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	03/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) titled, Unusual Occurrence (an unexpected event or accident that results in significant harm or requires significant additional measures), which indicated the facility will report unusual occurrences that threaten the welfare, safety, or health of the resident, to the California Department of Public Health (CDPH), within twenty^four (24) hours, when one of five sampled residents (Resident 1), had a right shoulder fracture (broken bone).This failure delayed the investigation by the CDPH and placed Resident 1 and other residents in the facility at risk for neglect and abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness), following cerebral infarction (ischemic stroke, a type of stroke caused by a blocked blood vessel [thrombosis or embolism], leading to tissue death [necrosis] in the brain due to lack of oxygen) affecting right dominant side (right-side of the body), other symptoms and signs involving the musculoskeletal system (pain, weakness, stiffness, swelling, and reduced mobility in bones, muscles, or joints) and other symptoms and signs involving the nervous system (motor dysfunction (weakness, tremors, gait changes). During a review of Resident 1's History and Physical (H&P) dated 1/27/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 was dependent on staff with the activities of daily living (ADLs) such as dressing, toilet use, transfer and mobility. Resident 1 was dependent with oral hygiene, toileting hygiene, shower/ bathing self, upper and lower body dressing and putting on footwear During a review of Resident 1's Change of Condition (COC) dated 3/15/2026 at 2:09 a.m., the COC indicated Resident 1 was transferred to acute hospital due to hypotension (low blood pressure) and elevated pulse rate. During a review of Resident 1's Order Summary Report dated 3/15/2026, the Order Summary Report indicated to transfer Resident 1 to a general acute care hospital (GACH) due to desaturation (a drop in the oxygen level in the blood which is considered dangerous and warrants urgent oxygen supplementation and/or treatment for lung condition. Normal oxygen saturation is between 96% and 98%), hypotension, shortness of breath, fever and for further evaluation. The order indicated bedhold (reserving resident's bed for 7 days while temporarily away from the facility, such as during hospitalization or therapeutic visits) for 7 days. During a review of Resident 1's GACH chest radiology (x-ray, process of taking pictures to diagnose and treat diseases) dated 3/15/2026 timed 5:14 a.m., the result indicated subacute (recent) appearing displaced fracture (a bone break where the fragments have moved out of alignment) of the surgical neck (narrowed, often fragile, part of the upper arm bone) of the right humerus (upper arm). During an interview on 3/26/2026 at 4:10 p.m. with Resident 1's family member (FM), the FM stated Resident 1's x-ray result at the GACH showed that Resident 1 had right shoulder fracture. FM stated on 3/17/2026 (2 days later), she went to the facility to ask about how the resident's right shoulder fracture happened. FM stated she spoke to the Director (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of Rehabilitation (DOR) and the Director of Nursing (DON) who were surprised about the fracture. FM stated the DOR and the DON stated the facility did not know about it (fracture). During an interview on 3/27/2026 at 2:00 p.m., the DON stated that on 3/17/2026, Resident 1's FM informed the facility of Resident 1's right shoulder fracture and were surprised to learn about it because there were no staff reports of falls or injuries involving Resident 1. The DON stated on 3/25/2026, she asked the admissions office to call the GACH to obtain Resident 1's Xˆray results. The DON stated the facility did not report Resident 1's fracture to CDPH because the facility did not know what happened. The DON stated it was important to report Resident 1's fracture to CDPH because it was part of ensuring the resident's safety during the investigation process. During an interview on 3/27/2026 at 2:45 p.m. with the Administrator (ADM), the ADM stated when something unusual (unexpected) occurs with a resident, the facility staff would discuss the findings among themselves to determine what happened. The ADM stated the facility was required to report such incident (unusual occurrence) to CDPH, and CDPH then determines through its investigation whether the event constitutes an unusual occurrence. During an interview on 4/6/2026 at 10:15 a.m. with the GACH Social Worker (SW), the GACH SW stated she called the facility on 3/16/2026 and informed the facility representative (name unknown) about Resident 1's right shoulder fracture. During a review of the facility's P&P titled, Unusual Occurrence, dated 3/2010, the P&P indicated, the facility should report unusual occurrences that threaten the welfare, safety, or health of patients, personnel, or visitors should be reported by the facility within twentyˆfour (24) hours, either by telephone (with written confirmation) or by telegraph, to the CDPH.