

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  05/28/2025
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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50379</p> <p>Based on interview and record review, the facility failed to implement its policy and procedure (P&amp;P) titled, Bed-Holds (when a nursing home holds [reserve] a bed for seven (7) days) when the resident goes to the hospital) and Returns, by failing to hold the sub-acute bed (specialized unit of the facility providing care and services to residents with tracheostomy [surgical opening in the neck area for breathing]) for 7 days, when one of four residents' (Resident 1), was sent to the General Acute Care Hospital (GACH 1).</p> <p>This failure resulted in Resident 1 not readmitted back to the facility within the 7-day bed-hold period.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility in room [ROOM NUMBER]A, in Sub-acute unit on 12/31/2024. The Admission Record indicated Resident 1 had a history of tracheostomy ([trache] a surgical opening in the neck for breathing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and recurrent major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Record indicated Resident 1 had a responsible party. The Admission Record indicated Resident 1 was discharged to GACH 1 on 4/28/2025.</p> <p>During a review of Resident 1's physician's order dated 12/31/2024, the physician's order indicated to connect Resident 1's trache to a T-Bar (T- shaped tubing connected to the trache and oxygen) with oxygen at 2 liters per minute. The physician's orders indicated to suction tracheal secretions and tracheostomy care every shift.</p> <p>During a review of Resident 1's Bed Hold Notification, Informed Consent form on admission, dated 12/31/2024, the Bed Hold Notification form indicated a resident/family representative signature indicating Resident 1 was informed of the right to request a 7-day bed-hold should the resident be transferred to a GACH. The bed-hold notification form indicated that on 4/28/2025 at 7:30 (am or pm not indicated), Family Member 1 (FM 1) notified the facility representative, to hold the bed for Resident 1.</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 0627</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 History and Physical (H&amp;P), dated 1/1/2025, the H&amp;P indicated Resident 1 did not have the ability to make medical decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2025, the MDS indicated Resident 1 did not speak and was never or rarely able to understand others or express ideas and wants. The MDS indicated Resident 1 was dependent (helper does all the effort) to roll left and right, perform personal hygiene, and dress herself.</p> <p>During a review of Resident 1's Progress Notes, dated 4/22/2025, the notes indicated Resident 1 had a planned transfer to GACH 1 on 4/28/2025 for a cardiology clearance (an assessment of the cardiovascular system [heart, blood vessels, and circulatory system] to identify any potential issues that could complicate a surgery).</p> <p>During a review of Resident 1's Progress Notes, dated 4/28/2025 at 3:35 p.m., the notes indicated Resident 1 was admitted to GACH 1 for cardiology clearance.</p> <p>During a review of Resident 1's Physician Order, dated 4/28/2025 at 3:29 p.m., the order indicated a 7-day bed hold for Resident 1.</p> <p>During a review of the facility's daily census dated 4/28/2025, the census indicated Resident 1 was discharged from the facility on 4/28/2025 and Resident 1's name was transferred from room [ROOM NUMBER]A (sub-acute) to room [ROOM NUMBER]B (Skilled Nursing unit where resident without trache is admitted ).</p> <p>During a review of the facility's daily census for 4/28/2025 until 5/4/2025, the census sheets indicated Resident 1's name was in room [ROOM NUMBER]B.</p> <p>During an interview on 5/28/2025 at 9:55 a.m. with Registered Nurse (RN 1), RN 1 stated Resident 1 had a right to a 7-day bed-hold. RN 1 stated Resident 1 had the potential to cognitively deteriorate and become anxious and withdrawn if she cannot return to the facility.</p> <p>During a concurrent interview and record review on 5/28/2025 at 3:45 p.m. with the Director of Nursing (DON), Resident 1's Nurses Notes dated 4/22/2025, Resident 1's Bed Hold Notification dated 4/28/2025, the facility's Daily Census dated 4/28/2025, the facility's P&amp;P titled Bed-Holds and Returns dated 10/2022, and the P&amp;P titled Transfer/Discharge Documentation, dated 10/2022, were reviewed. The DON stated the Nurses Notes indicated Resident 1's transfer to GACH 1 on 4/28/2025 was planned on 4/22/2025. The DON stated the Daily Census indicated Resident 1's bed-hold was transferred from the sub-acute side of the facility (room [ROOM NUMBER]A) to the basic skilled nursing side (room [ROOM NUMBER]B). The DON stated regarding the bed-hold notification, the facility should have kept a bed vacant and available in the sub-acute side for the resident, for seven days from the date Resident 1 was transferred (4/28/2025) to GACH 1 for the resident's readmission to the facility. The DON stated Resident 1's new room assignment (room [ROOM NUMBER]B, skilled nursing side) was not equipped to accommodate Resident 1's medical needs. The DON stated Resident 1 who had a tracheostomy, was not readmitted back to the facility because the bed held was on the skilled nursing side and could not accommodate the resident's medical needs. The DON stated Resident 1 was not provided an appropriate bed-hold. The DON stated Resident 1's bed held while in GACH 1 should have not been moved to another room (room [ROOM NUMBER]B, skilled nursing side).</p> <p>(continued on next page)</p>		

