

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Marycrest Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 10664 St. James Drive Culver City, CA 90230	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure for 43 of 44 medically compromised and vulnerable residents who received food from the kitchen: Ensure food items were labelled with opened and use by dates. Ensure dented cans were separated from useable stock and placed in specified labeled area. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins). Findings: 1. During a concurrent observation and interview on 1/6/2026 at 8:38 a.m., with Cook (CK) 1 in the kitchen, there were food items with no open or use-by date as follows: Opened and used caesar dressing without opened date or used by date. Cajun seasoning with opened date of 4/21/2025, missing used by date. Low sodium soy sauce with opened date of 9/29/2025, missing used by date. CK 1 stated dietary staff are responsible for labeling all food items with an opened date and use by date once a food item was opened. CK 1 stated labeling food items was important to ensure expired food items are not used when preparing meals for residents. CK 1 stated using food items past their used by date can effect the quality of food and place residents at risk of developing foodborne illness. During an interview on 1/7/2026 at 12:55 p.m. with the Registered Dietician (RD), the RD stated once a food item was opened, kitchen staff should label with an opened date. The RD stated kitchen staff use a product sheet based on food code to label foods with a used by date. The RD stated labeling food items was important because using expired foods can place residents at risk of gastrointestinal sickness. During a review of facility's policy and procedure (P&P) titled, Labeling and Dating of Foods dated 2020, indicated Newly opened food items will need to be closed and labeled with an open date and used by the date that follows guidelines. 2. During a concurrent observation and interview on 1/6/2026 at 9:02 a.m., with [NAME] (CK) 1 in the dry storage area, there were dented cans observed in remaining stock and not placed in specified area labeled Dented Cans Here as follows: One dented hoisin sauce can Three dented apple sauce cans One dented white beans can The CK 1 stated when new inventory was brought to the kitchen, staff assisting with organization of cans are responsible for identifying dented cans and placing them in designated dented can area. CK 1 stated dented cans should be separated because there was a risk of air and bacteria entrance, which can result in residents getting sick. During an interview on 1/7/2026 at 12:55 p.m. with the Registered Dietician (RD), the RD stated dented cans should be placed in designated dented can area. The RD stated dented cans can harm the integrity of food inside. During a review of facility's policy and procedure (P&P) titled, Food Storage-Dented Cans dated 2018, indicated All dented cans and rusty cans are to be separated from remaining stock and placed in specified labeled area for return to purveyor for refund.		

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure residents had an alternative system of notification of lunch menu substitutions when an overhead page was not heard by three of three sampled residents. (Resident 4, Resident 23 and Resident 24). This deficient practice had the potential for residents to not be notified and substitutions and preferences to not be honored. Findings: During a concurrent observation and interview on 1/6/2026 at 11:55 a.m. with [NAME] 1 (CK1) in the kitchen, the food prepared for lunch was observed. CK1 stated the lunch dessert cranberry crunch square was substituted with raspberry parfait and the lunch vegetable broccoli was substituted with sauteed spinach. CK1 stated per facility policy, residents must be notified when substitutions to the menu are made. During an interview on 1/7/2026 at 3:00 p.m. with Resident 4, Resident 4 stated she was not notified of the vegetable or dessert change for the lunch menu on 1/6/2026. Resident 4 stated she would like to be notified when changes to the menu are made so that she can request alternatives if she does not like what was being served. During an interview on 1/7/2026 at 2:52 p.m. with Resident 23, Resident 23 stated no one notified her of lunch menu changes on 1/6/2026. Resident 23 stated she likes to know what food is being served and wants to be notified if any menu changes are made. During an interview on 1/7/2026 at 3:00 p.m. with Resident 24, Resident 24 stated he remembers eating lunch yesterday (1/6/2026) and he was not notified of any lunch menu substitutions. During an interview on 1/8/2026 at 11:30 a.m. with the Registered Dietician (RD), the RD stated notifying residents of menu substitutions was important because notification gives the residents the opportunity to request an alternative if they do not like what is being served. The RD stated residents have the right to know what they are being served, and not notifying residents of menu substitutions could result in residents preferences not being honored. During a review of facility policy and procedure (P&P) titled Food Substitutions During Trayline dated 2020, the P&P indicated, When a menu item is not available, the cook will provide a substitute of similar nutritive value, document the change and the reason, and communicate the substitution to residents as appropriate. The menu substitutions will be approved by the dietician.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure therapeutic menu (meal plan that controls the intake of certain foods or nutrients) portion sizes were followed for 43 of 44 medically compromised and vulnerable residents who received food from the kitchen. This deficient practice had the potential to place residents at risk for not having nutritional needs met and potential weight gain. Findings: During an observation on 1/6/2026 at 11:55 a.m. in the kitchen, [NAME] (CK) 1 was observed scooping polenta onto resident's plates using one half cup scoop size. During a concurrent interview and record review on 1/6/2026 at 12:20 p.m. with [NAME] (CK) 1, the therapeutic menu spreadsheet dated 1/6/2026 was reviewed. The therapeutic menu spreadsheet indicated polenta to be served with a one third cup scoop size for a regular sized diet. CK 1 stated one third cup scoop size should have been used for residents on regular portion diet. CK 1 stated serving larger portions of food places residents at risk for unintended weight gain. During an interview on 1/8/2026 at 11:30 a.m. with the Registered Dietician (RD), the RD stated some residents have small or large portions indicated on their meal ticket and the amount of food served will align with their meal portion. The RD stated the cook should have served polenta with a one third cup scoop size to residents with a regular portion diet. The RD stated following the therapeutic menu portion sizes was important because it ensures all nutrient needs are being met. During a review of facility's policy and procedure (P&P) titled Therapeutic Diets dated 2018, indicated It is the policy of the facility to ensure that all therapeutic menus are planned, prepared and served in accordance with current Federal and State regulations. Menus must provide a variety of foods, indicate standard portions.