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of five sampled residents (Resident 1), the facility failed to:1). Assess and investigate Resident 1's right arm pain when a Certified Nurse Assistant (CNA) reported to a Charge Nurse.2). Investigate the note posted by a family member (FM) in Resident 1's room reminding the staff to be mindful when caring and repositioning Resident 1's right arm because of the pain. 3). Investigate when the family member notified the facility on 3/17/2026 regarding the resident's right shoulder fracture (broken bone) on 3/15/2026.4). Implement its policy and procedure (P&P) titled, Accidents and Incidents - Investigation and Reporting which indicated the nurses and / or the department director or supervisor shall promptly initiate and document investigation of the incident. The Nurse Supervisor, charge nurses and / or the department director or supervisor shall complete a report of incident form and submit the original to the Director of Nursing Services within 24 hours of the incident. These failures resulted in the facility not assessing the resident's right arm pain timely, not notifying the physician and not providing the resident intervention to manage and treat the right arm pain. On 3/15/2026, Resident 1 was sent to a general acute care hospital (GACH) for a change in condition (COC), chest radiology (x-ray, process of taking pictures to diagnose and treat diseases) was done in GACH on 3/15/2026 and revealed a right shoulder fracture.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness), following cerebral infarction (ischemic stroke, a type of stroke caused by a blocked blood vessel [thrombosis or embolism], leading to tissue death [necrosis] in the brain due to lack of oxygen) affecting right dominant side (right-side of the body), other symptoms and signs involving the musculoskeletal system (pain, weakness, stiffness, swelling, and reduced mobility in bones, muscles, or joints) and other symptoms and signs involving the nervous system (motor dysfunction (weakness, tremors, gait changes). During a review of Resident 1's History and Physical (H&P) dated 1/27/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 was dependent on staff with the activities of daily living (ADLs) such as dressing, toilet use, transfer and mobility. Resident 1 was dependent with oral hygiene, toileting hygiene, shower/ bathing self, upper and lower body dressing and putting on footwear During a review of Resident 1's Change of Condition (COC) dated 3/15/2026 at 2:09 a.m., the COC indicated Resident 1 was transferred to acute hospital due to hypotension (low blood pressure) and elevated pulse rate. During a review of Resident 1's GACH chest radiology dated 3/15/2026 timed 5:14 a.m., the result indicated subacute (recent) appearing displaced fracture (a bone break where the fragments have moved out of alignment) of the surgical neck (narrowed, often fragile, part of the upper arm bone) of the right humerus (upper arm). During an interview on 3/26/2026 at 1:36 p.m., the CNA 3 stated that every time she provides ADL care to Resident 1, and putting on his shirt, Resident 1 would move his right arm, and complained of pain, by moaning and saying ouch. CNA 3 stated Resident 1's right side was weak and had always complained of pain with movement. CNA 3 stated Charge Nurses had been made aware of the resident's pain (unable to recall dates and names of the Charge Nurses). CNA 3 stated that any changes in resident's condition (COC) should be reported to the Charge Nurse and documented on a Stop and Watch form (a written statement of the situation). CNA 3 stated Resident 1's pain could be a lifeˆthreatening situation. During an interview on 3/26/2026 at 4:10 p.m. with Resident 1's FM, the FM stated, I noticed my dad was having pain in his right arm when his arm was touched or moved. The FM stated she posted a note above Resident 1's bed reminding the staff to be mindful when caring and repositioning Resident 1's right arm because of the pain. The FM stated on 3/15/2026 when Resident 1 was at the hospital, the chest radiology (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(x-ray, process of taking pictures to diagnose and treat diseases) revealed Resident 1 had right shoulder fracture. The FM stated she went to the facility on 3/17/2026 (2 days later), to ask about how the resident's right shoulder fracture happened. FM stated she spoke to the Director of Rehabilitation (DOR) and the Director of Nursing (DON) who were surprised about the fracture. FM stated the DOR and the DON stated the facility did not know about it (fracture). During an interview on 3/27/2026 at 9:48 a.m., CNA 4 stated Resident 1's complain of right arm pain could indicate a possible fracture that staff were unaware and needed to be assessed, addressed and investigated. During an interview on 3/27/2026 at 10:00 a.m. with LVN 2, LVN 2 stated, she saw a note in Resident 1's room posted by a family member indicating instruction for staff to avoid touching his