing aids had the potential to negatively affect Resident 92's ability to communicate needs, participate in care and maintain psychosocial well-being.Findings:During a review of Resident 92's admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 92 was admitted to the facility on [DATE] with diagnoses of but not limited to encephalopathy (damage or disease that affects the brain), dementia (a progressive state of decline in mental abilities), anxiety (emotion characterized by feelings of tension, worried thoughts), and generalized muscle weakness.During a review of Resident 92's Order Summary, dated 3/20/2026, the Order Summary indicated Resident 92 may have a ENT (ear, nose and throat) and an Audiology (the study of hearing, balance, and related disorders) consultation (a formal meeting with a professional or expert to seek advice, evaluate, a specific situation or make a collaborative decision), and treatment as needed.During a review of Resident 92's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2025, the MDS indicated Resident 92 had adequate hearing. The MDS indicated Resident 92 did not use a hearing aid or other hearing appliance. The MDS indicated Resident 92 sometimes had the ability to express wants and ideas. The MDS indicated Resident 92 sometime had the ability to understand others. The MDS indicated Resident 92 was dependent (helper does all of the effort) on nursing staff for toileting, showering, dressing, sitting and standing.During an interview on 06/25/2026 at 1:38 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated all licensed nursing staff are responsible for initiating and implementing nursing care plans. LVN 4 stated Resident 92 should have a care plan for hearing aids and hearing loss.During an interview on 6/25/2026 at 3:00 p.m. with the Assistant Director of Nursing (ADON), the ADON stated any licensed nurse can initiate a care plan for hearing and should be updating the care plans or continuity of care.During a review of the facility's policy and procedure (P&P) titled, Care Plans Comprehensive Person-Centered, dated 6/2026, the P&P 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide one of one sampled resident (Resident 92) with her hearing aids (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing) stored in the Social Service Director's (SSD) file cabinet.This failure resulted in Resident 92 not being able to communicate effectively when spoken too.Findings:During a review of Resident 92's admission Record (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 92 was admitted to the facility on [DATE] with diagnoses of but not limited to encephalopathy (damage or disease that affects the brain), dementia (a progressive state of decline in mental abilities), anxiety (emotion characterized by feelings of tension, worried thoughts), and generalized muscle weakness.During a review of Resident 92's Order Summary, dated 3/20/2026, the Order Summary indicated Resident 92 may have a ENT (ear, nose and throat) and an Audiology (the study of hearing, balance, and related disorders) consultation (a formal meeting with a professional or expert to seek advice, evaluate, a specific situation or make a collaborative decision), and treatment as needed.During a review of Resident 92's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2026, the MDS indicated Resident 92 had adequate hearing. The MDS indicated Resident 92 did not use a hearing aid or other hearing appliances. The MDS indicated Resident 92 sometimes had the ability to express wants and ideas. The MDS indicated Resident 92 sometime had the ability to understand others. The MDS indicated Resident 92 was dependent (helper does all of the effort) on nursing staff for toileting, showering, dressing, sitting and standing.During an interview on 6/22/2026 at 2:26 p.m. with Resident 92, Resident 92 stated she could not hear when spoken too. Resident 92 stated it would be great to be seen by a hearing doctor. During an interview on 6/24/2026 at 10:07 a.m. with Certified Nursing assistant (CNA) 6, CNA 6 stated Resident 92 had problems with hearing. CNA 6 stated Resident 92 always asked staff to repeat certain words. CNA 6 stated Resident 92 does not use hearing aids.During an interview on 6/25/2026 at 8:34 a.m. with the Social Services Director (SSD), the SSD stated Resident 92 had hearing aids stored in her (SSD)'s file cabinet. The SSD stated she does not know how to turn them on and is not sure if they are in working condition. The SSD stated the hearing aids were supposed to be checked by ENT doctor. The SSD stated Resident 92 will not be able to express her needs and want and will not be able to communicate if not provided with her hearing aids.During an interview on 6/25/2026 at 3:00 p.m. with the Assistant Director of Nursing (ADON), the ADON stated no staff in the facility was aware Resident 92 had hearing aids.During a review of Resident 92's ENT visit documentation, dated 6/2/2026, the ENT document indicated Resident 92 had diminished hearing and hearing loss in the left ear.During a review of Resident 92's Resident Belonging List, dated 6/25/2026, the Resident Belonging List indicated Resident 92 had two hearing aids.During a review of the facility's Policy and Procedure (P&P) titled, Hearing Aid, Care of, dated 6/2026, the P&P indicated, The purpose of this procedure is to maintain the resident's hearing at the highest attainable level.The following information should be recorded in the resident's medical record: 1. The date and time the hearing aid was checked and/or battery was replaced. 2. The name and title of the individual(s) who checked the hearing aid and changed the battery. 3. If the resident refused the procedure, the reason(s) why and the intervention taken. 4. The signature and title of the person recording the data.