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Submit and transmit the Minimum Data Set ([MDS] - a resident assessment tool) within the regulatory timeframe to the Center for Medicare and Medicaid Service (CMS) for one of 12 sampled residents (Resident 3).This deficient practice had the potential to result in billing error and inaccurate data on resident care needs.Findings:During a review of Resident 3's admission Record, the admission Record indicated, Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included left femur fracture (break in the thigh bone), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both hips, and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D).During a review of Resident 3's History and Physical (H&P), dated 8/8/2025, the H&P indicated, Resident 3 can make needs known but could not make medical decisions.During a review Resident 3's MDS assessment, dated 12/6/2025, the MDS assessment indicated, Resident 3's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 3 was dependent (helper does all of the effort) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of the CMS MDS 3.0 Nursing Home (NH) Validation Report, the CMS 3.0 NH Validation Report indicated, Resident 3's MDS assessment was submitted late for more than 14 days after Z0500B (the date that the Registered Nurse Assessment Coordinator signed the assessment as complete).During a concurrent interview and record review on 1/7/2026 at 11:18 a.m., with the Minimum Data Set Nurse (MDSN), Resident 3's MDS assessment, dated 12/6/2025, was reviewed. The MDSN stated Resident 3's MDS Assessment was completed on 12/20/2025 and submitted late to the CMS on 1/5/2026. The MDSN stated Resident 3's MDS assessment data should have been submitted and transmitted within 7 days after the completion date. The MDSN stated each member of the interdisciplinary team ([IDT] team members from different disciplines who come together to discuss resident care) has their own responsibility to complete each section of the MDS. The MDSN stated the facility Social Service Director (SSD) was taking some time off and that was the reason for the late submission of Resident 3's MDS assessment to the CMS. The MDSN stated it was a federal requirement to complete, submit and transmit any MDS assessment in a timely manner to be compliant with the regulation and for the CMS to know the condition and plan of care of the resident.During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set Resident Assessment, dated 9/1/2024, the P&P indicated, The completed MDS records shall be encoded and transmitted to the State repository in accordance with Center of Medicare and Medicaid Services (CMS) established record specifications and timeframes.During a review of the facility's P&P titled, Transmission of MDS, dated 3/8/2024, the P&P indicated, All MDS assessment (admission, annual, significant change, quarterly review, etc.) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS IQIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data.		

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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, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for one of 12 sampled residents (Resident 14) by failing to:1. Ensure Resident 14's Plavix (classified as antiplatelet agent drug used to prevent blood clots) was not encoded as anticoagulant (blood thinner) medication.This failure resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Resident 14.Findings:During a review of Resident 14's admission Record, the admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls).During a review of Resident 14's History and Physical (H&P), dated 6/9/2025, the H&P indicated, Resident 14 can make needs known but could not make medical decisions.During a review Resident 14's MDS assessment, dated 11/14/2025, the MDS assessment indicated, Resident 14's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 14 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, upper body dressing, and personal hygiene.During a review of Resident 14's Order Summary Report (a document containing active orders), dated 1/8/2026, indicated the physician placed a telephone order on 5/21/2024 for Resident 14 to start on Plavix 75 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to take one 1 tablet by mouth in the morning for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prevention.During a review of Resident 14's Medication Administration Records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 11/1/2025 to 11/30/2025, indicated Resident 14 received Plavix 75mg by mouth once a day.During a concurrent interview and record review on 1/7/2026 at 11:36 a.m., with the Minimum Data Set Nurse (MDSN), Resident 14's MDS assessment, dated 11/14/2025, was reviewed. The MDSN stated MDS Section N (Medications) look back period (the specific time frame within which certain resident conditions and events are assessed) was 7 days before the completion date. The MDSN stated Resident 14's MDS assessment was completed inaccurately. The MDSN stated there should be no checked mark on Resident 14's MDS Section N0415 (High-Risk Drug Classes) E (anti-coagulant e.g., warfarin, heparin, or low-molecular weight heparin) since Plavix was not classified as anti-coagulant medication. The MDSN stated coding of medications in the MDS assessment should be based on the drug classification. The MDSN stated accuracy of MDS assessment was important in order to reflect the actual clinical condition of the resident. The MDSN stated inaccuracy of MDS assessment would affect the plan of care of the resident.During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set Resident Assessment, dated 9/1/2024, the P&P did not disclose the medications coding instructions and importance of completing the MDS assessment accurately.During a review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated 10/2025, page 481, under Coding Tips and Special Populations, indicated Code medications in item N0415 according to the medication's therapeutic category and/or pharmacological classification, not how it is used.		

