STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555786	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Park Healthcare	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)
F 0689 Level of Harm - 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** 48026 Based on interview and record review, for one of five sampled resident (Resident 1), Resident 1 who fell in the facility on 1/15/2025, the facility failed to ensure: 1) Certified Nurse's Aide (CNA) 2, closely monitored and supervised Resident 1 while assigned as Resident 1's one to one (1:1- a caregiver provides dedicated, focused attention and assistance to a single individual, ensuring their needs and well-being are met with personalized support) sitter on 3/02/2025 on the 11 PM to 7 AM shift. 2) CNA 2 immediately notified a licensed nurse that Resident 1 fell on [DATE] at 4:30 AM to ensure timely assessment and intervention(s) for the resident. 3) CNA 2 was not assigned as a 1:1 sitter for two residents (Residents 1 and 5) on 3/02/2025 on the 11 PM to 7 AM shift 4) Resident 1, who was a high risk for falls, had a care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) for 1:1 sitter to closely monitor and supervise to prevent the resident from falling. 5) CNA 2 was close and at arm's length to immediately assist Resident 1 when the resident was getting out of bed on 3/03/2025 at 4:30 AM As a result, on 3/03/2025 at 4:30 AM, Resident 1 fell and sustained a left hip fracture (break in a bone). Resident 1 suffered severe pain and mild swelling to the left hip on 3/03/2025 at 11:58 PM. Resident 1 sustained a comminuted (broken in three or more pieces) mildly displaced intertrochanteric fracture (a type of hip fracture where the broken pieces of the bone have moved or separated between the two bones that protrudes [sticks out]) of the left hip. On 3/04/2025, Resident 1 was transferred to a GACH) for further evaluation and care. Findings: (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

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 03/26/2025
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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's (Resident 5's roommate) Admission Record was admitted to the facility on [DATE] with the following diagnoses: generalized muscle weakness (lack of physical or muscle strength), difficulty in walking (inability to walk which includes problems standing, moving, and loss of balance), and unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of Resident 1's MDS dated [DATE], indicated, Resident 1 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS also indicated, Resident 1 used a walker and a wheelchair (devises used to assist a person walk or move from place to place when one has a disability or injury). The MDS also indicated, Resident 1 needed maximal assistance with toileting hygiene (maintaining cleanliness before and after using the toilet) due to urinary and bowel incontinence (lack of voluntary control over urination or bowel movement). A review of Resident 1's initial Fall Risk assessment dated [DATE], indicated, Resident 1 fall risk score was 18 (a fall risk score of 10 or above represents high risk for falls). A review of Resident 1's Fall Risk assessment dated [DATE] indicated, Resident 1 score for fall was 19 (high fall risk). A review of Resident 1's Interdisciplinary Team (IDT - a group of different healthcare professionals working together towards a common goal for a resident) Progress Notes dated 1/15/2025 at 2:27 PM, indicated, IDT recommended a 1:1 sitter to ensure safety for Resident 1. A review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) sign-in sheet dated 1/09/2025, indicated, CNA 2 signed confirming that CNA 2 received training on Preventing falls in the elderly. A review of Resident 1's history and physical (H&P - a physician's complete patient examination) dated 1/15/2025, indicated, Resident 1 was confused and disoriented , had impaired mobility (a condition that limits or prevents a person's ability to move or perform physical tasks, ranging from fine motor skills to gross motor skills like walking) and activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and generalized weakness. The H&P also indicated Resident 1 lacked the capacity to make medical decisions. A review of Resident 1's CP on impaired ambulation (act of walking) dated 1/15/2025, indicated, Resident 1 had difficulty in walking. The CP goal indicated stand-by