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	01/21/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an effective discharge with a safe and orderly discharge planning for one of three sampled residents, (Resident 1) by failing to:1. Implement the facility's policy and procedures (P&P), titled, Transfer or Discharge, Facility-Initiated to ensure Resident 1's discharge criteria was met with required orientation and documentation as specified in the policy. 2. Ensure a post-discharge plan was developed, documented and reviewed in discharge summary/post discharge plan of care at least 24 hours before resident's discharge or transfer from the facility.These deficient practices placed residents in an unsafe and ineffective discharge.Findings: During a review of Resident 1's Face Sheet (FS), the FS indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). The admission Record also indicated that Resident 1 was discharged on 1/14/2026. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/17/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Care Plan (CP), there was no CP initiated regarding Resident 1's plan of discharge with goal and interventions. During a review of Resident 1's Progress Notes, dated 1/14/2026, the Progress Notes indicated, Resident (1) was discharged to Board and Care Facility (BCF) 1. During a review of Resident 1's Discharge summary/post discharge plan of care (DSPOC), undated, the DSPOC form was missing information on the following documentation: Discharge Plan, effective date, discharge date , where resident is being discharge to, physician's appointment follow-up visit, post discharge plans/community agencies (referral), equipment needs, special considerations, medication reconciliation, nursing details such as functional status, most recent discharge vital signs, activity, nutrition status, and skin assessment. During a concurrent interview and record review with Director of Nursing (DON) on 1/21/2026 at 4:28 p.m., DON stated, the discharge process consists of the IDT meeting held prior to discharge to ensure the resident will be discharge safely to the appropriate placement. DON reviewed Resident 1's IDT meeting, dated 1/13/2026, and DON confirmed, the IDT meeting form did not have the information of where Resident 1 was discharged , the date of the discharge, post discharge plans and equipment needs, physician follow-up visits and functional status. DON stated the discharge plan was incomplete and there was no information of continuity of care. The DON further stated, there was no CP initiated regarding Resident 1's CP for discharge. During a review of the facility's P&P, titled, Transfer or Discharge, (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility-Initiated, date reviewed by facility on 4/2025, the P&P indicated, Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least 24 hours before the resident's discharge or transfer from the facility. A member of the IDT will review the final post-discharge plan with the resident and family at least 24 hours before the discharge is to take place. When a resident is transferred or discharged from the facility, the following information is documented in the medical record: The basis for the transfer or discharge; That an appropriate notice was provided to the resident and/or legal representative; The date and time of the transfer or discharge; The new location of the resident; The mode of transportation; A summary of the resident's overall medical, physical, and mental condition; Disposition of personal effects; Disposition of medications; Others as appropriate or as necessary; and the signature of of the person recording the data in the medical record. During a review of the facility's P&P, titled, Discharging the Resident, date revised on 3/2025, the P&P indicated, The following information should be recorded in the resident's medical record:1. The date and time the discharge was made.2. The name and title of the individual(s) who assisted in the discharge.3. All assessment data obtained during the procedure, if applicable.4. How the resident tolerated the procedure, if applicable.5. If the resident refused the discharge, the reason (s) why and the intervention taken.6. The signature and title of the person recording the data.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that one out of three sampled residents (Resident 1), who has a diagnosis of dysphagia (difficulty swallowing), was provided with nutritional and hydration care and services consistent with resident's comprehensive assessment by failing to:Ensure Resident 1 was closely monitored and evaluated when Resident 1 refused to eat.Ensure Resident 1's weight was closely monitored according to Resident 1's comprehensive care plan.Ensure Registered Dietitian (RD-is a credentialed, regulated healthcare professional authorized to provide medical nutrition therapy, counselling, and and evidence-based dietary planning to threat disease) followed-up when Resident 1 refused to eat. These deficient practices placed Resident 1 at