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	05/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an unusual occurrence to the state survey agency (SSA) within 24 hours for one of two sampled residents (Resident 1), who was diagnosed with a right humerus fracture and right scapular fracture one month after falling on 4/12/2026. Resident 1 continued to have pain weeks after the fall and an magnetic resonance imaging (MRI - a non-invasive scan that uses a giant magnet and radio waves to take 3D pictures inside of the body) completed on 5/5/2026 (3 weeks after the fall) indicated Resident 1 had a right nondisplaced humeral fracture and a right nondisplaced scapular fracture. This deficient practice had the potential to result in a delay of an investigation by the SSA to determine if abuse or neglect had occurred for Resident 1.Findings: A review of Resident 1's admission Record indicated the facility admitted the resident on 2/3/2026 with diagnoses abnormalities of gait and mobility, unspecified psychosis and a history of falling. A Review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/9/2026 (prior to the resident's fall), indicated that the resident's cognition (ability to think, understand and reason) was moderately impaired. The MDS also indicated the resident required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, dressing and personal hygiene. The MDS further indicated Resident 1 had no falls in the last 6 months, had no falls since entering the facility and had no fractures related to a fall in the past 6 months. A review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among residents) Communication Form, dated 4/12/2026, indicated Resident 1 had a fall incident and was found on the floor. The SBAR form also indicated Resident 1 complained of 10/10 (zero being no pain and 10 being the worst pain possible) to the right shoulder. The SBAR form further indicated Resident 1 reported tripping on the way back to the resident's room. The SBAR form indicated the resident was transferred to a general acute care hospital (GACH) via 911 (a telephone number used to reach emergency medical, fire, and police services). A review of Resident 1's GACH History and Physical (H&P) Note, dated 4/13/2026, indicated the resident had a ground level fall with resolving right shoulder and arm pain without any fracture as x-ray did not show any positive findings. A review of Resident 1's Physical Therapy Treatment Encounter Note, dated 4/30/2026, indicated the resident's physical therapy interventions focused on dynamic balance activities while standing, crossing midline to facilitate independence in functional skill performance, placement of objects out of reach to increase dynamic skill performance and range of motion techniques to increase functional task performance. The note further indicated therapy staff were awaiting MRI results of Resident 1's right humerus. A review of Resident 1's Progress Note, dated 5/5/2026 indicated the resident left the facility and went to the MRI appointment via private transportation with a facility staff member as escort. A review of Resident 1's Progress Note, dated 5/6/2026, indicated facility staff called the imaging center and was notified that Resident 1's full imaging report would be available in three days. A review of Resident 1's Radiology Report, dated 5/7/2026, indicated the resident had a nondisplaced humerus fracture and a nondisplaced scapular fracture. A review of the Assistant Director of Nursing's email indicated the imaging center notified the facility of Resident 1's imaging results on (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/11/2026 at 1:34 PM. A review of Resident 1's SBAR form, dated 5/12/2026, indicated the MRI results diagnosed Resident 1 with a proximal humerus nondisplaced fracture involving the surgical neck, greater tuberosity and lesser tuberosity. The MRI also indicated Resident 1 had a scapular non displaced fracture extending through the glenoid (the shallow, pear-shaped socket in the shoulder blade), scapular (shoulder blade) neck and scapular body. During an interview on 5/27/2026 at 1 PM, Licensed Vocational Nurse (LVN) 1 stated after the fall, Resident 1 continued to guard her right arm and was keeping it close to the body. LVN 1 stated this instigated her to speak to physical therapy and ask about the plan for Resident 1. LVN 1 stated it was decided that Resident 1 to get an MRI so as to clear the resident prior to making changes on the resident's therapy plan. LVN 1 stated she arranged for the MRI and followed up with the imaging company on 5/6/2026 and the imaging company told LVN 1 that the results would take 3 days to come back. LVN 1 stated the imaging company emailed Resident 1's MRI results to the Assistant Director of Nursing's (ADON), however, LVN 1 did not know when the MRI results was emailed to the ADON. During a concurrent interview and record review on 5/27/2026 at 1:46 PM, the ADON stated Resident 1's MRI results was emailed to the ADON's work email on 5/11/2026 at 1:34 PM. The ADON stated the facility did not report to the Resident 1's MRI results to the physician on 5/12/2026 because the ADON left the facility prior to the email coming in and that no one else in the facility has access to the ADON's email. The ADON stated critical test results are relayed to the physician immediately. The ADON further stated that on 