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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 develop a person-centered care plan for two of 12 sampled residents (Residents 5 and 14) by failing to:Address Resident 5's diagnosis of schizophrenia (a mental illness that is characterized by disturbance in thought).Address Resident 14's allergy to aspirin (drug used to reduce pain, fever, and prevent blood clot).This deficient practice had the potential to result in a lack of meeting necessary care and addressing medical needs for Resident 5 and Resident 14.Findings: A. During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 5 on 8/2/2017 and was readmitted on [DATE] with the diagnosis of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), metabolic encephalopathy(a problem in the brain caused by a chemical imbalance in the blood), atrial fibrillation (AFib - an irregular and often rapid heart rhythm), schizophrenia (a mental illness that is characterized by disturbances in thought), and depressive disorder (depression & a mental disorder involving a depressed mood or loss of interest in activities for long periods of time). During a review of Resident 5's History and Physical (H&P) dated 1/8/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS & a resident assessment tool) dated 11/18/2025, the MDS indicated Resident 5 had severe problems with thinking, making decisions and memory. The MDS indicated Resident 5 had an active diagnosis of schizophrenia. During a record review on 1/6/2026 at 11:02 a.m. of Resident 5's care plans, there was no care plan for Resident 5's active diagnosis of schizophrenia. During a concurrent interview and record review on 1/7/2026 at 10:28 a.m. with Licensed Vocational Nurse (LVN) 1 Resident 5's MDS was reviewed. LVN 1 stated, the MDS indicated Resident 5 had an active diagnosis of schizophrenia. During a concurrent interview and record review on 1/7/2026 at 10:33 a.m. with LVN 1 of Resident 5's Care Plan, LVN 1 stated there was no Care Plan for schizophrenia. LVN 1 stated there should be a Care Plan for every diagnosis to ensure the resident receives interventions specific to the diagnosis. LVN 1 stated if there was no Care Plan in place for a specific diagnosis, the resident would not progress or would get worse because the resident does not have interventions specific to a diagnosis. During a concurrent interview and record review on 1/7/2026 at 1:41 p.m. with the Director of Nursing (DON) Resident 5's MDS dated [DATE] and care plans were reviewed. The DON stated the MDS indicated Resident 5 had an active diagnosis of schizophrenia. The DON stated care plans should be implemented for every diagnosis to ensure the resident receives interventions specific to the diagnosis and to monitor the residents' decline or improvement. The DON stated if care plans were not implemented, the resident would not receive the interventions that could worsen the diagnosis. During a review of the facility's policy and procedure (P&P) titled Comprehensive Care Plan revised 10/16/2017, the P&P indicated, It is the policy of the facility to develop and implement a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objective and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.12. Care Plans are to be reviewed, on a minimum, once every quarter (every 90 days) and whenever necessary, either as a result of significant change in resident's status and condition, or if discontinued plan of care based on new information derived from the resident's assessment to assure the continued accuracy of the assessment. B. During a review of Resident 14's admission Record, the admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 14's History and Physical (H&P), dated 6/9/2025, the H&P indicated, Resident 14 can make needs known but could not make medical decisions. During a review Resident 14's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/14/2025, the MDS assessment indicated, Resident 14's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 14 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, upper body dressing, and personal hygiene. During a review of Resident 14's Order Summary Report (a document containing active orders), dated 1/7/2026, the Order Summary Report indicated, Resident 14 was allergic to aspirin. During a concurrent interview and record review on 1/9/2026 at 9:49 a.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 14's clinical records were reviewed. LVN 2 stated there was no care plan to address Resident 14's allergy to aspirin. LVN 2 stated Resident 14's allergy to aspirin was already identified on the Order Summary Report and that was the reason why facility did not develop a comprehensive care plan. LVN 2 stated it was important to develop a comprehensive care plan for each resident in order to provide the needs of the resident. LVN 2 stated it was important to have a care plan for a resident with known medication allergy for resident safety and to provide interventions promptly in case resident develop an allergic reaction (set of symptoms that happen after you touch, inhale, or administered something you are allergic to). During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan, dated 10/16/2017, the P&P indicated It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated care plans must show evidence of facility's effort to address or manage risk factors.