

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 02/21/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>During an interview and record review the facility failed to:</p> <p>1. Ensure one out of six sampled residents (Resident 69) Physician Orders for Life-Sustaining Treatment ([POLST] - a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) was completed.</p> <p>This deficient practice of not completing the POLST for Resident 69 placed the resident at risk for not receiving goods and services based on their needs.</p> <p>Findings:</p> <p>During a review of Resident 69's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 69's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 69's History and Physical (H&P), dated 3/8/2024, the H&P indicated, Resident 69 had the capacity to understand and make decisions.</p> <p>During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool), dated 12/3/2024, the MDS indicated Resident 69's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 69 required partial assistance from staff for showering, dressing, and personal hygiene.</p> <p>During a review of Resident 69's POLST, dated 3/7/2024, the POLST indicated part D was incomplete.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/19/2025 at 1:00 p.m. with Registered Nurse (RN) 3, the POLST, dated 3/7/2024 was reviewed. The POLST indicated part D was incomplete. RN 3 stated the POLST part D was incomplete, and it was unclear if Resident 69 had an advance directive or not. RN 3 stated all the nurses are responsible for filling out the POLST. RN 3 stated part D does not indicate if Resident 69 had an advance directive (a legal document indicating resident preference on end-of life treatment decisions). RN 3 stated once Resident 69 was admitted we are to identify her medical wishes. RN 3 stated it was important complete part D so we know what the resident wishes will be after a change of condition.</p> <p>During a review of facility policy and procedure (P&P) titled, Advance Directive, dated 9/2022, the P&P indicated the residents has the right to formulate an advance directive. The P&P indicated if the resident does not have an Advance Directive information about whether or not the resident has executed an advance directive is displayed in the medical record in a section retrievable by any staff.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042</p> <p>Based on observation and interview, the facility failed to:</p> <p>1. Ensure a comfortable sound level, when staff was setting off the alarm when exiting the emergency door for two of 19 sampled residents (Residents 33 and 56).</p> <p>This deficient practice resulted in Resident 33 and 56 feeling annoyed and not being able to sleep or rest.</p> <p>Findings:</p> <p>a. During a review of Resident 33's Admission Record, dated 2/20/2025, the Admission Record indicated, Resident 33 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 33's diagnoses included cellulitis (a skin infection that causes swelling and redness) to right and left leg, chronic kidney disease (CKD-condition which the kidneys are damaged and cannot filter blood as well as they should), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>A review of Resident 33's Minimum Data Set (MDS-a resident assessment tool), dated 12/24/2024, the MDS indicated the resident was assessed to have a clear cognition in daily decision making. The MDS indicated Resident 33 required moderate assistance from staff for activities of daily living (ADLs) such as toileting, personal hygiene, and showering.</p> <p>b. During a review of Resident 56's Admission Record, dated 2/20/2025, the Admission Record indicated, Resident 56 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 56's diagnoses included cardiomegaly (An enlarged heart), anxiety disorder (persistent and excessive worry that interferes with daily activities), anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 56's History and Physical (H&P), dated 10/27/24, the H&P indicated Resident 56 did have the capacity to understand and make decisions.</p> <p>During a review of Resident 56's Minimum Data Set (MDS-a resident assessment tool), dated 11/26/2024, the MDS indicated the resident was assessed to have a clear cognition in daily decision making. The MDS indicated Resident 56 required moderate assistance from staff for activities of daily living (ADLs) such as toileting, personal hygiene, and dressing.</p> <p>During a concurrent observation and interview on 2/18/2025 at 10:20 a.m., with Resident 33 in the resident's room, the exit door alarm went off frequently. On 2/18/2025 while interviewing Resident 33 the door alarm was heard at 10:20 a.m., 10:25 a.m., 10:28 a.m., and 10:36 a.m. Resident 33 stated the door alarm was constantly going off during the day and into the night. Resident 33 stated the ringing is annoying. Resident 33 stated the alarm sometimes would wake me up.