

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555786	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Ocean Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2828 Pico Boulevard Santa Monica, CA 90405	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three (Resident 2) received care and support through informed, deliberative decision making that promote respect for the values, needs, and interests through bioethics committee (crucial advisors, assisting with ethical decision-making in complex situations) by serving as decision makers on behalf of Resident 2 and providing psychoactive medication without consent.</p> <p>This deficient practice violated the residents' right to make an informed decision regarding the use of psychoactive medications.</p> <p>Findings:</p> <p>During a record review, Resident 2 ' s admission record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included psychosis (severe mental disorder that cause abnormal thinking and perceptions) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (Excessive worry or fear, Feeling tense or on edge, Difficulty concentrating, Irritability, and Feeling overwhelmed), and Parkinson ' s (chronic and progressive neurodegenerative disorder that affects the brain's ability to control movement)</p> <p>During a record review, Resident 2's History and Physical report completed on 9/17/2024, indicated Resident 2 could make needs known but cannot make medical decisions.</p> <p>During a record review, Resident 2s Minimum Data Set (MDS - a resident assessment tool) dated 9/17/2024, indicated Resident 2 ' S cognition was severely impaired.</p> <p>During a record review, Resident 2 ' s Physicians Order summary report dated 9/17/2024, indicated the following medications orders:</p> <ol style="list-style-type: none"> <li>1. Depakote Sprinkles capsule 125 give 2 capsules by mouth in the morning for mood Disorder manifested by (m/b) sudden outburst of anger that interferes with activities of daily living (ADL).</li> <li>2. Lorazepam Tablet 1 mg give 1 tablet by mouth every 6 hours as needed for increased agitation/aggression m/b yelling and throwing.</li> </ol> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Mirtazapine tablet 15mg give 1 tablet by mouth at bedtime for depression m/b poor oral (po) intake.</p> <p>4. Risperdal oral tablet 1mg give 1 tablet by mouth two times a day for schizoaffective disorder m/b striking out and yelling that interferes with ADL care.</p> <p>5. Invega Sustenna (Intramuscular [into muscle] suspension pre-filled syringe 156mg/1ml inject 156mg/ml intramuscularly one time day starting on the 9/27/2024 and ending on the 27th every month for psychosis (m/b) restlessness and persistently pacing that interfere with her ADL care.</p> <p>During record review, Resident 2's informed consent dated 9/17/2024, indicated the facility obtained informed consent for, Depakote, Lorazepam, Mirtazapine, Risperdal and Invega Sustenna. The informed consent listed the Resident ' s physician was signed by the Nurse Practitioner (NP), Activity Director (AD) and SSD. did not include the name of the physician who obtained the informed consent. The informed consent had no names or signatures verifying with the resident or resident's, responsible party (RP) and/or that the physician obtained informed consent prior initiation of therapy.</p> <p>During record review, Resident 2 ' s record indicated facility applied for probate conservatorship investigation for Resident 2 on 9/18/2024.</p> <p>During record review, Resident 2 ' s record indicated a letter dated 10/01/2024 received from Department of Mental Health (DMH) acknowledging receipt of facilities probate conservatorship investigation application, also indicated on the letter was the name and contact of the Senior Public Guardian (Sr. DPG) assigned to investigate if Resident 2 qualified for probate conservatorship.</p> <p>During a telephone interview on 2/27/2025 at 3:50 PM, the Sr. DPG stated a letter was sent to the facility on [DATE] indicating Resident 2 did not qualify for probate conservatorship.</p> <p>During an interview on 2/26/2025 at 2:55 PM Social Services Assistant (SSA) stated SSA received a letter dated 10/01/2024 from the DMH acknowledging receipt of Resident 2 ' s probate conservatorship application that listed the name and contact of the assigned investigator.</p> <p>During an interview on 2/26/2025 at 3:00 PM Director of Nursing (DON) stated the facilities Interdisciplinary Team (IDT- a group of health professionals from different disciplines who work together to treat a patient) was making medical decisions for Resident 2.</p> <p>During an interview on 2/26/2025 at 4:13 PM DON stated she was not sure Resident 2 had a bioethics committee, DON stated she was unsure Resident 2 ' s doctor was aware Resident 2 had no surrogate decision maker, guardian, next of kin and/or legal representative, DON also stated facility had applied for legal guardianship from department of mental health was awaiting response.</p> <p>During an interview on 2/26/2025 at 5:15 PM DON stated Resident 2 to did not have and should have had a Bioethics committee in place. DON stated the importance of a bioethics committee is to discuss patient ' s condition, overall health and to come up with a comprehensive plan of care for the Resident 2. DON stated plan of care could not be properly coordinated, complex decision could be delayed for Resident 2 by not having a Bioethics committee for the Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility Policy and Procedures (P&amp;P) titled Unrepresented Residents dated 12/2023 indicated, It is the policy of this facility to support a resident ' s right to have a legally-recognized representative to participate in care decisions. When there is not available decision-maker, and the resident lacks capacity to make medical decisions, the resident is considered unrepresented and the following procedure will be followed .Unrepresented Residents who present with complex healthcare or psychosocial needs, and who experience a change in condition wherein non-routine medical decisions must be met, are referred to the facility ' s Bioethics Committee for interdisciplinary case review prior to initiating, withholding or changing treatment which requires a physician ' s order.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45528</p> <p>Based on observation, interview, and record review, the facility failed to immediately separate residents after a report allegation of physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for one out of three sampled residents (Resident 1) in accordance with the facility's policy and procedures (P&amp;P) titled Abuse, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Revised 4/2021, by failing to protect resident from possible further abuse for a resident-to-resident altercation.</p> <p>This deficient practice had the potential to place Resident 1 at risk for further elder abuse.</p> <p>Findings:</p> <p>During a record review, Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 11/27/023 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough), generalized muscle weakness (feeling weak in most areas of the body), and metabolic encephalopathy (a brain condition that occurs when there ' s an imbalance of chemicals in the blood).</p> <p>During a record review, Resident 1 ' s history and physical (H&amp;P - physician ' s examination of the patient) dated 11/28/2024, indicated Resident 1 had altered mental status to understand and make decisions.</p> <p>During a record review, Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 11/30/2024, indicated Resident 1 had cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 required partial/moderate staff assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a record review, the facility ' s census dated 2/23/2024, indicated Resident 1 and Resident 2 remained in the same room where the resident-to-resident altercation happened on 2/19/2025.</p> <p>During an interview on 2/24/2025, at 12:50 P.M., the Director of Nursing (DON) stated that on 2/19/2025 at 3:45 A.M., Licensed Vocational Nurse 1 (LVN 1) called her a few minutes after the incident stating that Resident 2 hit Resident 1 on the hand. The DON stated she spoke with both Resident 1 and Resident 2, but both Resident 1 and Resident 2 did not seem to recall the incident and so the facility did not conduct a room change for Resident 1 and/or Resident 2. The DON further stated that Resident 1 and Resident 2 were cognitively impaired, could make needs known but were unable to make sound decisions. The DON stated that the facility process after a resident-to-resident altercation, the residents involved in the altercation are immediately separated to prevent escalation or reoccurrence of the incident and further aggression that can cause injury to the resident/s.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility P&amp;P, titled Abuse, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 4/2021, indicated the resident abuse, neglect and exploitation prevention program consist of a facility wide commitment and resource allocation to support the following objectives:</p> <ol style="list-style-type: none"> <li>1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to:             <ol style="list-style-type: none"> <li>b. other residents .</li> </ol> </li> <li>10. Protect residents from any further harm during investigations.</li> </ol>		