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<p>F 0627</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 P&amp;P titled, Bed-Holds and Returns, dated 10/2022, the P&amp;P indicated residents who seek to return to the facility within the bed-hold period must be allowed back to their room, if available, regardless of payor source or outstanding debt.</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50379</p> <p>Based on interview and record review, the facility failed to follow its policy and procedure (P&amp;P), titled Bed-Holds and Returns and the Transfer/Discharge Documentation, by not providing the written Notice of Discharge and the written Notice of Bed-hold (to save the bed for 7 days) upon the residents' transfer to a general acute care hospital (GACH 1), for three of four residents (Residents 1, 2 and 3) or their family representatives.</p> <p>This failure had the potential to result in Resident 1, Resident 2, and Resident 3 and their representatives not knowing their rights.</p> <p>Findings:</p> <p>1). During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and discharged to General Acute Care Hospital (GACH 1) on 4/28/2025. The Admission Record indicated Resident 1 had a history of tracheostomy (a surgical opening fitted with a device to allow air to be administered through the neck, common for people with breathing problems), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and recurrent major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Record indicated Resident 1 had a responsible party.</p> <p>During a review of Resident 1's History and Physical (H&amp;P), dated 1/1/2025, the H&amp;P indicated Resident 1 did not have the ability to make medical decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2025, the MDS indicated Resident 1 did not speak and was never or rarely able to understand others or express ideas and wants. The MDS indicated Resident 1 was dependent (helper does all the effort) to roll left and right, perform personal hygiene, and dress herself.</p> <p>During a review of Resident 1's Nurses Notes, dated 4/22/2025, the Nurses Note indicated Resident 1 had a planned transfer to GACH 1 on 4/28/2025 for a procedure.</p> <p>During a review of Resident 1's Physician Order, dated 5/28/2025, the Physician Order indicated a bed hold for seven days was ordered for Resident 1.</p> <p>During a review of Resident 1's Bed Hold Notification on admission, dated 12/31/2024, the Bed Hold Notification indicated Resident 1 was aware of the option to request a 7-day bed-hold to keep a bed vacant and available for return to the facility. On 4/28/2025 at 7:30 (am or pm not indicated), the Bed Hold Notification indicated the facility representative was notified within 24 hours by Family Member 1 (FM 1) to hold the bed for Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Daily Census dated 4/28/2025, the census indicated Resident 1 was discharged from the facility on 4/28/2025 and Resident 1's name was transferred from room [ROOM NUMBER]A to 8B. Resident 1's name was at the census sheet in room [ROOM NUMBER]B from 4/28/2025 until 5/4/2025.</p> <p>During a concurrent interview and record review on 5/28/2025 at 3:45 p.m. with the Director of Nursing (DON), Resident 1's Nurses Notes dated 4/22/2025, Resident 1's Bed Hold Notification dated 4/28/2025, the facility's Daily Census dated 4/28/2025, P&amp;P titled Bed-Holds and Returns dated 10/2022, and P&amp;P titled Transfer/Discharge Documentation dated 10/2022, were reviewed. The DON stated the Nurses Notes indicated Resident 1's transfer to GACH 1 on 4/28/2025 was planned on 4/22/2025. The DON stated the facility's P&amp;P titled Bed-Holds and Returns was not followed because Resident 1 and her resident representative were not provided a written notice of bed-hold within 24 hours of transfer. The DON stated the facility's P&amp;P titled Transfer/Discharge Documentation dated 4/28/2020, was not followed because Resident 1 and Resident 1's representative was not notified of Resident 1's transfer in writing. The DON stated the facility did not have a process in place to create and deliver a written Notice of Transfer/Discharge and Bed-Hold Notification. The DON stated these failures to provide written notices could have resulted in Resident 1 and her resident representative's rights not being upheld</p> <p>During an interview on 6/2/2025 at 10:25 a.m. with Resident 1's Family Member (FM 1), FM 1 stated she did not receive written Notice of Transfer/Discharge and written notice of bed-hold policies at the time of transfer and not informed of Resident 1's rights when Resident 1 was transferred to GACH 1 on 5/28/2025. FM 1 stated the facility never informed her about Resident 1's room change.