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/20/2025 in the hallway next to room [ROOM NUMBER] and the exit door, the staff would go out with carts of the door setting off the alarm when they exited and entered. The alarm was heard at 9:39 a.m., 9:54 a.m., 10:05 a.m., 10:58 a.m., 11:59 a.m., 12:01 p.m., 12:15 a.m., 12:16 p.m.</p> <p>During an interview on 2/20/2025 at 12:21 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the alarm did go off all day. LVN 1 stated the staff had to use that door go out to take carts out and to get the shower chairs. LVN 1 stated it would not be good to hear the alarm all day. LVN 1 stated residents could potentially get woken up by the alarm and get annoyed that it went off so often.</p> <p>During an interview on 2/20/2025 at 12:30 p.m., with Resident 56, Resident 56 stated that the alarm went off all day long. Resident 56 stated it was very annoying to hear that noise all day.</p> <p>During an interview on 2/20/2025 at 12:35 p.m., with the Director of Nursing (DON), the DON stated the alarms went off every time the door was opened. The DON stated this door is used to get the shower chairs that are outside, to take carts and to get to the trash bins. The DON stated the alarm going off so much was annoying. The DON stated this would affect the resident by possibly making them feel annoyed and not able to sleep.</p> <p>During a review of the policy and procedure (P&P) titled, Quality of Life - Homelike Environment, dated May 2017, the P&P indicated, residents are provided with safe, clean, comfortable and homelike environment. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include comfortable noise levels.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on interview and record review the facility failed to ensure one out of six sampled residents (Resident 69) was accurately assessed for smoking.</p> <p>This deficient practice had the potential for the facility to not develop and implement an individualized plan of care for resident 69.</p> <p>Findings:</p> <p>During a review of Resident 69's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 69's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 69's History and Physical (H&P), dated 3/8/2024, the H&P indicated, Resident 69 had the capacity to understand and make decisions.</p> <p>During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool), dated 12/3/2024, the MDS indicated Resident 69's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 69 required partial assistance from staff for showering, dressing, and personal hygiene.</p> <p>During an observation on 2/19/2025 at 10:30 a.m. Resident 69 outside on patio smoking.</p> <p>During a review of Resident 69's MDS, dated [DATE] there was no indication that Resident 69 currently used tobacco.</p> <p>During a concurrent interview and record review on 2/20/2025 at 12:24 p.m. with Minimum Data Set (MDS) Nurse, Resident 69's MDS, dated [DATE] was reviewed. The MDS indicated Resident 69 currently was not using tobacco. The MDS Nurse stated the MDS was coded that Resident 69 was not using tobacco, yet she does smoke. The MDS Nurse stated the MDS is updated annually, quarterly, and could be modified. The MDS Nurse stated the MDS needed to be coded accurately to assess the resident to prevent harm while smoking and when using oxygen.</p> <p>During a review of facility's policy and procedure (P&P) titled, Resident Assessment Instrument, date unknown, the P&P indicated this facility to establish an organized Resident Assessment Instrument (RAI) process based on the needs of the Resident. The P&P indicated the facility will utilize and apply the most updated RAI guidelines related to administrative, clinical, compliance requirement on resident assessment, care planning, and resource utilization. The P&P indicated the MDS Nurse will be responsible to update assessment schedule manually or electronically for reference.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47042</p> <p>Based on interview and record review the facility failed to:</p> <p>1. Ensure a care plan (the process of identifying a patient's needs and facilitating holistic care and ensures collaboration among nurses, patients, and other healthcare providers) was formulated for one of 19 sampled residents (Residents 76).</p> <p>This failure placed Resident 19 at risk of not having his care needs met.