assist (SBA) for ambulation, and that Resident 1 used a front wheel walker (FWW) for mobility. The CP interventions included gait training (focuses on improving a person's ability to walk, often involving exercises to strengthen muscles, improve balance, and enhance overall mobility), and caregiver education (equip caregivers with the knowledge and skills needed to effectively care for others). A review of Resident 1's CP on ADLs dated 1/16/2025, indicated, Resident 1 demonstrated ADL decline because of generalized weakness, decreased overall safety awareness, and fall risk. The CP goal indicated Resident 1 will demonstrate improved safety awareness and decreased risk of fall. The CP interventions included caregiver education. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's In-Service Education sign-in sheet dated 2/04/2025 indicated, CNA 2 signed in and received education on What to do when a patient fall. The In-service education lesson plan indicated that after a fall, the resident is not moved until assessed by a physical therapist (PT - healthcare professional who helps people improve their movement and physical function, manage pain, and recover from injuries and chronic conditions through a variety of treatments) or charge nurse. A review of Resident 1's Psychology Notes (a standardized tool used by psychologists to record resident's mental and emotional state, behavior and any changes in their condition, to inform care planning and treatment) dated 2/07/2025, indicated, Resident 1's dementia impacted Resident 1's awareness (not specified) requiring continued monitoring. A review of the facility Nursing Assignment Sheet dated 3/02/2025 for the 11 PM to 7 AM shift, indicated, CNA 2 was assigned as a 1:1 sitter for Resident 1 and Resident 5. A review of Resident 5's Sitter Log Sheet dated 3/02/2025 from 11 PM to 7 AM shift, indicated, CNA 2 was assigned as 1:1 sitter for Resident 5. A review of the facility Sitter Log Sheet (a document used to record information about the observation and/or assistance to a resident during a specific shift or period) dated 3/02/2025 on the 11 PM - 7 AM shift, indicated CNA 2 documented that Resident 1 was awake from 1 AM until 5 AM on 3/03/2025. There was no documentation that Resident 1 fell on [DATE] at 4:30 AM. A review of Resident 1's CP on alteration in musculoskeletal (a system of muscles, bones, tendons, ligaments, joints, and cartilage that work together) status dated 3/03/2025, indicated, Resident 1 had a fracture (a break or crack) of the left trochanter/femur (left hip bone) and pain to the left lower extremity (the part of the body that includes the hip, thigh, knee, leg, ankle, and foot) during movement. The CP goal indicated Resident 1 will remain free from pain or at a level of discomfort acceptable to Resident 1. The CP interventions included to assist Resident 1 with ADLs, mobility (ability to move freely and easily), and immobilize (reduce or eliminate movement) the left lower extremity, provide pain medicine as ordered by the physician, and transfer Resident 1 to GACH for further evaluation and treatment. A review of Resident 1's Nursing Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) dated 3/03/2025 at 9:20 AM, indicated, Licensed Vocational Nurse (LVN) 1 documented that CNA 1 approached LVN 1 because Resident 1 complained of pain during perineal care (washing of the private parts). The Nursing Progress Notes indicated LVN 1 assessed Resident 1 who had pain on the left hip area .and left leg area noted with mild swelling. The Nursing Progress Notes indicated LVN 1 instructed CNA 1 to not to mobilize (move) patient (Resident 1), LVN 1 then notified Registered Nurse Supervisor (RNS), and Resident 1 was medicated with pain medicine, acetaminophen (mild pain reliever) 1000 mg (milligram - a unit of measure of mass [amount of material it contains] in the metric system) by mouth (PO) on 3/03/2025 at 9:21 AM. A review of Resident 1's Nursing Progress Notes dated 3/03/2025 at 9:25 AM, indicated, RNS assessed, and that Resident 1 had left hip area with pain upon touching the area, of 5 out of 10 pain level (5/10 - a numerical pain assessment tool where 0 [zero] pain is no pain, and 10 pain is the worst possible pain). RNS stated MD ordered for an x-ray (pictures of the inside of a body to look at bones and joints). RNS stated RNS called and left a message to family member of Resident 1 (FMR1) to call RNS back. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's x-ray report dated 3/03/2025 indicated, Resident 1 had a comminuted (broken in three or more pieces) mildly displaced intertrochanteric fracture (a type of hip fracture where the broken pieces of the bone have moved or separated between the two bones that protrudes [sticks out]) of the left hip. A review of Resident 1's Nursing Progress Notes documented by LVN 2, dated 3/03/2025 at 11:09 PM, indicated, Resident 1 complained of left leg pain with a pain scale of 4/10, pain medicine, acetaminophen 1000 mg, was given on 3/03/2025 at 5:30 PM. The Nursing Progress Notes that on 3/04/2025 at 6:30 PM, x-ray result was received which confirmed Resident 1 sustained a left hip fracture, and a medical doctor (MD) was informed who ordered to transfer Resident 1 to GACH for further evaluation. A review of Resident 1's Physician Order Summary Report dated 3/04/2025, indicated, a physician ordered Resident 1 to be transferred out from the facility to GACH on 3/03/2025 due to left hip fracture. A review of the facility Sitter Log Sheet dated 3/03/2025 at 11:58 PM, indicated, a sitter documented that Resident 1 was transferred to a GACH. During an interview on 3/17/2025 at 1:24 PM with CNA 1, CNA 1 stated that on 3/03/2025 at around 9 AM when CNA 1 attempted to turn Resident 1 onto the right side to perform perineal care (washing of the private parts) because Resident 1 was wet, but Resident 1 started to scream. CNA 1 stated Resident 1 said something in Resident 1's native language. CNA 1 stated CNA 1 asked CNA 4 (who speaks Resident 1's native language) to translate what Resident 1 was saying. CNA 1 stated Resident 1 told CNA 4 pain, pain, pain in Resident 1's native language and immediately notified LVN 1 who immediately went to Resident 1's room and assessed Resident 1. CNA 1 stated LVN 1 instructed CNA 1 [Resident 1] should not get up . because of pain. CNA 1 stated Resident 1 has dementia and forgets a lot . I've seen [Resident 1] try to get out of bed without assistance. CNA 1 stated Resident 1 needs assistance from staff to get out of bed, because the resident is not stable on the feet, he [Resident 1] is weak, he's [AGE] years old . During an interview on 3/17/2025 at 1:52 PM with LVN 1, LVN 1 stated that on 3/03/2025 at 9:20 AM CNA 1 called LVN 1 to Resident 1's room because Resident 1 was complaining of pain. LVN 1 stated Resident 1 was in the bed and was crying. LVN 1 stated LVN 1 asked CNA 4 (speaks Resident 1's native language) to translate what Resident 1 was saying. LVN 1 stated CNA 4 reported that Resident 1 said that Resident 1 was in pain, Resident 1 fell in the middle of the night and that a man picked up the resident and put Resident 1 back to bed. LVN 1 stated Resident 1 made noises (did not specify) when touched on the left hip and when LVN 1 and CNA 1 attempted to perform perineal care because Resident 1 was wet from urine and that LVN 1 notified RNS of Resident 1's change of condition (COC - a significant change in a resident's health or functional status) and administered acetaminophen 1000 mg to Resident 1. LVN 1 stated Resident 1 has episodes of trying to get out of bed sometimes; that's why there is a sitter. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/17/2025 at 2:25 PM with RNS, RNS stated that on 3/03/2025 at 9:25 AM LVN 1 reported to RNS that Resident 1 had pain to the left hip area. RNS stated RNS assessed and identified that Resident 1's left hip and left leg areas was swollen with no discoloration (any change in your natural skin tone). RNS stated Resident 1 said dolor (pain) and ouch during the assessment. RNS stated RNS asked CNA 4 to translate what Resident 1 was saying. RNS stated CNA 4 told RNS that Resident 1 answered yes when asked if in pain and then pointed to the [Resident 1's] the left hip area. RNS stated [Resident 1] said a guy picked [Resident 1] up from the floor [NAME] (night). RNS stated, I was called into [Resident 1's] at 9:30 AM. I know nothing bad happened to [Resident 1] from the time we started our shift at 7 AM. RNS stated RNS instructed LVN 1 to administer pain medicine to Resident 1, instructed the nursing staff not to move Resident 1, and contacted the MD and Resident 1's family regarding Resident 1's COC. RNS stated MD ordered an x-ray of Resident 1's left hip which was completed after RNS left work at 3:30 PM on 3/03/2025. RNS stated [Resident 1] climbs out of bed, this is a daily thing and that