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	02/05/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure titled Charting and Documentation, for one of three residents (Resident 1) when:Respiratory Therapist (RT 1) wrote a progress note on 1/6/2026 at 4:15 p.m. for an event that occurred at 4:23 p.m Licensed Vocational Nurse (LVN 1) did not document his respiratory assessment findings in Resident 1's medical record.These failures resulted in Resident 1's medical record being inaccurate and incomplete. These failures had the potential to result in delayed identification of Resident 1's change in condition, and delayed interventions.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure, pneumonia (an infection/inflammation in the lungs), tracheostomy (an opening in the neck into the windpipe for direct and improved airflow) and respirator (ventilator- a medical device to help support or replace breathing) dependence.During a review of Resident 1's History and Physical (H&P), dated 12/24/2025, the H&P indicated Resident 1 could make needs known but cannot make medical decisions. The H&P indicated Resident 1's breath sounds were coarse (gurgling sounds heard during inhalation and exhalation indicating air moving through mucus or fluid).During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/24/2025, the MDS indicated Resident 1 had moderate cognitive impairment, was usually able to understand and be understood. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, shower/ bathing self, upper and lower body dressing, personal hygiene and in rolling from lying on back to left and right side and return to lying on back on the bed.During a review of Resident 1's Licensed Nurse Record, dated 1/6/2026, the record was blank for the area indicated Resident 1's breath sound assessment.During a review of Resident 1's Progress Notes, dated 1/6/2026 at 4:15 p.m., the notes indicated Resident 1 experienced respiratory distress, and required emergency transportation to the General Acute Care Hospital (GACH 1) on 1/6/2026 at 4:15 p.m During a review of Resident 1's Change of Condition (COC- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/6/2026 at 4:23 pm., the COC indicated Resident 1 experienced respiratory distress, and required emergency transportation to GACH 1 at 4:23 p.m During a review of Resident 1's Paramedic Run Sheet (a legal document recording all details of an emergency medical call, including patient demographics, assessment, treatments, vitals, and transport data), the sheet indicated paramedics were dispatched on 1/6/2026 at 4:26 p.m During a concurrent interview and record review on 2/5/2026 at 4:15 p.m., with LVN 1, Resident 1's Licensed Nurse Report, dated 1/6/2026, and Resident 1's Progress Notes, dated 1/6/2026, and the facility's P&P titled Charting and Documentation, dated 01/2023, were reviewed. LVN 1 stated on 1/6/2026, he assessed Resident 1's breath sounds but did not document findings of his assessment in the Licensed Nurse Report or Progress Notes as he should have. LVN (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

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marina Pointe Healthcare & Subacute	5240 Sepulveda Blvd Culver City, CA 90230

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 stated he left the findings of his assessment of the breath sound section of the Licensed Nurse Report blank. LVN 1 stated the P&P indicated all observations should have been documented objectively, completely, and accurately in Resident 1's medical record. LVN 1 stated all services provided to the resident, such as a breath sound assessment, should have been documented in the resident's medical record to facilitate communication between care team members regarding Resident 1's condition and response to care. LVN 1 stated inaccurate documentation prevents the care team from knowing Resident 1's condition and could delay identification of changes in condition.During a concurrent interview and record review on 2/5/2026 at 1:40 p.m., with the Respiratory Manager (RM), Resident 1's Progress Notes, dated 1/6/2026, and Resident 1's COC, dated 1/6/2026 were reviewed. The RM stated the COC on 1/6/2026 indicated Resident 1 was found on 1/6/2026 at 4:23 pm. The RM stated RT 1 was likely estimating the event occurred and had inaccurately written the progress notes as late entry (late documentation) on 1/6/2026 timing it at 4:15 p.m. instead of 8 p.m. when written. The RM stated all documentation must be accurate to identify changes in resident condition and prevent deterioration.During a concurrent interview and record review on 2/5/2026 at 4:34 p.m., with the Director of Nursing (DON), Resident 1's Progress Notes, dated 1/6/2026, Resident 1's COC, dated 1/6/2026, and the facility's P&P titled Charting and Documentation, dated 01/2023, were reviewed. The DON stated Resident 1's lung sounds should have been assessed and documented at least once per shift. The DON stated the Licensed Nurse Record should not have been left blank after LVN 1 assessed Resident 1's breath sounds. The DON stated the Progress Notes indicated Resident 1 was unresponsive and pulseless at 4:15 p.m. on 1/6/2026, while the COC indicated Resident 1 was unresponsive and pulseless at 4:23 p.m The DON stated Resident 1's records were confusing and unclear, indicating Resident 1 did not receive aid for 8 minutes after identification. The DON stated the time of Progress Note was inaccurate because Resident 1 was assessed at 4:23 p.m. and interventions were immediately provided. The DON stated the P&P indicated the date and time of procedures and assessments must be accurate to inform the care team of Resident 1's change of condition.During an interview on 2/12/2026 at 1:24 p.m., with Respiratory Therapist (RT 1), RT 1 stated she could not recall exactly what time Resident 1's unresponsiveness was identified and interventions were immediately provided. During a review of the facility's P&P titled Charting and Documentation, dated 1/2023, the P&P indicated all services provided to the resident and any changes in the resident's medical and physical condition shall be documented in the resident's medical record to facilitate communication between interdisciplinary team members. The P&P indicated all events and incidents involving the resident will be objectively, completely, and accurately documented.During a review of the facility's P&P titled Change in a Resident's Condition or Status, dated 5/2017, the P&P indicated documentation must be accurate, objective, and reflect assessment findings.