</p> <p>Findings:</p> <p>During a review of Resident 76's Admission Record, dated 2/20/2025, the Admission Record indicated, Resident 76 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 76's diagnoses included chronic respiratory failure with hypoxia (a serious condition where the lungs can't get enough oxygen into the blood), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).</p> <p>During a review of Resident 76's History and Physical (H&P), dated 7/5/2024, the H&P indicated Resident 76 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 76's Minimum Data Set ([MDS], a resident assessment tool), dated 2/7/2025, the MDS indicated the resident was assessed to have severely impaired cognition in daily decision making. The MDS indicated Resident 76 required dependent assistance from staff for activities of daily living (ADLs) such as toileting, showering, and dressing.</p> <p>During a concurrent interview and record review, on 5/9/2024 at 1:05 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated care plans were initiated upon admission and with any residents' change of condition. LVN 1 stated care plans were guides on the care a resident should have. LVN 1 stated there should have been a care plan for the use of hand mittens. LVN 1 stated a care plan not completed was as if staff only did half the care for the resident. LVN 1 stated we may not have followed all the interventions for the total care of the resident.</p> <p>During a concurrent interview and record review on 2/20/2025 at 2:20 p.m., with Registered Nurse (RN) 2, Resident 76's electronic medical record, care plan was reviewed. There was no care plan for the hand mittens or restraints. RN 2 stated there was not a care plan for the use of hand mittens or restraints. RN 2 stated a care plan should have been created for the hand mittens. RN 2 stated a care plan was to show the interventions needed to achieve resident goals. RN2 stated if a care plan was not completed, potentially a resident's goals would not be met.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/21/2025 at 10:45 a.m., with the Director of Nursing (DON), the DON stated care plans were to implement the plan of care to meet the resident's needs. The DON stated the staff incorporated the goals and interventions for the resident. The DON stated a care plan was needed when a resident had restraints. The DON stated if a care plan was not developed the needs of the residents may not be met.</p> <p>During a review of the policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated December 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 is developed and implemented for each resident.</p> <p>During a review of the policy and procedure (P&P) titled, Use of Restraints, dated April 2017, the P&P indicated, Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptoms(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on observation, interview, and record review the facility failed to:</p> <p>1. Ensure one out of six sampled residents (Resident 69) had a revised care plan (a previously established care plan for a patient that has been updated to reflect changes in their condition, needs, or response to treatment) to wear protective gear while smoking.</p> <p>This deficient practice had the potential to place the Resident at risk burns.</p> <p>Findings:</p> <p>During a review of Resident 69's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 69's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 69's History and Physical (H&P), dated 3/8/2024, the H&P indicated, Resident 69 had the capacity to understand and make decisions.</p> <p>During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool), dated 12/3/2024, the MDS indicated Resident 69's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 69 required partial assistance from staff for showering, dressing, and personal hygiene.</p> <p>During an observation on 2/19/2025 at 10:30 a.m. Resident 69 was on the patio smoking a cigarette without protective gear.</p> <p>During a review of Resident 69's care plan titled, Resident wishes to smoke and is designated as an impaired smoker, dated 3/6/2024, the care plan indicated Resident 69 needs the following while smoking 1. Observation 2. Constant supervision and 3. Protective gear. The care plan did not indicate under interventions for Resident 69 to wear protective gear.</p> <p>During a concurrent interview and record review with Registered Nurse (RN) 3, the care plan titled, Resident wishes to smoke and is designated as an impaired smoker, dated 3/6/2024 was reviewed. The care plan indicated Resident 69 needs the following while smoking 1. Observation 2. Constant supervision and 3. Protective gear. The care plan did not indicate under interventions for Resident 69 to wear protective gear. RN 3 stated the protective gear would be an apron to protect the resident from accidents to prevent burns while smoking. RN 3 stated the care plan was to be revised every three months. RN 3 stated Resident 69 had refused to wear the protective gear while smoking. RN 3 stated when the resident was non-complaint that was a change, and the care plan should be revised to reflect the refusal of not wearing the protective gear.</p> <p>(continued on next page)</p>		