is why we put a 1:1 sitter for the resident. RNS did state for how long CNA 2 was assigned as a sitter for Resident 1. During a telephone interview on 3/17/2025 at 3:35 PM with CNA 2, CNA 2 stated that on 3/03/2025 at around 4:30 AM, Resident 1 got out of bed and I rushed to [Resident 1] because [Resident 1] was struggling. [Resident 1] started lowering himself, so I assisted [Resident 1] to the floor. CNA 2 stated CNA 2 asked CNA 5 to assist CNA 2 place Resident 1 back in bed and that CNA 3 assisted CNA 2 clean Resident 1 because Resident 1 had a bowel movement (stool/feces). CNA 2 stated, Resident 1, There is nothing to report (about the fall). CNA 2 then stated, it was important to report a fall incident so the resident can be evaluated right away. CNA 2 also stated if the fall incident is not reported, Resident 1, may get hurt, more sick. CNA 2 stated Resident 1 never got out of bed until that time (fall incident on 3/03/2025 at 4:30 AM). CNA 2 also stated that on 3/02/2025 on 11 PM to 7 AM shift, the facility assigned CNA 2 as a sitter for Resident 1 and Resident 5 and also to care for Resident 1 and Resident 5. CNA 2 stated that Resident 1 and Resident 5 were roommates. A review of the facility undated document titled Assisted Falls, indicated, . If a resident is going down to the ground and you assist them to the floor , this is a fall and must be reported. During a phone interview on 3/26/2025 at 11:19 AM with CNA 2, CNA 2 stated that on 3/03/2025 at around 4:30 AM, I was sitting in a chair against the wall by the bedside by the door in Resident 1's room. CNA 2 stated, I rushed to [Resident 1] when I saw [Resident 1] trying to get out of bed on the other (opposite) side. I was sitting by the side of the resident's bed, between the resident's bed and the door. CNA 2 stated Resident 1 took two to three steps, was struggling to balance and held on to CNA 2. CNA 2 stated as a 1:1 sitter CNA 2 is responsible in making sure Resident 1 does not fall because the resident is a fall risk, keep an eye on the resident, take Resident 1 to the bathroom, and perform care on Resident 1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/26/2025 at 12:05 PM with CNA 2, CNA 2 stated, I was sitting close to [Resident 1's] feet, at the foot of the bed. CNA 2 as a 1:1 sitter, the only thing I need to do is sit close to the patient [Resident 1] at arm's length. When I stretch my arm and touch him that is an arm's length. CNA 2 stated during a 1:1 sitter assignment, CNA 2 is supposed to only have and care for one resident. CNA 2 stated that on 3/02/2025 on the 11 PM to 7 AM shift, CNA 2 was assigned to care for Resident 1 and Resident 5 who were in the same room. CNA 2 stated, The fact is, normally [Resident 1] does get out of bed and [Resident 5] doesn't normally get out of bed. I watch [Resident 5] because [Resident 5] is confused. CNA 2 stated that on 3/02/2025 on the 11 PM to 7 AM shift, both bed side rails were down on Resident 1's bed. CNA 2 stated, When I picked up [Resident 1], the resident was on the floor between Resident 1's bed and Resident 5's bed. That is the reason why I had to rush to him. CNA 2 did not report this incident. During a phone interview on 3/26/2025 at 1:18 PM with CNA 3, CNA 3 stated that on 3/03/2025 at almost 5 AM, CNA 3 walked into Resident 1's room to assist CNA 2 with Resident 1's perineal care. CNA 3 stated Resident 1 was crying and hurting on the left side around the hip. CNA 3 stated, I heard [Resident 1] say something in [in the resident's native language] my leg, my leg, while holding [Resident 1's] left leg. I speak a bit of (in the resident's native language). CNA 3 stated CNA 3 saw a chair used by CNA 2 by the door in Resident 1's room. During a concurrent interview and concurrent record review on 3/26/2025 at 3:21 PM with RNS, RNS stated, a 1:1 sitter is one staff that only takes care of one patient for a resident who tries to get out of bed unassisted, has periods of confusion or disorientation. RNS stated the 1:1 sitter should sit, About 5 feet away from the resident, but no more than that. As long as the sitter can stop the patient from getting out of bed to prevent from falling. RNS stated a sitter can have more than one patient (resident) to care for if the residents are in the same room, Depends on the acuity (the severity and complexity of a patient's condition, or their need for care and resources) of the patient. Some patients only stay in bed. The