right arm due to pain. LVN 2 stated she touched Resident 1's right arm to assess for swelling or redness. LVN 2 stated she did not move or extend the arm to further assess for pain on movement or changes with the range of motion. LVN 2 stated she did not call the family member to ask about the note because she assumed the family just posted. LVN 2 stated she did complete a COC and did not inform the doctor about the posted note due to the resident's pain. LVN 2 stated that if Resident 1 had pain, staff should have assessed the resident, assessed the pain level, provide medication, complete a COC and report to the doctor. LVN 2 stated that leaving Resident 1 in pain could cause discomfort and possible anxiety. During an interview on 3/27/2026 at 2:00 p.m., the Director of Nursing (DON) stated that the sign posted on the wall in Resident 1's room referred to the resident's contracted right arm. The DON stated that nurses are required to address concerns about Resident 1's right arm pain. The DON also stated that Charge Nurses were responsible for completing a COC, and that Registered Nurses (RNs) will assess Resident 1's arm and notify the physician as needed. The DON added that the risks of leaving a resident in pain include increased heart rate, elevated respirations, and anxiety. The DON stated on 3/15/2026 Resident 1 was transferred to acute hospital due to hypotension (low blood pressure) and elevated pulse rate. The DON stated that on 3/17/2026, Resident 1's FM informed us (facility) of Resident 1's right shoulder fracture and were surprised to learn about it because there were no staff reports of falls or injuries involving Resident 1. The DON stated that when she became aware of Resident 1's right arm fracture, she conducted a verbal investigation with the nurses. The DON could not provide evidence of her investigation. The DON stated she usually completes a written investigation, but in this case, she only conducted a verbal one. The DON stated she asked the admissions office on 3/25/2026 to call the hospital to obtain the Xˆray results. During a review of the facility P&P titled Accidents and Incidents - Investigation and Reporting dated 7/2017, the P&P indicated the Nurse Supervisor, charge nurses and / or the department director or supervisor shall promptly initiate and documented investigation of incident. The Nurse Supervisor, charge nurses and / or the department director or supervisor shall complete a report of incident form and submit the original to the Director of Nursing Services within 24 hours of the incident.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a resident-centered care plan, for one of five sampled residents (Resident 1), who had mobility deficit, requiring assistance with activities of daily living (ADLs) and who had complained of right arm pain. This deficient practice had the potential to result in providing poor quality patient care and had the potential to affect in maintaining the highest practicable physical, mental and psychosocial well-being of the resident.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness), following cerebral infarction (ischemic stroke, a type of stroke caused by a blocked blood vessel [thrombosis or embolism], leading to tissue death [necrosis] in the brain due to lack of oxygen) affecting right dominant side (right-side of the body), other symptoms and signs involving the musculoskeletal system (pain, weakness, stiffness, swelling, and reduced mobility in bones, muscles, or joints) and other symptoms and signs involving the nervous system (motor dysfunction (weakness, tremors, gait changes). During a review of Resident 1's History and Physical (H&P) dated 1/27/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 was dependent on staff with the ADLs such as dressing, toilet use, transfer and mobility. Resident 1 was dependent on oral hygiene, toileting hygiene, shower/ bathing self, upper and lower body dressing and putting on footwear. During a review of Resident 1's Physical Therapy (PT) progress report dated 3/9/2026, the progress notes indicated Resident 1's bed mobility, required maximal assistance. Resident 1's sitting balance required maximal assistance and upper extremities support. During a review of Resident 1's Occupational Therapy (OT) progress report dated 3/14/2026, the progress notes indicated Resident 1's sitting balance during ADLs was poor poor requiring maximal assistance and upper extremities support. During a review of Resident 1's care plans, there were no care plans develop for pain management, mobility deficit and ADL care. During an interview on 3/26/2026 at 1:36 p.m. with CNA 3, CNA 3 stated that every time she provides ADL care to Resident 1, and putting on his shirt, Resident 1 would move his right arm, and complained of pain, by moaning and saying ouch. CNA 3 stated Charge Nurses had been made aware of the resident's pain (unable to recall dates and names of the Charge Nurses). CNA 3 stated there was a note posted by a family member (FM) in Resident 1's room wall indicating to treat his weaker side with care. CNA 3 stated