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<p>F 0657</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 policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated to identify problem areas and their causes, and developing interventions that are targeted and meaningful to the resident. The P&P indicated assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on observation, interview, and record review the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure one out of six sampled residents (Resident 6) had heel protectors on while lying in bed. <p>This had the potential of Resident 6 not receiving the appropriate care and services.</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included metabolic encephalopathy (a brain dysfunction that occurs due to an imbalance of chemicals in the blood), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 6's History and Physical (H&P), dated 10/30/2024, the H&P indicated, Resident 6 had limited capacity.</p> <p>During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 6's rarely had the ability to understand. The MDS indicated Resident 6 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 6 was at risk of pressure injury (localized, pressure-related damage to the skin and /or underlying tissue usually over a bony prominence).</p> <p>During a review of Resident 6's physician orders titled, Order Summary Report, dated 12/26/2023, the Order Summary Report indicated, Resident 6 was to have heel protectors on while in bed for skin management (the care of the skin to promote healing and prevent infection).</p> <p>During an observation on 2/18/2025 at 4:35 p.m. Resident 6 was not wearing heel protectors while lying in bed.</p> <p>During a concurrent observation and interview on 2/20/2025 at 10:53 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 6's room, Resident 6 was lying in bed with no heel protectors on heels. LVN 4 stated there were no heel protectors on Resident 6 and there were no heel protectors in Resident 6's room. LVN 4 stated the heel protectors were to prevent the resident from rubbing her heels on the sheets and to prevent pressure on her legs when she crossed her legs. LVN 4 stated not having the heel protectors on while the resident was lying in the bed could cause the resident to have pressure sores (areas of damage to the skin and the underlying tissue caused by constant pressure or friction) on the heels.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility's policy and procedure (P&P) titled, Support Surface Guidelines, dated 9/2013, the P&P indicated the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. The P&P indicated redistributing support surfaces are to promote comfort for all bedbound or chair bound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction.</p>

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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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> Ensure one of seven sampled residents (Resident 9) received supervision while smoking <p>This deficient practice had the potential to result in Resident 9 being injured while smoking.</p> <ol style="list-style-type: none"> Ensure the entrance and exit doors were monitored to prevent the resident from leaving the facility unattended. <p>This deficient practice had the potential for a resident to sustain an accidental injury while outside the facility's premises without staff supervision.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), dementia (a progressive state of decline in mental abilities), and congestive heart failure ([CHF]-a heart disorder which causes the heart to not pump the blood efficiently). <p>During a review of Resident 9's History and Physical (H&P), dated 9/29/2024, the H&P indicated Resident 9 has the capacity to understand and make decisions.</p> <p>During a review of Resident 9's Minimum Data Set ([MDS] a resident assessment tool) dated 2/5/2025, the MDS indicated Resident 9 needed supervision for showering, dressing the lower body, and performing personal hygiene.</p> <p>During a review of Resident 9's care plan, dated 1/22/2020, the care plan indicated Resident 9 required supervision while smoking. The care indicated the facility will supervise Resident 9 per the Smoking Assessment.