STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555340	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marina Pointe Healthcare & Subacute	5240 Sepulveda Blvd 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 0689 Level of Harm - Minimal harm or potential for 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** 49131 Based on observation, interview, and record review, the facility failed to: 1. Ensure all doors that lead to the outside of the facility had an alarm to prevent one of five sampled residents (Resident 1), who was assessed as a high risk for elopement, (leaving the health care facility unsupervised and undetected) from leaving the facility without staff knowledge. This deficient practice had the potential for Resident 1 to be injured while out of the facility premises without supervision from staff. Findings: a. A review of Resident 1 ' s Admission Record (Face Sheet), indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and toxic encephalopathy (brain dysfunction caused by exposure to toxic substances). A review of Resident 1 ' s Minimum Data Set ([MDS]- a standardized assessment and care planning tool), dated 6/12/2024, indicated Resident 1 had severe cognitive impairment (ability to reason, understand, remember, judge, and learn). A review of Resident 1 ' s Elopement Screening, dated 6/12/2024, indicated Resident 1 was at high risk for elopement from the facility. A review of Resident 1 ' s care plan, dated 6/24/2024, indicated Resident 1 was at risk for wandering or elopement and interventions included to call attention of the resident and redirect when seen going towards the exit door, and frequent check of the resident ' s whereabouts. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 4:15 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was notified by the Registered Nurse (RN) Supervisor on shift that Resident 1 was missing and began to search for Resident 1. He stated he and others looked for Resident 1 inside and outside the facility and drove around the neighborhood but was unable to locate Resident 1. LVN 1 stated he did not hear any alarms on any of the doors that lead outside of the facility go off during the shift, and Resident 1 did not have any devices on her that would notify the staff if she left the facility. LVN 1 stated if he heard an alarm that went off, that would alert him and other staff to check in the area in case a resident left through the door where the alarm sounded. During an interview on 7/11/2024 at 9:58 AM with the Director of Nursing (DON), the DON stated she believed Resident 1 left the facility through the front door, but it can ' t be confirmed because nobody watched her leave and the staff that night did not hear the alarms on the emergency exit doors go off. During an interview on 7/11/2024 at 10:55 AM with Certified Nursing Assistant (CNA) 2, CNA 2 stated there was only one door in and out of the facility for staff, residents, and visitors to come in and out and that was the front door. During an interview on 7/11/2024 at 12:33 PM with RN 1, RN 1 stated she last saw Resident 1 on 6/27/2024 around 10:30 PM while she was making her last check on the residents that night. She stated she saw Resident 1 in bed but awake. RN 1 stated around 11:00 PM, a nurse from the next shift stated Resident 1 was not in the room and they immediately began to search for Resident 1. RN 1 stated there were no alarms she heard during her shift that would have alerted the staff a resident may have left the facility. She stated if an alarm went off, you would be able to hear it because it is very loud. RN 1 stated it was very possible Resident 1 left through the front door undetected because there was no alarm on the front door that night. During an interview on 7/11/2024 at 2:10 PM with a Maintenance Personnel (MP), MP stated there was no exit alarm ever installed on the front door. MP stated the exit alarms placed at the doors is to let the staff know if the door has been opened and someone is trying to come in or leave. If there is no alarm, or the alarm is broken, there will be no sound to alert the staff. During an interview on 7/11/2024 at 3:15 PM with the DON, the DON stated there was no exit alarm installed on the front door, and because there was no alarm, if the door was opened, there would be no sound to alert the staff that a resident could have potentially left through the front door undetected. A review of the policy and procedure titled, Elopement, undated, indicated the facility shall safeguard (something that protects) exit doors with devices such as audible (capable of being heard) alarms, if possible, to alarm staff whenever resident attempts to leave the facility unsupervised.