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 resident (Resident 7)'s mouth was rinsed after administration of prescribed inhaler Arnuity Ellipta [an inhaler used as a maintenance medication for asthma (a condition that causes the respiratory airways to swell up, shrink, and fill with mucus)]. This failure had the potential to result in Resident 7's developing irritation of the mouth, discomfort, and an increased risk of infection of the mouth and throat due to medication remaining in the mouth after inhaler use. Findings: During a review of Resident 7's admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 7 on 5/14/2024 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), morbid obesity (serious disease that involves excess body fat that increases risk of health problems), obstructive sleep apnea (a sleep disorder when breathing repeatedly stops and starts during sleep because the airway shrinks or blocked), and dysphagia (difficulty swallowing). During a review of Resident 7's History and Physical (H&P) dated 9/12/2025, the H&P indicated Resident 7 had the capacity to make needs known but was unable to make medical decisions. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 7 had normal thinking and memory. The MDS indicated Resident 7 was independent with eating and oral hygiene, needed maximum assistance from staff with toileting, showering, lower body dressing, putting on and taking off footwear, and needed partial assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort to complete the activity) with upper body dressing and personal hygiene. During an observation on 1/8/2026 at 8:07 a.m. during medication administration with Licensed Vocational Nurse (LVN) 3 in Resident 7's room, LVN 3 did not instruct Resident 7 to rinse her mouth after administration of inhaler Arnuity Ellipta. During a review of pharmacy's label for Arnuity Ellipta 200 mcg (micrograms - a unit of measurement) inhaler starting 1/2/2026 indicated, inhale one puff by mouth one time a day for COPD rinse mouth with water after use. During an interview on 1/8/2026 at 9:19 a.m. with LVN 3, LVN 3 stated she did not instruct Resident 7 to rinse her mouth after taking the inhaler. LVN 3 stated the importance of rinsing mouth after the inhaler was to prevent the growth of bacteria or fungus in the mouth. LVN 3 stated if the resident did not rinse her mouth after taking the inhaler, there would be a potential that the resident could develop infection in the mouth leading to a greater infection. During an interview on 1/8/2026 at 2:51 p.m. with the Director of Nursing (DON), the DON stated the importance of following pharmacy instructions to rinse mouth after administration of inhaler was to prevent mouth infection. The DON stated if the resident did not rinse her mouth after taking the inhaler, there would be a risk for mouth infection that would lead to other infections of the body.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Document the medical appointment for one of one sampled resident (Resident 14).This deficient practice had the potential to place Resident 14 of not receiving appropriate care and delay in communication among staff due to incomplete medical records.Findings:During a review of Resident 14's admission Record, the admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls).During a review of Resident 14's History and Physical (H&P), dated 6/9/2025, the H&P indicated, Resident 14 can make needs known but could not make medical decisions.During a review Residewas4's MDS assessment, dated 11/14/2025, the MDS assessment indicated, Resident 14's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 14 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, upper body dressing, and personal hygiene.During a review of Resident 14's Outpatient Referral Form, dated 12/1/2025, the Outpatient Referral Form indicated, Resident 14 to be referred to orthopedic surgery (a medical specialty that focuses on treating injuries and diseases of the musculoskeletal system) to evaluate for limited range of motion ([ROM] - full movement potential of a joint) of right shoulder and pain. The Outpatient Referral Form indicated, Resident 14 had a history of right shoulder rotator cuff injury (one or more of the tendons connecting your upper arm bone to your shoulder blade are torn, inflamed, or damage) and dislocation.During a review of Resident 14's Order Summary Report (a document containing active orders), dated 1/8/2026, indicated the physician placed a telephone order on 12/2/2025 for Resident 14 to have orthopedic surgery appointment on 12/22/2025.During a concurrent interview and record review on 1/8/2026 at 9:32 a.m., with the Director of Nursing (DON), Resident 14's Progress Notes, were reviewed. The DON stated Resident 14's medical records were incomplete. The DON stated there was no documentation by nursing staff indicating Resident 14 went to the orthopedic surgery appointment on 12/22/2025. The DON stated there was no documentation on Resident 14's Progress Notes that she refused to go to her scheduled orthopedic surgery appointment on 12/22/2025. The DON stated resident's medical records should be complete for coordination of care among interdisciplinary team ([IDT] team members from different disciplines who come together to discuss resident care) and for resident's continuity of care.During a review of the facility's policy and procedure (P&P) titled, Documentation by Nursing Personnel, dated 5/1/2019, the P&P indicated Resident documentation will reflect the resident's condition in a timely and accurate manner.		