</p> <p>During a review of Resident 9's Smoking Safety Evaluation, dated 2/5/2025, the evaluation indicated Supervision will be required for all Residents during designated smoking times. This evaluation will be utilized for the Resident's smoking care plan on admission and as indicated.</p> <p>During a review of the facility's Smokers Supervision Times form, (no date), the form indicated the daily smoking times are 8:30 a.m., 10:00 a.m., 2:00 p.m., 4:00 p.m., and 7:00 p.m. The form indicated there was a dedicated staff member assigned to supervise at the specified times.</p> <p>During an observation on 2/19/2025 at 1:58 p.m. on the smoking patio, Resident 9 was observed entering the patio with a cigarette in his hand. Resident 9 sat at the table, pulled a lighter from his pocket, and lit the cigarette. Resident 9 stated the cashier gives the cigarettes and he keeps his lighter. There were no staff on the patio supervising. Resident 9 left the patio at 2:03 p.m. after smoking the cigarette.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 2/19/2025 at 2:16 p.m. with the Activity Assistant (AA) on the smoking patio, the AA stated the smoking time started at 2:00 pm. The AA was observed entering the smoking patio at 2:16 p.m. The AA stated she was not on the patio at 2:00 p.m. because she was on her break. The AA stated her role is to supervise the residents and ensure they don't burn themselves. The AA stated since no staff were on the patio monitoring someone could have burned themselves.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safe Smoking-Resident, dated August 2022, the P&P indicated the facility will provide residents who wish to smoke the opportunity to do so with optimal safety of themselves and others.</p> <p>47042</p> <p>b. During an observation on 2/20/2025 at 12:17 p.m. in the hallway next to room [ROOM NUMBER] and the emergency exit door, staff would come in and out of the unlocked door. On the door there was a notice to keep door closed and locked at all times. The gate outside of the door was unlocked throughout the day.</p> <p>During a concurrent observation and interview on 2/20/2025 at 12:21 p.m., with Licensed Vocational Nurse (LVN) 1, at the door next to room [ROOM NUMBER] that exited to the outside gate. LVN 1 stated the door was kept unlocked during the day. LVN 1 stated this exit door is used by the staff. LVN 1 stated the door should be locked. LVN 1 stated the gate to the outside should always be locked. LVN 1 stated if both doors were unlocked it would be a safety issue. LVN 1 stated a resident could possibly leave the facility and get hurt.</p> <p>During a concurrent observation and interview on 2/20/2025 at 12:25 p.m., with the Dietary Supervisor (DS), outside side gate that led out to the street where the gate was unlocked. The DS stated that the gate was left unlocked. The DS stated the gate should always be locked. The DS stated if the gate had to be opened for any reason it should be locked as soon as the task is done. The DS stated if the gate was not locked it would be a safety concern, a resident could potentially leave the facility and get hurt.</p> <p>During an interview on 2/20/2025 at 12:35 p.m., with the Director of Nursing (DON), the DON stated we do not lock this exit door during the day, the staff used this door to take out the carts, the trash, and shower chairs. The DON stated the door did have a sign that showed to always keep door locked. The DON stated that the staff needed to use that specific door, it would be a lot if we kept unlocking the door. The DON stated the outside gate should always be locked. The DON stated if the gate was not locked it would be a safety issue. The DON stated a resident could possibly leave the facility and be harmed or have an accident.</p> <p>During a review of the policy and procedure (P&P) titled, safety and Supervision of Residents, dated December 2007, the P&P indicated, our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712</p> <p>Based on interview and record review, the facility failed to</p> <ol style="list-style-type: none"> 1. Provide appropriate intravenous (IV- a long thin catheter in the vein to deliver medications or fluids) care for one of three sampled residents (Resident 87) by not changing the IV dressing every 7 days and not changing the IV site every 72 hours as ordered. 2. Ensure one of three sampled resident's (Resident 5) intravenous line ([IV]- a thin, flexible tube inserted into a vein) site was labeled with the date/time of insertion. <p>These deficient practices had the potential for Resident 87 and Resident 5 to experience complications associated with having an IV.