

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Marina Pointe Healthcare & Subacute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331</p> <p>Based on observation, interview and record review, the facility failed to provide a safe environment for one of 4 sampled residents by failing to:</p> <ol style="list-style-type: none"> 1. Provide adequate supervision and implement interventions for one of 4 sampled residents (Resident 1), who verbalized wanting to go Out on Pass ([OOP] short term leave from facility) and had previous episodes of leaving the facility without an Out on Pass ([OOP] short leave from facility) physician ' s order. 2. Implement Resident 1 ' s Care Plan to monitor Resident 1 ' s behavior symptoms such as wandering, inappropriate response to verbal communication and document. 3. Accurately assess Resident 1 ' s Elopement Risk 4. Ensure the facility ' s exit doors alarms were activated and monitored. <p>These failures resulted in Resident 1 eloping (the act of leaving a facility unsupervised and without prior authorization) and placed other residents at risk for eloping which could lead to accidents, injuries, and death.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included encephalopathy (any brain disorder, disease, or damage that affects the brain's structure or function), atrial fibrillation (a heart condition that causes an irregular heartbeat), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic back pain</p> <p>During a review of Resident 1 ' s Physician ' s Order dated 7/13/2024, the Order indicated Resident 1 may go out on pass with responsible party.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Interdisciplinary Care Team ([IDT] a group of healthcare professionals from different disciplines who work together to manage the resident ' s care) Notes dated 9/27/2024, the IDT Notes indicated on 9/27/2024, Resident 1 was seen moving a vehicle on the facility parking lot. The IDT notes indicated Resident 1 purchased the vehicle from his friend and planned on driving the vehicle (working for ride share/delivery service) to earn money for a down payment on rent once discharged . The IDT Note indicated Resident 1 did not want to leave the facility to be discharged to an Assisted Living Facility or Board and Care. The IDT Note indicated the following recommendations for the resident: Discontinue OOP order and resident will be discharged (DC ' D) Against Medical Advice (AMA) if resident insisted to leave the premises, Social Services Director to assist Resident 1 to find an apartment to stay as soon as possible.</p> <p>During a review of Resident 1 ' s Physician ' s Order dated 9/27/2024, the Order indicated Resident 1 may not go OOP.</p> <p>During a review of Resident 1 ' s Nurse Note dated 9/27/2024, the Note indicated the Director of Nursing (DON) discussed with the physician that Resident 1 was not safe to go out of the facility and received an order to discontinue OOP.</p> <p>During a review of Resident 1 ' s Release of Responsibility for Leave of Absence (OOP) log dated 8/2024-10/2024, the log indicated Resident 1 ' s last signed out on pass from the facility to go to the bank on 10/2/2024 at 4:03 (p.m.) and returned on 10/2/2024 at 4:57 p.m.</p> <p>During a review of Resident 1 ' s Nurse Notes dated 10/5/2024, the Note indicated, on 10/5/2024 at 12:50 p. m., Resident 1 left the facility without authorization and OOP order.</p> <p>During a review of Resident 1 ' s IDT Notes dated 10/7/2024, the IDT notes indicated on 10/5/2024 at 5:00 p. m., Resident 1 went OOP with a friend without signing out himself despite multiple attempts by staff to stop the resident from leaving since there was no OOP order given by the physician. The IDT Notes indicated Resident 1 refused to sign AMA. The IDT notes indicated the resident was considered DC ' D AMA from the facility, however on 10/5/2024 at 5:00 p.m., Resident 1 returned to the facility and insisted to go in the facility. The IDT Notes indicated Resident 1 indicated leaving to find a place to go once he was discharged from the facility. The IDT Notes indicated Resident 1 had a history of drug-seeking behavior and illicit drug use especially while the resident was out of the facility by himself. The IDT Notes indicated Resident 1 would be allowed to go OOP for 4 hours only with staff supervision and for discharge planning related situation.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 10/8/2024, the MDS indicated Resident 1 was able to understand others and make self understood. The MDS indicated Resident 1 was independent with Activities of Daily Living (ADLs) such as eating, personal hygiene and walking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Care plan with a focus on Resident 1 ' s high risk for recurrent illicit drug use while OOP, dated 10/5/2024, the Care Plan indicated Resident 1 had a history of opioid (group of medicines used to relieve pain) abuse and episode of drug seeking behaviors (Narcotics). The Care plan also indicated Resident 1 went OOP against physician ' s orders, non-compliant (not obeying a particular rule or law, especially one that controls a particular industry, or type of work or activity) with treatment/regulations in the facility. The Care Plan nursing interventions included to analyze of key times, places, circumstances, triggers, what de-escalates behavior, document and anticipate the resident ' s needs.</p> <p>During a review of Resident 1 ' s Physician ' s Order dated 10/8/2024, the Order indicated Resident 1 may go OOP for 4 hours only with staff supervision and for discharge planning related situation.</p> <p>During a review of Resident 1 ' s Psychiatric Consultation Note dated 10/8/2024, the Note indicated Resident 1 had a depressed mood, fair impulse control, marginal judgement, flight of ideas (rapid, erratic speech that switches quickly between thoughts and ideas).</p> <p>During a review of Resident 1 ' s Care Plan with a focus on Resident 1 ' s use of anti-anxiety medication dated 10/8/2024, the Care plan indicated Resident 1 had anxiety disorder manifested by irritability/inability to relax. The Care Plan indicated Resident 1 was taking anti-anxiety medication which were associated with an increased risk of confusion, loss of balance and cognitive (ability to think and reason) impairment. The Care Plan indicated nursing interventions included monitoring the resident for safety and monitor/record occurrence of target behavior symptoms such as pacing, wandering, inappropriate response to verbal communication, violence/aggression towards others and document.</p> <p>During a review of Resident 1 ' s Care Plan addressing the residents OOP dated 10/8/2024, the Care Plan indicated Resident 1 was allowed to go OOP for 4 hours with staff supervision or with family related to discharge planning. The Care Plan indicated staff interventions included making sure the resident signed OOP binder before leaving and making sure staff or family member accompanied the resident during OOP.</p> <p>During a review of Resident 1 ' s Elopement Screening dated 10/8/2024, the Elopement Screening indicated Resident 1 was a Low Risk for elopement. The Elopement Screening indicated Resident 1 had no history of elopement, no diagnosis that would affect his judgment and safety awareness and had no exit seeking behavior. The Elopement Screening did not indicate Resident 1 ' s diagnoses of encephalopathy, bipolar disorder and major depressive disorder. The Elopement Screening did not indicate Resident 1 ' s history of leaving the facility without authorization or physician ' s order.</p> <p>During a review of Resident 1 ' s Leaving Facility Against Medical Advice form, dated 10/22/2024 at 12:40 a. m., the form indicated Resident 1 left the facility without notifying staff. The form did not indicate Resident 1 signed to Leave the facility Against Medical Advice.</p> <p>During a review of the General Acute Care Hospital (GACH) records dated 10/22/2024, the GACH records indicated Resident 1 presented in the emergency room Department with dental pain and requesting opioids.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the IDT Notes dated 10/23/2024, the IDT Notes indicated Resident 1 went out of the facility without notifying staff. The IDT Notes indicated Resident 1 was on visual monitoring every 15-30 minutes and was last seen by staff in his room at around 12:00 a.m. The IDT notes indicated, Resident 1 was in the nursing station on 10/22/2024 at 11:45 p.m. asking staff if he could go OOP and staff informed the resident, he did not have an order for OOP without supervision. The IDT Notes indicated on 1/22/2024 at around 12:15 a.m., Resident 1 was not in his room and staff immediately initiated a search. The IDT Notes indicated the staff noted that the resident ' s car which was parked in the facility ' s parking area was also missing. The IDT Notes indicated has episodes of going OOP unsupervised without signing himself out despite multiple attempts by staff to stop him from leaving without supervision and a physician ' s order.</p> <p>During a concurrent observation and interview on 10/28/2024 at 10:50 a.m. with the Dietary Supervisor (DS), the Emergency exit/Ambulance entrance door alarm was turned off, and no sound was heard upon entering or exiting the door. The door opens to the parking lot and approximately 400 feet away was a busy 4-lane street. DS stated, staff would not hear the alarm to alert them if a resident tried to leave the facility, and the resident may get hit by a car.</p> <p>During an interview on 10/28/2024 at 1:10 p.m., with the Director of Nursing (DON), the DON stated the door alarms should always be on and activated. The DON stated staff failed to activate the alarm when the ambulance left.</p> <p>During a concurrent observation and interview on 10/30/2024 at 12:00 p.m. with Central Supplies Staff (CS), the Emergency exit/Ambulance entrance door alarm was turned off, and no alarm sound was heard upon entering/exiting the door. CS stated she unlocked the door at 9:30 a.m. (on 10/30/2024) to bring shipment of supplies inside. CS stated she went to lunch at 11:30 a.m. and did not turn the alarm on. CS stated, failing to turn the door alarm on could result in accidents and residents leaving the facility without staff hearing the alarm.</p> <p>During a concurrent record review and interview on 10/30/2024 at 12:35 p.m. with the DON, the Elopement Screening form dated 10/08/2024 was reviewed. The Elopement Screening form indicated Resident 1 has a low-risk score of 4 for elopement, based on no history of elopement, no exit seeking behavior/expression of wanting to go home, and no reported episodes of elopement in the past 6 months. The DON stated Resident 1 was not cognitive impaired and not exit seeking. The DON stated Resident 1 left AMA on 10/5/2024 and did not elope.</p> <p>During a concurrent record review and interview on 11/14/2024 at 3:19 p.m. with the DON, Resident 1 ' s Care Plans, IDT Notes and OOP physician ' s orders were reviewed. The DON stated Resident 1 ' s Care Plan indicated for nurses to monitor the resident ' s behavior symptoms manifested by wandering. The DON stated, there was no supporting documentation to indicate this was done. The DON stated, Resident 1 verbalized wanting to leave the facility on 10/22/2024 at around 11:45 p.m. The DON stated, nurses (unnamed) notified Resident 1 he could not go OOP. The DON stated, it was expected for the nurses to monitor the resident and increase supervision of the resident due to the resident ' s history of noncompliance and leaving without authorization, however, was not done. The DON stated, she does not know how the resident left the facility. The DON stated, none of the nurses heard the alarm go off and if nurses were supervising the resident, was not sure how the resident was able to leave unnoticed. The DON stated, it was important to ensure nurses implemented Care Plan interventions and provided adequate supervision to ensure safety for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s Policy and Procedure (P&P) titled, Safety and Supervision of Residents dated 12/2007, the P&P indicated Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. The P&P indicated staff should use various sources to identify risk factors for residents, including information obtained from the medical history, physical exam, observation if the resident, and the MDS. The P&P indicated the IDT care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risk for the resident and target interventions to reduce the potential for accidents. The P&P also indicated resident supervision is a core component of the systems approach to safety and the type and frequency of resident supervision is determined by the individual resident ' s assessed needs and identified hazards.</p> <p>During a review of the facility ' s P&P titled, Elopement, dated 5/25/2022, the P&P The policy indicated Resident ' s will be screened by a licensed nurse on admission/readmission, quarterly, upon identification of significant change in condition and at least within 24 to 72 hours post-elopement situation. The P&P indicated how to identify residents who are at risk are as follows: Resident with a history of wandering or elopement, who has reported incident of attempt to leave the facility premises, who has reported of exit-seeking behavior and who have impaired cognition and decision-making skills yet verbalizes wanting to leave the facility without supervision. The P&P indicated, if the staff member observes a resident leaving the premises without having followed proper procedure, he/she may: get help from other facility staff member and inform nursing supervisor, if the resident exits the facility despite efforts to stop the resident, a staff member shall accompany or follow the resident to ensure safety until assistance arrives.</p>		