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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. The facility failed to ensure a skills competency was done upon hire for the licensed staff. This failure had the potential to place residents at risk by allowing licensed staff to perform clinical tasks without confirmation they were competent to do so placing the residents at risk for staff providing care incorrectly or inconsistently and delayed recognition of changes in condition. Findings:During a concurrent interview and record review on 6/25/26 at 9:42 a.m. with the Director of Staff Development (DSD) , the Assistant Director of Nurses (ADON)'s employee file was reviewed, The DSD stated nurse competencies are done upon hire and annually thereafter. The DSD stated the ADON was hired on 12/1/25. The DSD stated competencies were not done for the ADON upon hire. The DSD stated skills competencies are done to ensure the staff are knowledgeable and competent in the job they were hired to do. The DSD stated there was a possibility for the residents to experience a delay in care if the nurse is not competent in providing the care needed.During an interview on 6/25/25 at 11:37 a.m. with the ADON, the ADON stated skills competencies are done upon hire and annually thereafter. The ADON stated she had not had any skills competencies done since being hired. The ADON stated if staff are not competent in providing care to the residents there is a potential for the resident to harmed (physical injury or mental distress).During an interview on 6/25/26 at 2:01p.m. with the Administrator (ADM). The ADM stated skills competencies are done upon hire and annually to ensure the staff are competent in the care they will be providing to the residents. The ADM stated there was a potential for a negative outcome to occur when nurses are not competent in their job responsibilities.During a review of the facility's policy and procedure (P&P) titled Competency of Nursing Staff dated 3/2025, the P&P indicated, all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. The P&P indicated facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. The P&P indicated, competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 37 and Resident 53) were free of unnecessary medication by failing to:1.Ensure Resident 37 who was receiving lorazepam (medication used to treat anxiety) was used without clinical justification, adequate monitoring and documentation.2.Ensure Resident 53 who was receiving lorazepam for anxiety and inability to sleep had documented behavior and sleep monitoring.This failure had the potential to place Resident 37 and Resident 53 at risk for unnecessary medication and adverse effects (unwanted and harmful result that can occur after taking a medication) associated with the prescribed medications. Findings: 1.During a review of Resident 37's physician's order dated 5/22/26 and 6/9/26, the physician order indicated lorazepam to be given every 12 hours as needed for anxiety. During a review of Resident 37's physician order dated 5/30/26, physician order indicated monitoring episodes of anxiety every shift for lorazepam use. During a review of Resident 37's June 2026 the Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) was reviewed. The MAR indicated Resident 37 received lorazepam on 6/1/26 8:02 a.m. and 8:56 p.m. with no documented anxiety episode, 6/2/26 9:30 p.m. with no documented anxiety episode, 6/3/26 9:10 a.m. and 9:34 p.m. with no documented anxiety episode, 6/9/26 8:40 p.m. with no documented anxiety episode, 6/12/26 8:48 p.m. with no documented anxiety episode, 6/13/26 9:00 p.m. with no documented anxiety episode, 6/14/26 8:35 a.m. with no documented anxiety episode, 6/19/26 9:29 p.m. with no documented anxiety episode, and 6/22/26 10:30 p.m. with no documented anxiety episode. During an interview on 6/25/26 at 8:29 a.m. with Licensed Vocational Nurse (LVN) 2, the LVN 2 stated that lorazepam was administered because Resident 37 would request for it daily. LVN 2 stated resident would repeatedly approach staff at the permissible frequency without indication, monitoring and documentation of anxiety behaviors. LVN 2 stated this practice could result in inappropriate anxiety management and reliance on lorazepam. During an interview on 6/25/26 at 8:55 a.m., the Assistant Director of Nursing (ADON), the ADON stated that lorazepam was prescribed as needed for the resident's anxiety and restlessness, but it was administered regularly without behavior monitoring or documentation. The ADON stated that as-needed medications such as lorazepam required clear justification, monitoring, and documentation before administration because failing to do so risks improper dosing and potential sedation. During a review of the facility's Policy And Procedures (P&P) titled Unnecessary Drugs dated 2/05/25, the P&P indicated Adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any safer treatments have been deemed clinically contraindicated. 