</p> <p>Findings:</p> <p>a. During a review of Resident 87's Face Sheet, it indicated Resident 87 was readmitted on [DATE] with diagnoses that included sepsis (a life-threatening blood infection), and urinary tract infection (UTI- an infection in the bladder/urinary tract).</p> <p>During a review of Resident 87's Order Summary Report, it indicated Resident 87 was prescribed Zosyn (an antibiotic) 3.375 grams (gm- a unit of measurement) to be administered via IV every 8 hours for sepsis for 10 days until 9/18/2024.</p> <p>During a review of Resident 87's IV Administration Record, dated 9/8/2024, an order indicated for the nurse staff to ensure the IV site is without signs and symptoms of complication and no adverse reaction and to restart the IV every 72 hours and as needed for complications and may extend the IV site for poor venous (vein) access.</p> <p>During a review of Resident 87's Minimum Data Set (MDS- a resident assessment tool), dated 2/7/2025, it indicated Resident 87 is rarely/never understood and has issues with short and long-term memory.</p> <p>During a review of Resident 87's care plan, dated 9/7/2024, it indicated Resident 87 would not have any complications related to IV therapy.</p> <p>During a record review with Registered Nurse (RN) 2, Resident 87's Nurses Notes were reviewed and were documented as follows:</p> <p>9/7/2024 9:15 p.m. Resident had IV lines on both arms</p> <p>9/8/2024 6:17 p.m. Resident noted with two IV sites on left and right arm.</p> <p>9/9/2024 3:22 p.m. Resident had IV lines on the back of the right hand.</p> <p>9/10/2024 6:58 a.m. Resident had IV lines on both arms.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9/11/2024 7:08 a.m. Resident had IV lines on both arms.</p> <p>9/11/2024 2:02 p.m. Resident had an IV line on the right forearm.</p> <p>9/13/2024 1:36 p.m. Resident had an IV line on the right forearm.</p> <p>9/14/2024 12:37 a.m. Resident had an IV line on the right forearm.</p> <p>9/14/2024 6:42 a.m. Resident had an IV line on the right forearm.</p> <p>9/15/2024 5:18 a.m. Resident had an IV line on the right forearm.</p> <p>9/16/2024 1:12 p.m. Resident had an IV line on the right forearm.</p> <p>9/17/2024 1:21 a.m. Resident had an IV line on the right forearm.</p> <p>9/17/2024 6:19 a.m. Resident had an IV line on the right forearm.</p> <p>9/18/2024 3:53 p.m. Resident had IV line intact.</p> <p>During an interview on 2/20/2025 at 11:05 a.m. with RN 2, RN 2 stated IV sites should be changed approximately every 7 days or as needed if there are complications with the IV. RN 2 stated Resident 87 should have their IV site changed every 72 hours per the order documented in the IV administration record. RN 2 stated there were no documentations that stated the IV site was changed, and therefore it wasn't done. RN 2 also stated there were no documentations that showed the nurse changed the transparent dressing on the IV site every 7 days as they typically do. RN 2 stated it is important to change the IV site and change the IV dressing to prevent infection or other complications.</p> <p>During a review of the facility's policy and procedure titled Peripheral Catheter Dressing Change, dated 2/2023, it indicated transparent dressings are changed each site rotation and/or at least every 7 days or if the integrity of the dressing is compromised.</p> <p>49131</p> <p>b. During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), dementia (a progressive state of decline in mental abilities), and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 5's History and Physical (H&P), dated 1/7/2025, the H&P indicated Resident 5 has the capacity to understand and make decisions.</p> <p>During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 2/5/2025, the MDS indicated Resident 5 was dependent on staff for toileting and dressing the lower body. Resident 5 needed substantial assistance showering and dressing the upper body.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 2/20/2025 at 11:03 a.m. with the Director of Staff Development (DSD), at the bedside of Resident 5, Resident 5's IV dressing was noted without an insertion date/time. The DSD stated the IV should be dated so staff will know when it was inserted so you know when it needs to be changed. You need to be able to monitor. The DSD stated if you leave the IV in too long it can cause an infection.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Peripheral Venous Catheter Insertion dated March 2023, the P&P indicated nurses will write the date, time, and initials on the dressing label after IV insertion.