it was not acceptable to allow Resident 1 to remain in pain for a long period of time because it can affect his overall health. During an interview on 3/26/2026 at 4:10 p.m. with Resident 1's FM, the FM stated, I noticed my dad was having pain in his right arm when his arm was touched or moved. The FM stated she posted a note above Resident 1's bed reminding the staff to be mindful when caring and repositioning Resident 1's right arm because of the pain. During an interview on 3/27/2026 at 9:48 a.m., with CNA 4, CNA 4 stated that when providing Resident 1's ADL care, she would place Resident 1's Tˆshirt on his right arm first, and during movement or touch of the arm, Resident 1 would complain of pain. CNA 4 stated Resident 1 would moan when his arm was touched. CNA 4 stated she thought it was normal for him to complain of pain with movement because his arm was contracted. CNA 4 stated Resident 1's complaint of right arm pain with movement could indicate a possible fracture that staff were unaware and needed to be assessed, addressed and investigated. During an interview on 3/26/2026 at 2:58 p.m., Registered Nurse (RN) 1 stated that a care plan should be developed to guide patient care and to serve as a reference for nurses on how to provide the resident's care. RN 1 stated that when residents have a mobility deficit, nurses must develop a mobility care plan that outlines how staff should manage and assist the residents. RN 1 stated that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failing to initiate a care plan for Resident 1 could place Resident 1 at risk for falls and injuries. During a concurrent interview and record review on 3/27/2026 at 1:44 p.m., with the MDS nurse, the MDS nurse reviewed Resident 1's care plan and stated, Honestly, there was no care plan for mobility, ADLs, or pain. The MDS nurse stated she oversees this process and acknowledged that a care plan had not been created. The MDS nurse stated residents are assessed at admission by PT and OT, and based on those evaluations, the information is relayed to the nursing staff. The MDS nurse stated nurses are responsible for developing a care plan based on the residents' needs, and that the care plan should be followed because it serves as the guide for care. The MDS nurse stated that if residents are dependent on staff assistance, nurses must create an ADL care plan. The MDS nurse further stated a pain care plan is developed when a resident is at risk for pain due to impaired mobility. The MDS nurse stated that not following care guidance for Resident 1 can jeopardize the resident's safety and care. During an interview on 3/27/2026 at 2:00 p.m. with the Director of Nursing (DON), the DON stated the care plan includes goals and interventions. The DON stated the care plan interventions serve as guidance for nurses on how to provide care to Resident 1. The DON stated that if nurses fail to create a care plan, Resident 1 is at risk of not receiving proper care. The DON stated Resident 1 should have mobility, pain, and ADL care plan. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs are developed and implemented for each resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure pain management was provided for one of five sampled residents (Resident 1). consistent with professional standards or practice. The facility failed to ensure: 1). Certified Nursing Assistants (CNA) 3 documented on a Stop and Watch form (a written statement of the situation), Resident 1's constant complains of right arm pain during movement and when it was reported to the charge nurse.2). Licensed Vocational Nurse (LVN) 2 properly assessed Resident 1's rightˆarm pain after noting the family member's (FM) posted instruction in Resident 1's room reminding staff to be mindful when touching, moving or repositioning the resident's right arm, because of the pain.3). Implement its policy and procedure (P&P) titled Pain Assessment and Management, which indicated to assess the potential for pain, recognize the presence of pain, identify the characteristics of pain, address the underlying causes of the pain, develop and implement approaches to pain management, monitor the effectiveness of interventions and modify approaches as necessary. These failures resulted in delayed assessment, not notifying the physician and not providing the resident intervention to manage and treat the right arm pain. On 3/15/2026, Resident 1 was sent to a general acute care hospital (GACH) for a change in condition (COC), chest radiology (x-ray, process of taking pictures to diagnose and treat diseases) was done in GACH on 3/15/2026 and revealed a right shoulder fracture.