2.During a review of Resident 53's admission Record, the admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses including malignant neoplasm of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	colon(cancerous tumor that grow uncontrollably and invading surrounding tissues in the colon), anxiety disorder (a condition where fear or worry lingers and interfere with daily life), atrial fibrillation(irregular heartbeat) and pneumonia(an infection/inflammation in the lungs). During a review of Resident 53's Minimum Data Set (MDS- a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 53 had moderately impaired cognitive skills (noticeable trouble with thinking, learning, remembering, making decisions) and was dependent on staff with bathing and toileting hygiene. During a review of Resident 53's Physician Order dated 6/22/2026, the Physician Order indicated a telephone order received and written by a licensed nurse without a time documented when it was ordered. The Physician Order indicated an order of Lorazepam (Ativan- medicine used to treat anxiety) 0.5 milligram (mg.- unit of measurement) po (by mouth) every HS (bedtime) for sleep. During a concurrent interview and record review on 6/24/2026 at 4:22 p.m. with the Assistant Director of Nursing (ADON), Resident 53's Order Summary Report, and Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 6/2026 were reviewed. ADON stated Resident 53 had a physician order of Lorazepam 0.5 mg. 1 tablet by mouth at bedtime for anti-anxiety (medicine that treats anxiety) manifested by inability to sleep. ADON stated there was no documentation monitoring the behavior of inability to sleep or manifested specific behavior of anxiety for the use of Lorazepam. ADON stated not monitoring behavior before administering lorazepam could cause overdose or underdose of lorazepam and could be unnecessary medication. ADON agreed lorazepam is a psychotropic medicine (drugs that affect the mind, emotions and behavior) and could carry side effects like increased confusion, risk for falls or sedation (state of calmness or sleepiness induced by a medication). During an interview on 6/25/2026 at 2:18 p.m. with the Quality Assurance (QA), QA stated there should be a monitoring of behavior in place for the use of Resident 53's lorazepam to ensure the medication is appropriate for the resident's condition. QA stated the resident should be monitored for behavior related to the use of lorazepam because it could cause sedation, increased confusion and fall. During a review of facility's policy and procedure titled, Unnecessary Drugs, dated 2/5/2025, the P&P indicated indications for initiating a medication is determined by evaluating the residents' physical, behavioral, mental and psychosocial signs and symptoms. The P&P indicated resident's medical record should include documentation and evaluation for chosen treatment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were free of a medication error rate of 5% or greater. During a medication administration pass on 6/23/26, one licensed nurse failed to administer three prescribed medications Rena Vite (supplement), vitamin c (supplement) and zinc sulfate (supplement) to Resident (68).This resulted in a 10.34% medication error rate, based on three medication errors observed out of 29 medication opportunities.Findings:During an observation on 6/23/26 at 8:45 a.m. in Resident 68's room with licensed vocational Nurse 3, (LVN 3) was observed administering Resident 68 her 9:00 a.m. medications. LVN 3 was observed to not give Resident 68's prescribed Rena Vite, vitamin c and zinc sulfate during Resident 68's 9:00 a.m. medication administration pass.During a review of Resident 68's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/19/26, the MDS indicated, Resident 68's cognition (memory) was intact. The MDS indicated, Resident 68 was partial to moderate assist (helper does less than half the work with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 68 had a stage three reopened pressure injury (PI-full-thickness loss of skin. Dead and black tissue may be visible).During a review of Resident 68's History and Physical (H&P) dated 5/22/26, the H&P indicated, Resident 68 had the capacity to understand and make decisions.During a review of Resident 68's admission Record (face sheet) dated 5/25/26, the admission record indicated, Resident 68 was admitted on [DATE] and readmitted on [DATE] with diagnoses including, anemia (a condition in which there is lack of enough red blood cells), type 2 diabetes (a condition in which the body fails to process glucose (sugar) correctly) and hypertension (HTN-high blood pressure).During a review of Resident 68's Order Summary Report dated 6/25/26, the order summary report indicated, Resident 68 was prescribed [NAME]- Vite two times a day (BID), vitamin C 500 milligrams (mg- unit of measure) twice a day, and zinc sulfate 220 mg one time a day. The order summary report indicated, Resident 68 had a sacrococcyx (tailbone) PI and was being treated with Santyl (wound debridement medication) one time a day.During a review of Resident 68's Care plan titled Resident 68 has a stage 3 sacrococcyx PI. The care plan indicated, Resident 68 was at risk for infection. The care plan indicated Resident 68 would be provided with wound supplements to promote wound healing for Resident 68's sacrococcyx stage 3 PI.During an interview on 06/23/2026 2:07 p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she missed giving Resident 68 her [NAME]-Vite, vitamin c and zinc sulfate. LVN 3 stated she was not sure what happened. LVN 3 stated Resident 68 was taking those medications to help with healing her sacrococcyx PI.During an interview on 6/25/26 at 11:28 a.m. with