</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on interview and record review the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure one out of six sampled residents (Resident 6) staff followed physician orders. <p>This deficient practice had the potential to cause a delay in Resident's 6 plan of care.</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included metabolic encephalopathy (a brain dysfunction that occurs due to an imbalance of chemicals in the blood), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 6's History and Physical (H&P), dated 10/30/2024, the H&P indicated, Resident 6 had limited capacity.</p> <p>During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 6's rarely had the ability to understand. The MDS indicated Resident 6 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 6 was at risk of pressure injury (localized, pressure-related damage to the skin and /or underlying tissue usually over a bony prominence).</p> <p>During a review of Resident 6's physician orders titled, Order Summary Report, dated 12/26/2023, the Order Summary Reported indicated, Resident 6 was to have heel protectors on while in bed for skin management (the care of the skin to promote healing and prevent infection).</p> <p>During an observation on 2/18/2025 at 4:35 p.m. Resident 6 was not wearing heel protectors while lying in bed.</p> <p>During a concurrent observation, interview, and record review on 2/20/2025 at 10:47 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 6's room, Resident 6 was lying in bed with no heel protectors on heels. The Order Summary Report, dated 12/26/2023, was reviewed. The Order Summary Reported indicated, Resident 6 was to have heel protectors on while in bed for skin management. LVN 4 stated the physician orders does say to put the heel protectors on while lying in bed. LVN 4 stated its important to follow the physician orders because it's the physician who decides the skin treatment for the residents. LVN 4 stated the physicians orders needed to be followed to prevent skin breakdown.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician's Order-Recapping, dated 1/2020, the P&P indicated it is the policy of this facility to review all physician orders for accuracy on a monthly basis. The P&P indicated the Order Summary Report will be reviewed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48712</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Ensure a bottle of Pro-Stat (a liquid protein supplement) and drawer in medication cart #4 was free of a sticky substance.</p> <p>This deficient practice had the potential to result in cross contamination (movement of bacteria from one place to another) that could result in an infection.</p> <p>Findings:</p> <p>During a current observation and interview on 2/20/2025 at 7:41 a.m. with Licensed Vocational Nurse (LVN) 1 at medication cart #4, a bottle of Pro-Stat was found with a large amount of sticky spillage down the container. There was a plastic bag with another medication stuck to the Pro-Stat bottle. Pro-Stat was spilled inside the medication drawer. LVN1 stated, It's sticky, staff are supposed to clean it. LVN1 stated there could be cross contamination that can lead to infection.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated April 2007, the P&P indicated the nursing staff shall be responsible for maintaining storage and preparation areas in a clean and sanitary manner.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712</p> <p>Based on interview and record review, the facility failed to:</p> <p>1. Ensure one of four sampled residents (Resident 71) had a Depakote level (a blood test to check the amount of this drug in your body) completed on the first Monday of every month per physician's order. Depakote is a drug given to control seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).</p> <p>This deficient practice had the potential to result in Resident 71 not receiving appropriate dosing of his Depakote.</p> <p>Findings:</p> <p>During a review of Resident 71's Admission Record, the Admission Record indicated Resident 71 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and seizure.</p> <p>During a review of Resident 71's History and Physical (H&P), dated 9/3/2024, the H&P indicated Resident 71 had mental retardation and is non-verbal. The H&P indicated the plan of action was to order relevant labs to monitor the resident's overall health and specific conditions.</p> <p>During a review of Resident 71's Minimum Data Set ([MDS] a resident assessment tool) dated 2/11/2025, the MDS indicated Resident 71 was dependent on staff for showering, toileting, and dressing.</p> <p>During a review of Resident 71's care plan, dated 2/11/2025, the care plan indicated for recurrent seizures the facility would complete lab work as ordered and report abnormal results to the doctor.