increased risk for impaired nutrition, weight loss, and dehydration (when the body uses or loses more fluid than it takes in).Findings:During a review of Resident 1's Face Sheet (FS), the FS indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia, urinary tract infection (UTI- an infection in the bladder/urinary tract), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 12/17/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Care Plan (CP) for actual/potential nutritional problem and dehydration risk related to (r/t) cognitive impairment and recent hospitalization, date initiated 12/17/2025, the CP indicated a goal of, The resident (1) will have no signs and symptoms (s/sx) of malnutrition through next review date, and interventions that included, RD (Registered Dietitian) to evaluate and make diet change recommendations as needed. Weight the resident weekly or monthly as ordered. During a review of Resident 1's Order Recap Report (ORR), dated 12/26/2025, the ORR indicated, physician ordered, Monitor episodes of poor oral intake (meal intake less than 50% and/or meal refusal) every shift - document percentage of meal. During a record review of Resident 1's Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) Care Conference Notes, dated 7/24/2025, the Registered Dietitian (RD) noted that Resident 1's weight was 97 pounds (lbs - unit of measurement) was admitted on a regular diet, mechanical soft, finely chopped texture. Resident (1) usual body weight range (UBWR - balances weight against height to indicate lower risk for weight-related health issues) is 120 - 130 lbs. Will continue to monitor weights and PO (oral/mouth) intake. During a record review of Resident 1's Amount Eaten for January 2026, the log indicated, Resident 1 ate most meal about 0-25% and 25 - 100% on other times of her meal. During a record review of Resident 1's Weight Record (WR) indicated the following:Dated 12/4/2025, the WR indicated, Resident 1's weight was 106 lbs.Dated 9/3/2025, the WR indicated, Resident 1's weight was 110 lbs.Dated 8/5/2025, the WR indicated, Resident 1's weight was 105 lbs.Dated 7/29/2025, the WR indicated, Resident 1's weight was 102 lbs. During a record review of Resident 1's Weight Record (WR) indicated there was no Resident 1's weight recorded and documented for the month of 10/2025 and 11/2025. During an interview with Certified Nursing Assistant (CNA) on 1/21/20226 at 2:47 p-m., CNA 1 stated, Resident 1 refused to eat during the morning shift. CNA 1 stated, he would attempt to give Resident 1 food and feed her, but the resident would spit it out or throw the food away. CNA 1 stated, it is difficult to get her to eat. During an interview with CNA 2 on 1/22/2026 at 1:29 p.m., (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 2 stated, Resident 1 would eat about 25 percent during dinner time and sometimes, she would not eat at all. CNA 2 stated they would try to give alternate food tray for Resident 1 since she won't eat her meal but Resident 1 would still refuse and would say she was not hungry. During an interview with Licensed Vocational Nurse (LVN) 1 on 1/21/2026 at 2:55 p.m., LVN 1 stated, Resident 1 does not eat much and has little appetite. LVN 1 stated, Resident 1 would mostly just drink Ensure (ready-to-drink supplements) and would not eat food on her tray. During a concurrent interview and record review with Director of Nursing (DON) on 1/21/2026, the DON stated, according to Resident 1's meal intake, Resident 1 eats only about 0-25% to sometimes more the resident was not consistently eating according to their (facility) documentation. DON further stated the last progress notes by RD was on July 2025 and there was no follow-up done regarding Resident 1's nutritional needs with risk of nutritional problems and dehydration. DON further stated, Resident 1's nutritional and hydration needs were not closely evaluated by the dietitian as there were no follow-up notes by the RD after July 2025. DON stated, there should a follow-up notes by the RD especially that Resident 1 was not consistently eating her meal and with no appetite. DON stated, if residents are not eating, they (facility) must check with residents the reason of why they are not eating and notify the physician then have an IDT meeting. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2025, the P&P indicated that, 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. The IDT reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the facility's P&P titled, Food and Nutrition Services, revised 11/2025, the P&P indicated that, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. During a review of the facility's P&P titled, Dietitian, revised 11/2025, the P&P indicated that, A qualified, competent, and skilled dietitian will help oversee the food and nutrition services in the facility. Dietitian is responsible for, but not necessarily limited to: assessing nutritional needs of residents; developing and evaluating regular and therapeutic diets, developing and evaluating regular and therapeutic diets.