facility nursing assignment sheet dated 3/02/2025 for the 11 PM to 7 AM shift was reviewed with RNS. The facility nursing assignment sheet indicated CNA 2 was assigned as a 1:1 sitter for Resident 1 and Resident 5. RNS stated I think it's because (CNA 2 assigned as a sitter for Resident 1 and Resident 5) the patients were in the same room. Both patients were sleeping at night most of the time. RNS stated the main responsibility of a 1:1 sitter is to make sure the resident is safe .prevent from falling, not getting up at night without assistance. The Sitter Log Sheet for March 2025 for the 11 Pm to 7 AM was also reviewed with RNS. RNS stated that a Sitter Log Sheet is a log of what the patient is doing during the time sitter is caring for them. If awake, asleep, in bed, up in wheelchair. RNS stated CNA 2 should have documented the date and time Resident 1 fell . RNS stated, Yes, not only that, but the sitter also (CNA 2) should report to the charge nurse (LVN 1) right away. RNS stated, resident may have some injury .fracture some bones . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and concurrent record review on 3/26/2025 at 3:55 PM with the DON, the DON stated a 1:1 sitter was a staff that is designated to stay or be with one resident. To make sure that there is somebody that closely checking or monitor the residents. The DON stated Resident 1 needed 1:1 sitter to make sure there is someone to assist Resident 1 whenever Resident 1 needs to ambulate . The DON stated Resident 1 is unstable on the feet and is restless at times. DON stated, a 1:1 sitter should be close enough to the resident where they can help the resident right away . within arm's length . the sitter should be within arm's length. The facility nursing assignment dated 3/02/2025 for the 11 PM to 7 AM shift was reviewed with the DON. The DON did not know why CNA 2 was assigned as a 1:1 sitter for Resident 1 and Resident 5. The DON stated, from what I know, 1:1 cannot be assigned to anyone else, one CNA to one patient (resident). The Sitter Log Sheet for March 2025 was reviewed with the DON. The DON stated, the Sitter Log Sheet is to account for what happens to a resident during that shift and day. The DON stated assisting Resident 1 to the floor by CNA 2, is considered a fall, it is an assisted fall. The DON stated if a fall incident is not reported, We can delay treatment .for fracture. Or delay identifying resident's needs. We would have missed something for [Resident 1] that needed to be assessed because we did not know it (fall) happened. The DON stated assigning CNA 2 as a sitter to Resident 1 and Resident 5, can result in one of the residents to not be closely monitored, result in accidents for the residents, and the residents' needs will not be attended to in a timely manner. A review of the facility policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Falls-Clinical Protocol reviewed on 3/29/2024, indicated, resident may require 1:1 sitter as recommended by the IDT members and sitters will .complete the sitter log provided to them . A review of the facility P&P titled Assessing Falls and Their Causes reviewed on 3/29/2024 indicated, when a resident falls to notify the nursing supervisor on duty. A review of the facility P&P titled Safety and Supervision of Residents reviewed date on 3/29/2024, indicated, employees shall .demonstrate competency on how to identify and report .avoidable accidents. Resident supervision is the core component of the facility's approach to safety. A review of the facility P&P titled Falls and Fall Risk, Managing, review on 3/29/2024, indicated, Cognitive impairment (trouble participating in conversations), lower extremity weakness, incontinence, and balance and gait disorders (difficulties with maintaining balance and walking leading to unsteadiness, increased risk of falls, and altered walking patterns) were factors that may contribute to residents' risk of falls. A review of the facility P&P titled Care Giver/Sitter reviewed on 3/29/2024, indicated, Caregiver/sitter must report changes in a resident condition to the nurse supervisor/charge nurse immediately, and the facility's staff may serve as a caregiver/sitter when approved by the DON or facility care team. A review of the facility P&P titled Sitter Responsibilities/Accountabilities reviewed on 3/29/2024, indicated, Caregiver/sitter should be able to supervise residents, and to report any unusual occurrence to the charge nurse.