the Assistant Director of Nurses (ADON), the ADON stated she was aware LVN 3 did not give Resident 68 Rena Vite, vitamin c and zinc sulfate when administrating Resident 68's 9:00 a.m. medications on 6/23/26. The ADON stated Resident 68 was on those specific medications to help with healing Resident 68's stage 3 sacrococcyx PI.During a review of the facility's policy and procedure (P&P) titled Administering Medications dated 4/2019, the P&P indicated, only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. The P&P indicated, medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow up necessary dental services for one of four sampled residents (Residen16). This failure put Resident 16 at risk for development of tooth decay and weight loss. Findings: During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was admitted on [DATE] to the facility with diagnoses including cardiomegaly(enlarged heart), enthesopathy(any disease or injury that affects where the tendons and ligaments connect in the bones), hypertension(HTN- high blood pressure), and congestive heart failure(CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 16 had moderately impaired cognitive (ability to make decisions of daily living) skills and required supervision or touching assistance (helper provides verbal cues and touching/steadying as resident completes the activity) with oral hygiene.During a review of Resident 16's Social Services Note dated 5/15/2026 at 12:01 p.m., the Social Services Note indicated the dentist recommended teeth cleaning for the resident and the family agreed to pay out-of-pocket (covering an expense with your own personal money rather than using funds from an insurance) for 200 dollars for Resident 16's dental cleaning.During a review of Resident 16's Dental Progress Note dated 5/29/2026, the Dental Progress Notes indicated a recommendation of full mouth x-rays (detailed x-ray pictures of all the teeth) when eligible. The Dental Progress Notes indicated the resident had no dental insurance coverage.During a review of Resident 16's Dental Care Note dated 6/23/2026, the Dental Care Note indicated Resident 16 had heavy tartar(a hard crusty buildup of mineral deposits on the teeth that forms when plaque is left on the teeth for too long leading to gum disease and tooth decay).The Dental Care Note indicated scaling (professional cleaning procedure used to remove tartar and plaque), root planning (dental procedure that smooths out the rough root surfaces of a tooth after tartar has been scraped away)and x-rays(painless medical imaging test) were recommended. The Dental Care Note indicated the resident was self-paying and recommendations are subject to insurance and responsible party authorization.During a concurrent observation and interview on 6/24/2026 in Resident 16's room, Resident 16 stated there was something stuck in his teeth and could not get it out. Observed Resident 16's mouth had crowded and overlapping teeth. Resident 16 stated he had told the staff about his concern regarding his teeth.During a concurrent interview and record review on 6/25/2026 at 9:23 a.m. with the Social Services Director (SSD), Resident 16's Social Services Notes dated 5/15/2026, Dental Care Note dated 6/23/2026 were reviewed. The SSD stated Resident 16's family agreed to cover the out-of-pocket in the amount of $200 for dental cleaning. The SSD stated Resident 16 had no dental insurance but if a resident needed dental services the facility covered the expenses. The SSD stated she did not follow up on Resident 16's dental service. The SSD stated it was her responsibility to take care of the dental needs of the residents. The SSD stated Resident 16 was at risk for poor meal intake, discomfort which can affect resident's appetite and weight loss if dental services recommended by the dentist were not followed up on.During an interview on 6/25/2026 at 2:25 p.m. with the Quality Assurance (QA), QA stated if Resident 16's dental needs and dentist recommendations were not followed up on, Resident 16 was at risk for pain, and his food intake will be negatively affected leading to weight loss.During a review of facility's policy and procedure (P&P) titled, Dental Services, dated 6/2026, the P&P indicated social services representatives will assist residents with appointments, transportation arrangements and dental reimbursements. The P&P indicated routine and 24-hour emergency dental services are provided by the facility through referrals.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the terms and condition of the arbitration agreement (legally binding contract in which parties agree to resolve any future or current disputes out of court) was clearly explained to the resident/ resident representative for one of three sampled residents (Resident 90).This failure had the potential to result in Resident 90 unknowingly giving up the right to resolve any disputes with the facility through a court of law before a jury.Findings:During a review of Resident 90's admission Record, the admission Record indicated the facility initially admitted Resident 90 on 9/2/2024 and readmitted on [DATE] with diagnoses including Parkinson's disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), unspecified dementia(a progressive state of decline in mental abilities), anxiety disorder and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 