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness), following cerebral infarction (ischemic stroke, a type of stroke caused by a blocked blood vessel [thrombosis or embolism], leading to tissue death [necrosis] in the brain due to lack of oxygen) affecting right dominant side (right-side of the body), other symptoms and signs involving the musculoskeletal system (pain, weakness, stiffness, swelling, and reduced mobility in bones, muscles, or joints) and other symptoms and signs involving the nervous system (motor dysfunction (weakness, tremors, gait changes). During a review of Resident 1's History and Physical (H&P) dated 1/27/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2026, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 was dependent on staff with the ADLs such as dressing, toilet use, transfer and mobility. Resident 1 was dependent on oral hygiene, toileting hygiene, shower/ bathing self, upper and lower body dressing and putting on footwear. During a review of Resident 1's Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) meeting, dated 10/23/2025, the IDT meeting indicated Resident 1's barrier with rehabilitation therapy were cognition, spasticity, right hemiplegia, multiple joint contractures, balance deficit, endurance deficits, generalized weakness. During an interview on 3/26/2026 at 1:36 p.m., CNA 3 stated that every time she provides ADL care to Resident 1, and putting on his shirt, Resident 1 would move his right arm, and complained of pain, by moaning and saying ouch. CNA 3 stated Resident 1's right side was weak and had always complained of pain with movement. CNA 3 stated Charge Nurses had been made aware of the resident's pain (unable to recall dates and names of the Charge Nurses). CNA 3 stated that any changes in resident's condition (COC) should be reported to the Charge Nurse and should have been documented on a Stop and Watch form (a written statement of the situation). CNA 3 stated Resident 1's pain could be a lifeˆthreatening situation. During an interview on 3/26/2026 at 1:45 p.m. with LVN 1, LVN 1 stated that Resident 1 had contractures (tightening of muscles, tendons, and skin that causes joints to become short and stiff) on the right side of his body. LVN 1 stated that he assisted some CNAs in repositioning Resident 1 and would notice a facial grimace (sign of pain) during repositioning. LVN 1 stated the facial grimacing was not documented as a COC because there (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	were no observed changes in the resident's pain. LVN 1 stated all staff were aware that Resident 1's right side must be treated with caution because of the pain. During an interview on 3/26/2026 at 4:10 p.m., with Resident 1's family member (FM), the FM stated, a note was posted above Resident 1's bed (unable to recall date) to remind staff to be mindful when caring for him, when touching, moving or repositioning his right arm, because of the pain. During an interview on 3/27/2026 at 9:48 a.m. with CNA 4, CNA 4 stated even when Resident 1's T^shirt was put on on his right arm first; Resident 1 would complain of pain during movement or when the right arm is touched. CNA 4 stated Resident 1 would moan when his arm was touched. CNA 4 stated she reported the pain to various LVNs, but she could not remember their names. CNA 4 stated she thought it was normal for him to complain of pain with movement because his arm was contracted. CNA 4 stated it was not right to leave Resident 1 in pain, as it could be considered as nurses not taking proper care of him. CNA 4 stated that if Resident 1 complained of pain with movement, it could indicate a possible fracture the staff were unaware of and that needed to be addressed or assessed. During an interview on 3/27/2026 at 10:00 a.m. with LVN 2, LVN 2 stated, she saw a note posted in Resident 1's room by a FM instructing staff to avoid touching his right arm (unable to recall date). LVN 2 stated she did not move or extend the arm to assess for pain. LVN 2 stated she did not call the FM to ask what the note was about and assumed the family just posted it. LVN 2 stated she did not call the doctor to inform about the posted note or complete a change of condition (COC) report. LVN 2 stated that if Resident 1's right arm was in pain, staff should have performed assessment, asked for the pain level, provide medication, report it to the doctor, and complete a COC. LVN 2 stated that leaving Resident 1 in pain could cause discomfort and possible anxiety. During an interview on 3/27/2026 at 2:00 p.m. with the Director of Nursing (DON), the DON stated the sign posted on the wall in Resident 1's room was related to the right arm, that was contracted. The DON stated the Charge Nurses were responsible for completing a COC when a report was made by the CNA that Resident 1 complained of pain. The Registered Nurses (RNs) were to assess Resident 1's arm and notify the doctor. The DON stated the risk when a resident was left in pain included increased heart rate, elevated respirations, and anxiety. During a review of P&P titled Certified Nursing Assistance, which states that CNAs must inform the Nurse Supervisor/Charge Nurse of any change in a resident's condition so that appropriate information can be entered into the resident's care plan. During a review of the P&P titled Pain Assessment and Management, dated 10/2022, the P&P indicated its purpose to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&P indicated to assess the potential for pain, recognize the presence of pain, identify the characteristics of pain, address the underlying causes of the pain, develop and implement approaches to pain management, monitor the effectiveness of interventions and modify approaches as necessary. Acute pain or significant worsening of chronic pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.