5/12/2026, ADON notified the Director of Nursing (DON) of Resident 1's MRI results. The ADON did not respond when asked what would to residents if the ADON is not at work and or unable to access the residents' diagnostic tests results. During an interview on 5/27/2026 at 2:50 PM, the DON stated Resident 1 fell on a Sunday, 4/12/2026, and was transferred to a GACH that day. The GACH performed an x-ray which did not show a fracture. The DON stated Resident 1 continued to have pain, so the physician ordered an MRI for the resident. The DON further stated Resident 1's MRI result was emailed to the ADON work email. The DON further stated the facility reported Resident 1's fractures on 5/13/2026 to the SSA. The DON further stated that, we must report a fracture to the SSA within 24 hours to allow the state can investigate and make sure we competently cared for the resident. The DON stated, we must work on this (accessing results) when asked what can happen to residents if the DON is not at work and or unable to access the residents' diagnostic tests results. A review of the facility's policy and procedures, Unusual Occurrence Reporting, dated 2/2026, indicated, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. The P&P also indicated, our facility will report the following events to appropriate agencies:g. Allegations of abuse, neglect and misappropriation of resident property; andh. Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors.2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review and interview, the facility staff failed to promptly check the magnetic resonance imaging (MRI-a noninvasive medical test that uses a strong magnetic field, radio waves, and a computer to produce detailed, cross-sectional images of the body's internal organs, tissues, and skeletal system) scan results and immediately notify the ordering physician of the MRI scan results for one (1) of two sample residents (Resident 1). On 4/12/2026 Resident 1 suffered an unwitnessed fall and complained of pain to the right shoulder pain., Xray completed at a general acute care hospital (GACH) showed no fracture/s. On 5/5/2026, Resident 1's MRI scan results indicated Resident 1 had suffered right humerus (is the long bone located in the upper arm) and scapula (shoulder blade) fractures (broken bones). The MRI results were emailed the facility on 5/11/2026 at 1:34 PM. The facility did not notify the physician of Resident 1's physician of the MRI results until 5/12/2026 at 10:26 AM. This deficient practice resulted in 21 hours physician notification delay placing Resident 1 at increased risk of delay of necessary care and needs.Findings: A review of Resident 1's admission Record indicated the facility admitted the resident on 2/3/2026 with diagnoses including abnormalities of gait and mobility, unspecified psychosis and a history of falling. A Review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/9/2026 (prior to the resident's fall), indicated that the resident's cognition (ability to think, understand and reason) was moderately impaired. The MDS also indicated the resident required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, dressing and personal hygiene. The MDS further indicated Resident 1 had no falls in the last 6 months, had no falls since entering the facility and had no fractures related to a fall in the past 6 months. A review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 4/12/2026, indicated Resident 1 had a fall incident and was found on the floor. The SBAR form also indicated Resident 1 complained of 10/10 (zero being no pain and 10 being the worst pain possible) to the right shoulder. The SBAR form further indicated Resident 1 reported tripping on the way back to the resident's room. The SBAR form indicated the resident was transferred to a general acute care hospital (GACH) via 911 (a telephone number used to reach emergency medical, fire, and police services). A review of Resident 1's GACH History and Physical (H&P) Note, dated 4/13/2026, indicated the resident had a ground level fall with resolving right shoulder and arm pain without any fracture as x-ray did not show any positive findings. A review of Resident 1's Physical Therapy Treatment Encounter Note, dated 4/30/2026, indicated the resident's physical therapy interventions focused on dynamic balance activities while standing, crossing midline to facilitate independence in functional skill performance, placement of objects out of reach to increase dynamic skill performance and range of motion techniques to increase functional task performance. The note further indicated that the therapy staff were awaiting MRI results of Resident 1's right humerus A review of Resident 1's Progress Note, dated 5/5/2026 indicated the resident left the facility and went to the MRI appointment via private transportation with a facility staff member. A review of Resident 1's Progress Note, dated 5/6/2026, indicated facility staff called the imaging center and was notified that Resident 1's full imaging report would be available in three days. A review of Resident 1's SBAR form, dated 5/12/2026, indicated Resident 1 was observed with right upper extremity range of motion limitations and complained of 3/10 pain. The Nurse Practitioner (NP) ordered a right humerus MRI. The SBAR also indicated the MRI results diagnosed Resident 1 with a proximal humerus nondisplaced fracture involving the surgical