</p> <p>2). During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 2 had a history dementia (a progressive state of decline in mental abilities) and major depressive disorder.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment and always needed assistance reading written material. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) from staff to bathe and dress himself. The MDS indicated Resident 2 required substantial assistance to stand up form a sitting position and roll left and right.</p> <p>During a review of Resident 2's eInteract Transfer Form, dated 4/28/2025, the eInteract Transfer Form indicated Resident 2 was transferred to GACH 2 on 4/28/2025.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review 5/28/2025 at 3:45 p.m. with the DON, P&amp;P titled Bed-Holds and Returns dated 10/2022, and P&amp;P titled Transfer/Discharge Documentation dated 10/2022, were reviewed. The DON stated Resident 2 was not provided a written Notice of Transfer/Discharge and written notice of bed-hold when he was transferred out of the facility on 4/28/2025. The DON stated the facility did not have a process in place to create and deliver a written Notice of Transfer/Discharge and Bed-Hold Notification. The DON stated the facility's P&amp;P titled Bed-Holds and Returns was not followed because Resident 2 and his resident representative were not provided a written notice of bed-hold within 24 hours of transfer. The DON stated the facility's P&amp;P titled Transfer/Discharge Documentation dated 4/28/2020, was not followed because Resident 2 or his representative was not notified of Resident 2's transfer in writing. The DON stated these failures to provide written notices resulted in Resident 2 and his resident representative not knowing about their rights and rights being violated.</p> <p>3). During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 3 had a history of tracheostomy, gastrostomy, and ventilator dependence.</p> <p>During a review of Resident 3's H&amp;P, dated 5/20/2025, the H&amp;P indicated Resident 3 did not have the ability to make medical decisions.</p> <p>During a review of Resident 3's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 3 was moderately cognitively impaired, was not able to speak, and often needed help to read written material. The MDS indicated Resident 3 was dependent on staff for personal hygiene and to dress herself. The MDS indicated Resident 3 required substantial assistance to roll left and right and move from sitting to lying.</p> <p>During a review of Resident 3's eInteract Transfer Form, dated 5/13/2025, the eInteract Transfer Form indicated Resident 3 was transferred to GACH 2 on 5/13/2025.</p> <p>During a concurrent interview and record review 5/28/2025 at 3:45 p.m. with the DON, P&amp;P titled Bed-Holds and Returns dated 10/2022, and P&amp;P titled Transfer/Discharge Documentation dated 10/2022, were reviewed. The DON stated Resident 3 was not provided a written Notice of Transfer/Discharge and written notice of bed-hold when she was transferred out of the facility on 4/28/2025. The DON stated the facility did not have a process in place to create and deliver a written Notice of Transfer/Discharge and Bed-Hold Notification. The DON stated the facility's P&amp;P titled Bed-Holds and Returns was not followed because Resident 3 and her resident representative were not provided a written notice of bed-hold within 24 hours of transfer. The DON stated the facility's P&amp;P titled Transfer/Discharge Documentation dated 4/28/2020, was not followed because Resident 3 and her representative was not notified of Resident 3's transfer in writing. The DON stated these failures to provide written notices resulted in Resident 3 and her resident representative not knowing about their rights and rights being violated.</p> <p>During a review of the facility's P&amp;P titled, Bed-Holds and Returns , dated 10/2022, the P&amp;P indicated residents must be provided written notice of bed-hold policies at the time of transfer, or within 24 hours. The P&amp;P indicated multiple attempts must be made to provide the written notice and all attempts must be documented.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled Transfer/Discharge Documentation dated 10/2022, the P&amp;P indicated residents and resident's representatives must be notified in writing as soon as practicable before a resident's transfer or discharge. The P&amp;P indicated the facility may not transfer a resident to another room unless given prior reasonable notice.</p>