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	01/02/2026

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility to follow its policy and procedure (P&P) titled, Resident Going Out On Pass (OOP-short term leave from the facility) Policy, for three of three sampled residents (Resident 1, 2 and 3) by failing to:1.Ensure Residents 1, 2 and 3's OOP orders indicated whether the Residents may leave OOP without a responsible person and/or indicated the length of time the Resident may be OOP. 2.Ensure Resident 3 was assessed before and after the Resident went OOP. 3.Ensure Residents 1 and 3 had a responsible person to accompany the Residents while OOP when the physician did not specify whether the Residents may leave OOP without a responsible person. These failures had the potential to negatively affect Resident 1, 2, and 3's safety and well-being while OOP. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included polyneuropathy (damage to nerves outside the brain and spinal cord causing problems, sensation, and movement) and spinal stenosis, lumbar region without neurogenic claudication (narrowing in the lower back's spinal canal without leg pain, numbness, or weakness).During a review of Resident 1's History and Physical (H&P) dated 12/14/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's OOP order, dated 12/19/2025, the OOP order indicated, Resident 1 May go out on pass. The OOP order did not indicate whether Resident 1 could leave OOP unaccompanied by a responsible person and the length of time the resident may be on pass. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 12/16/2025, the MDS indicated Resident 1 had moderate cognitive impairment (problems with thinking, memory, and decision-making). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for Activities of Daily Living (ADLs) such as toileting hygiene and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to perform movements such as changing position from sitting to stand and transferring from bed to chair.During a concurrent interview and record review on 1/2/2026 at 1:43 p.m., with Registered Nurse (RN) 1, Resident 1's OOP order, dated 12/19/2025, was reviewed. RN 1 stated staff should document whether the Resident was stable prior to the Resident leaving to go out OOP. RN 1 stated she received Resident 1's OOP order on 12/19/2025. RN 1 stated she did not verify with the medical doctor (MD) how long Resident 1 should have been OOP for. RN 1 stated she should have verified this with the MD when the order was placed for Resident 1.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 2's diagnoses included polyneuropathy. During a review of Resident 2's H&P, dated 11/26/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had no cognitive impairment. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) for ADLs such as showering/bathing self and required partial/moderate assistance (helper does less than half the effort) to perform movements such as changing positions from sitting to stand and toilet transfer.During a review of Resident 2's OOP order, dated 12/28/2025, the OOP order indicated, OK for out on pass with family member. The OOP order did not indicate the length of time Resident 2 may be on pass.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included unspecified open wound of the left lower leg (non-specific cut or injury on the left lower leg after initial care). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment. The MDS indicated Resident 3 required substantial/maximal assistance for ADLs such as showering/bathing self and required partial/moderate assistance to perform movements such as changing positions from sitting to stand and toilet transfer.During a review of Resident 3's OOP order, dated 12/30/2025, the OOP order indicated, Standing out on pass. The OOP order did not indicate whether Resident 3 could leave out on pass unaccompanied by a responsible person and the length of time the resident may be on pass.During an interview on 1/2/2026 at 1:11 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated staff should document and ensure that residents are assessed prior to leaving the facility when they go OOP to establish the resident's baseline (state to determine if there was any change) for safety. LVN 1 stated, OOP orders should include how long the primary care provider (PCP) approved the resident to be OOP for During a concurrent interview and