90's Minimum Data Set (MDS - resident assessment tool) dated 6/12/2026, the MDS indicated Resident 90 had moderately impaired cognitive skill (a person has noticeable decline with memory, attention, learning and reasoning).During a review of Resident 90's Physician Progress Note dated 5/13/2026 at 3:23 p.m., the Physician Progress Note indicated Resident 90 could make needs known but could not make medical decisions. The Physician Progress Note indicated a family member (FM) 1 was the responsible party (RP- person designated to handle decisions, communications, and financial matters on behalf of a resident).During an interview on 6/25/2026 at 11:24 a.m. and subsequent telephone interview on 6/25/2026 at 12:18 p.m. with FM 1, FM1 stated he never signed an arbitration agreement for Resident 90. FM 1 stated the arbitration agreement was never explained to him and this was the first time he was hearing about it.FM 1 stated he is responsible for signing all forms and consents for Resident 90.During a concurrent interview and record review on 6/24/2026 at 11:36 a.m. with the admission Coordinator (AC), Resident 90's arbitration agreement was reviewed. The AC stated FM1 signed the Arbitration agreement on 3/20/2026. The AC stated a signed Arbitration Agreement indicated Resident 90 could not file against the facility, in court in case of a dispute. The AC stated she could not remember if she had spoken to FM1 directly about the form. The AC stated the Arbitration form should be explained to the resident or resident representative before signing to ensure validity of the agreement. The AC stated not explaining the purpose of the Arbitration Agreement could violate the resident's right to be informed.During an interview on 6/25/2026 at 2:28 p.m. with the Quality Assurance Nurse (QA), QA stated AC should discuss the purpose of Arbitration Agreement and ensure the resident or the resident's representative understand the context of the consent before signing.QA stated importance of explaining the context of the Arbitration Agreement will ensure Resident 90 and RP understand the terms or conditions and the effect of signing the form.During a review of facility's policy and procedure (P&P) titled, Arbitration Agreement, revised 2023, the P&P indicated the facility will explain the agreement in a manner and language the resident and representative understand. The P&P indicated if the resident does not have the capacity to make a decision, the resident representative will be responsible for making decision and sign or decline the arbitration agreement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Point Care Center	1430 West 6th Street San Pedro, CA 90732

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure all Certified Nursing Aides (CNA's) received the mandatory five-hour annual dementia management training.This deficient practice had the potential to effect all residents residing in the facility specifically those with dementia by placing them at risk for receiving care from staff who lack current, mandatory competency in managing behavioral expressions and cognitive (memory) decline.Findings:During a concurrent interview and record review on 6/25/26 at 9:42 a.m. with the Director of Staff Development (DSD), CNA trainings and the annual (2026) mandatory in service calendar were reviewed. The DSD stated staff are to be provided with five hours of dementia training annually. The DSD stated one hour of dementia training was provided within the last year. The DSD stated dementia training was important, to ensure staff are equipped with the knowledge and skills needed to take care of residents with cognitive concerns. The DSD stated there was a potential for the residents to receive poor care if the staff could not effectively communicate with the dementia residents.During an interview on 6/25/26 at 11:37 a.m. with the Assistant Director of nurses (ADON), the ADON stated dementia training was mandatory and all staff must complete five hours of dementia training annually. The ADON stated the dementia residents were at risk to be mistreated and neglected when the staff are not educated on how to provide care.During an interview on 6/25/26 at 2:01p.m. with the Administrator (ADM). The ADM stated dementia training is a mandatory annual training and staff are to be provided with five hours of dementia trainings annually. The ADM stated there was a potential for a negative outcome when the staff are not educated on how to provide care for the dementia residents.During a review of the facility's policy and procedure (P&P) titled, Facility Inservice Education Program dated no date, the P&P indicated, an in-service education program will be offered at the facility. This program will meet or exceed regulation and facility requirements. The P&P indicated, each employee will have an Employee Educational Profile completed at hire and annually. The Staff Development Department will maintain record of all in-services which the employee attends. The DSD will monitor the total hours attended to date for the Certified Nursing Assistants. The DSD shall monitor mandatory in-services to ensure all staff are represented. Lack of staff attendance will be reported to the Administrator and Department Heads. The P&P indicated, dementia specific care-giver training (5 hours per year for CNA's).