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	03/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Certified Nursing Assistants (CNA) 1 and 2 implemented the Enhanced Barrier Precautions (EBP, an approach to the use of personal protective equipment [PPE] to decrease transmission of multidrugˆresistant organisms [MDROs] when contact precautions do not apply) when providing care to two of five sampled residents (Residents 2 and 3). This deficient practice had the potential to the transmission of diseaseˆcausing MDROs to other residents, staffs and visitors in the facility, affecting the health conditions and causing infections, hospitalization or death. Findings: 1). During an observation on 3/26/2026 at 10:00 a.m., an isolation cart and an EBP sign were observed at the entrance of Resident 2's room. CNA 1 entered Resident 2's room without wearing an isolation gown (a personal protective equipment) and assisted Resident 2 with ADL care. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and re admitted on [DATE]. Resident 2's diagnoses included chronic respiratory failure (a long-term condition where the lungs cannot adequately oxygenate the blood or remove carbon dioxide), Chronic Obstructive Pulmonary Disease (COPD, a progressive, irreversible lung disease, that restricts airflow, causing severe breathing difficulties, chronic cough, and fatigue) and dependence on respirator ventilator status (patient's inability to sustain spontaneous breathing, requiring long-term mechanical ventilation [life support machine]). During a review of Resident 2's History and Physical (H&P) dated 2/21/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Residents 2's Minimum Data Set (MDS - a resident assessment tool) dated 1/13/2026, the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 was dependent on staff with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 2's Care Plan titled, Altered bladder elimination due to incontinence, dated 10/23/2025, the care plan indicated to implement enhance barrier precaution. 2). During an observation on 3/26/2026 at 10:20 a.m., an isolation cart and an EBP sign were observed at the entrance of Resident 3's room. CNA 2 was in Resident 3's room without wearing an isolation gown while providing ADL care to Resident 3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re admitted on [DATE]. Resident 3's diagnoses included chronic respiratory failure, Parkinson Disease (a progressive, incurable neurodegenerative disorder affecting dopamine-producing neurons in the brain, causing motor issues like tremors, bradykinesia (slowness), rigidity, and postural instability) and dependence on respirator ventilator status. During a review of Resident 3's H&P dated 11/7/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Residents 3's MDS dated [DATE], the MDS indicated Resident 3 had severe cognitive impairment. The MDS indicated Resident 3 required dependent assistance with ADLs such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 3's Physicians Orders dated 12/16/2025, the physician's order indicated EBP related to gastrostomy tube (GT- a surgical opening in the stomach for nutrition and medication administration) and tracheostomy (Trach, a surgical opening in the neck for an airway). Apply EBP to prevent spread of infection for specific care activities such as toileting, changing incontinent briefs. During a review of Resident 3's Care Plan titled, Altered incontinence of bowel incontinent of bladder,, dated 1/4/2026, the care plan indicated to implement EBP. During an interview on 3/26/2026 at 10:30 a.m., CNA 1 stated the blue sign that was posted at the door indicated a gown should be used before providing ADL care to the resident for infection control prevention. During a concurrent observation and interview on 3/26/2026 at 10:35 a.m., CNA 2 stated she was not wearing a gown inside Resident 3's room which had the EBP sign posted outside the room. CNA 2 stated a gown should be worn because it is for infection control and protection. During an interview on 3/27/2026 at 1:17 p.m. with Licensed Vocational Nurse (LVN) (continued on next page)

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	555340	A. Building B. Wing	03/27/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3, LVN 3 stated EBP includes the use of a gown, mask, and gloves before providing care for infection control and preventing the transmission of MDROs to other residents. During a review of the facility's Policies and Procedures (P&P) titled, Enhanced Barrier Precaution, dated 6/20/2024, the P&P indicated, the facility staff should don (put on) gowns and gloves before performing high-contact residents' activities like bathing/showering, providing hygiene and changing briefs or assisting with toileting.