neck, greater tuberosity and lesser tuberosity. The MRI also indicated Resident 1 had a scapular non displaced fracture extending through the glenoid, scapular neck and scapular body. A review of Resident 1's Radiology Report, dated 5/7/2026, indicated the resident had a nondisplaced humerus fracture and a nondisplaced scapular fracture. A review of Resident 1's Physician Order, dated 5/11/2026, indicated the resident was to receive a right humerus MRI related (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to pain status post (after a) fall. A review of Resident 1's PT (Physical Therapy) Progress Report, dated 5/13/2026, indicated the changes the resident was experiencing included a right upper extremity range of motion. A review of Resident 1's Progress Notes, dated 5/7/2026 through 5/10/2026, did not indicate any documented that the facility followed up Resident 1's imaging report. During an interview on 5/27/2026 at 12:02 PM, Certified Nursing Assistant (CNA) 1 stated prior to Resident 1 falling, Resident 1 walked well, was able to shower independently, and required set up assistance with her ADLS. CNA 1 stated that after the fall, Resident 1 requires more assistance and that the facility staff have to help the resident take showers. During an interview on 5/27/2026 at 12:38 PM, the Director of Rehabilitation (DOR) stated prior to the Resident's falling on 4/12/2026 the resident was very functional. The DOR stated since the resident sustained the fracture, Resident 1's range of motion is limited and the resident has lost strength and started having difficulty reaching the arm over the head. The DOR stated Resident 1 was receiving occupational therapy (OT- therapy to improve a person's everyday life activities). During an interview on 5/27/2026 at 1 PM, Licensed Vocational Nurse (LVN) 1 stated after the fall, Resident 1 continued to guard the right arm and kept the right arm close to the body. LVN 1 stated this instigated her speaking to physical therapy and asking about the plan for Resident 1. LVN 1 stated this instigated her to speak to physical therapy and ask about the plan for Resident 1. LVN 1 stated it was decided that Resident 1 to get an MRI so as to clear the resident prior to making changes on the resident's therapy plan. LVN 1 stated she arranged for the MRI and followed up with the imaging company on 5/6/2026 and the imaging company told LVN 1 that the results would take 3 days to come back. LVN 1 stated the imaging company emailed Resident 1's MRI results to the Assistant Director of Nursing's (ADON), however, LVN 1 did not know when the MRI results was emailed to the ADON. During an interview on 5/27/2026 at 1:30 PM, CNA 3 stated that Resident 1 fell on a Sunday, 4/12/2026 between 1 PM and 1:50 PM. CNA 3 stated CNA 3 was in the activities room, when CNA 3 heard Resident 1 scream. CNA 3 stated CNA 3 went to the hallway and saw Resident 1 on the floor. CNA 3 stated the nurses assessed the resident and Resident 1 started screaming when the nurses attempted to lift the residents right arm. CNA 3 further stated that after the fall, Resident 1 required more help with ADL. During a concurrent interview and record review on 5/27/2026 at 1:46 PM, Resident 1's MRI results was reviewed with the Assistant Director of Nursing (ADON). The MRI results indicated Resident 1 had a right nondisplaced humeral fracture and a right nondisplaced scapular fracture. The ADON stated Resident 1's MRI results was emailed to the ADON's work email on 5/11/2026 at 1:34 PM. The ADON stated the MRI results were not reported to the physician on 5/12/2026 because the ADON left the facility prior to the MRI results email came in. The ADON stated that no one else in the facility has access to the ADON's work email. The ADON further stated that on 5/12/2026, ADON notified the Director of Nursing (DON) of Resident 1's MRI results. The ADON did not respond when asked what would to residents if the ADON is not at work and or unable to access the residents' diagnostic tests results. The ADON stated that critical test results must relayed to the physician immediately. During an interview on 5/27/2026 at 2:50 PM, the Director of Nursing (DON) stated Resident 1 fell on a Sunday, 4/12/2026, and was transferred to a GACH the same day. The DON stated that the x-ray at GACH did not show a fracture. The DON stated Resident 1 continued to experience pain, so the physician ordered an MRI. The DON further stated Resident 1's MRI result was emailed to the ADON's work email. The DON stated, we must work on this (accessing results) when asked what can happen to residents if the DON is not at work and or unable to access the residents' diagnostic tests results. The DON further stated nursing should follow up on test results and there can be a delay in care. A review of the facility's policy and procedures, Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2025, indicated:Assessment and Recognition The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility.Review by Nursing Staff1. When test results are reported to the facility, a nurse will first review the results.a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. Identifying Situation that Warrant Immediate Notification1. Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the physician has requested to be notified as soon as a result is received. Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison.