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	05/07/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to ensure two of five sampled residents (Resident 4 and Resident 5) received respiratory care and services according to professional standards, by failing to ensure: 1.Resident 4 ' s ventilator (a medical device to help a person breathe when they are unable to do so on their own) alarm (visual and/or audible warnings that alert caregivers to changes in a patient's condition or the ventilator's status) located outside Resident 4 ' s room (secondary alarm) was turned on in a timely manner. 2. Resident 5 ' s ventilator alarm located at the bedside (primary alarm) was set to high. These failures had the potential to result in a delay in care and services, respiratory compromise and death for Residents 4 and 5. Findings: a. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 4 ' s diagnoses included anoxic brain damage (occurs when the brain is deprived of oxygen), tracheostomy (surgical procedure to create an opening in the trachea [windpipe] for breathing), and respiratory failure (a condition where the lungs fail to adequately oxygenate the blood, leading to a deficiency of oxygen in the tissues). During a review of Residents 4 ' s Care Plan for impaired gas exchange dated 12/8/2023, the Care Plan indicated interventions included Respiratory Therapist (RT) to monitor the settings of Resident 4 ' s ventilator. During a review of Resident 4 ' s History and Physical (H&P) dated 6/18/2024, the H&P indicated Resident 4 did not have the capacity to understand and make medical decisions. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Residents 4 ' s Minimum Data Set (MDS - a resident assessment tool) dated 4/16/2025, the MDS indicated Resident 4 was cognitively (ability to think and reason) impaired. The MDS indicated Resident 4 was totally dependent on staff for Activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how residents move from lying to turning side to side). The MDS indicated Resident 4 had oxygen therapy, tracheostomy and a mechanical ventilator. During a concurrent observation and interview on 5/7/2025 at 10:35 a.m. with RT 1, Resident 4 ' s ventilator alarm outside Resident 4 ' s room (secondary ventilator alarm), was observed to be turned off. RT 1 stated she turned Resident 4 ' s alarm off when the resident had to take a shower. RT 1 stated did not turn the ventilator back on as soon as the resident returned from the shower (approximately 25 minutes ago). During an interview on 5/7/2025 at 11:15 a.m. with Certified Nursing Assistance (CNA) 1, CNA 1 stated when residents return to the room after a shower, the RT was responsible for reconnecting the resident to the ventilator machine and turning on the ventilator alarms. CNA 1 stated Resident 4 received a shower in the morning (on 5/7/2025) at around 9:30 a.m. and came back at around 10:10 a.m. CNA 1 stated RT 1 connected Resident 4 to the ventilator and left the room. CNA 1 stated I am not sure if RT 1 turned the resident ' s ventilator (secondary) alarm on. b. During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 5 ' s diagnoses included dependence on respiratory ventilator status (need for mechanical ventilation), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and chronic respiratory failure with hypoxia (low oxygen in the tissues of the body). During a review of Resident 5 ' s H&P dated 6/3/2024, the H&P indicated Resident 5 could make needs known but could not make medical decisions. During a review of Residents 5 ' s MDS dated [DATE], the MDS indicated Resident 5 had moderate cognitive impairment. The MDS indicated Resident 5 required substantial to maximal assistance (staff does more than half the effort) for ADLs such as dressing, toilet use, personal hygiene, and transfers. During a concurrent observation and interview on 5/7/2025 at 10:38 a.m. there was no ventilator alarm outside Resident 5 ' s room (secondary ventilator alarm). RT 1 stated Resident 5 ' s ventilator alarm was broken, and she had dropped it off to maintenance for repair earlier in the morning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/7/2025 at 11:00 a.m., with Resident 5, and RT 2, in the resident ' s room, Resident 5 stated her bedside ventilator alarm (primary ventilator alarm) was set to low and was difficult to hear when the room door was closed. Resident 5 stated it was too low for her (Resident 5) to hear, and it must be difficult for staff to also hear it. RT 2 stated Resident 5 ' s ventilator alarm volume setting was set to low. RT 2 stated the ventilator volume should always be set to medium or high and was not sure why the ventilator volume was set to low. RT 2 stated if Resident 5 ' s (primary) ventilator alarm was set to low inside the room and the residents (secondary) ventilator alarm outside the room was not in place, Resident 5 was at risk of not being assisted in a timely manner in case the resident ' s ventilator was disconnected or the resident needed to be suctioned (clearing the airway of mucus). RT 2 also stated yes, it was very important to have the ventilator alarm set to high and the backup alarm outside the room in place. RT 2 stated Resident 5 could not be without oxygen for more than 15 seconds because it could cause brain anoxia to the resident. During an interview on 5/7/2025 at 3:36 p.m. with the Maintenance Supervisor (MS). The MS stated he did not see Resident 5 ' s ventilator alarm at his office when he arrived to work at 7:30 am. The MS stated he saw Resident 5 ' s ventilator alarm at around 10:30 a.m. and gave it back to the RT (unnamed) at around 10:45 a.m. The MS stated nobody had informed him about the resident ' s broken alarm that needed to be fixed until he saw it in his office. During an interview on 5/7/2025 at 4:45 p.m. with the Director of Nursing (DON), the DON stated both ventilator alarms (primary and secondary) were connected to residents ' ventilators, and should sound if residents were in respiratory distress, needed suction or tubing was kinked. The DON stated if the alarm is broken it should be fixed right away and put it back. The DON stated it is very important that alarms should be always set high volume, so Resident can get a prompt care. The risk for Resident 4 and Resident 5 not having (both) ventilator alarms on could cause a delay in care in any episodes of respiratory distress or hypoxia. During a review of the facility ' s undated policy and procedures (P&P) titled Respiratory Policies and Procedures, the P&P indicated Respiratory Therapy is an Allied Health Specialty employed under medical direction and supervision in the treatment, management, control, diagnostic evaluation and care of individuals with deficiencies and abnormalities associated with the cardiopulmonary system. This includes the measurement of ventilator volume, pressures, flows, blood gas analysis, and other related physiological monitoring. During a review of the facility ' s undated P&P titled, Ventilator Alarms and Corrective Action, the P&P indicated It is the responsibility of all health care provides to respond immediately to all ventilator alarms. Personnel will perform corrective action within their scope of practice to resolve the problem.