</p> <p>During a concurrent interview and record review on 2/20/2025 at 11:06 a.m. with Registered Nurse (RN) 1, Resident 71's medical record was reviewed. The record indicated on 12/26/2024 the physician entered an order to complete a Depakote level every 1st Monday of the month. RN1 stated the Depakote level was last completed on 1/6/2025. RN1 stated the next Depakote level should have been completed on 2/3/2025. The Depakote level was not completed on 2/3/2025. RN1 stated the Depakote level is ordered so you can monitor the level of the drug in the resident's system. The dose can be increased/decreased based on the level. If the level is too low the resident can have a seizure. If the level is too high the resident can have a negative outcome.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, dated November 2018, the P&P indicated the staff will arrange for tests. The nurse will try to determine whether the test was done to monitor a drug level.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131</p> <p>Based on interview, and record review, the facility failed to:</p> <p>1. Ensure one of three sampled residents (Resident 87) had documentation related to the insertion and discontinuation of the intravenous (IV- a long thin catheter in the vein to deliver medications or fluids) line.</p> <p>This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 87.</p> <p>Findings:</p> <p>During a review of Resident 87's Face Sheet, it indicated Resident 87 was readmitted on [DATE] with diagnoses that included sepsis (a life-threatening blood infection), and urinary tract infection (UTI- an infection in the bladder/urinary tract).</p> <p>During a review of Resident 87's Order Summary Report, it indicated Resident 87 was prescribed Zosyn (an antibiotic) 3.375 grams (gm- a unit of measurement) to be administered via IV every 8 hours for sepsis for 10 days until 9/18/2024.</p> <p>During a review of Resident 87's IV Administration Record, dated 9/8/2024, an order indicated for the nurse staff to ensure the IV site is without signs and symptoms of complication and no adverse reaction and to restart the IV every 72 hours and as needed for complications and may extend the IV site for poor venous (vein) access.</p> <p>During a review of Resident 87's Minimum Data Set (MDS- a resident assessment tool), dated 2/7/2025, it indicated Resident 87 is rarely/never understood and has issues with short and long-term memory.</p> <p>During a review of Resident 87's care plan, dated 9/7/2024, it indicated Resident 87 would not have any complications related to IV therapy.</p> <p>During a record review with Registered Nurse (RN) 2, Resident 87's Nurses Notes were reviewed and were documented as follows:</p> <p>9/7/2024 9:15 p.m. Resident had IV lines on both arms</p> <p>9/8/2024 6:17 p.m. Resident noted with two IV sites on left and right arm.</p> <p>9/9/2024 3:22 p.m. Resident had IV lines on the back of the right hand.</p> <p>9/10/2024 6:58 a.m. Resident had IV lines on both arms.</p> <p>9/11/2024 7:08 a.m. Resident had IV lines on both arms.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9/11/2024 2:02 p.m. Resident had an IV line on the right forearm.</p> <p>9/13/2024 1:36 p.m. Resident had an IV line on the right forearm.</p> <p>9/14/2024 12:37 a.m. Resident had an IV line on the right forearm.</p> <p>9/14/2024 6:42 a.m. Resident had an IV line on the right forearm.</p> <p>9/15/2024 5:18 a.m. Resident had an IV line on the right forearm.</p> <p>9/16/2024 1:12 p.m. Resident had an IV line on the right forearm.</p> <p>9/17/2024 1:21 a.m. Resident had an IV line on the right forearm.</p> <p>9/17/2024 6:19 a.m. Resident had an IV line on the right forearm.</p> <p>9/18/2024 3:53 p.m. Resident had IV line intact.</p> <p>During an interview on 2/20/2025 at 11:05 a.m. with RN 2, RN 2 stated Resident 87 does not have any IV's anymore. RN 2 stated Resident 87 was originally readmitted to the facility on [DATE] with an IV on both arms. RN 2 stated Resident 87 suddenly had an IV on the right hand on 9/9/2024 at 3:22 p.m. but there was no documentation prior to that in the medical records of when or who placed the IV in the right hand because the resident did not come with it. In addition, there was also no more mention of the IV in the right hand after 9/9/2024 so it was also unsure when the IV in the right hand was removed. RN 2 also stated that between the nurse's notes on 9/11/2024 at 7:08 a.m. and 9/11/2024 at 2:02 p.m., Resident 87 went from having an IV in both arms to only having an IV in the right forearm, and there was no documentation that the IV on the left arm was removed. RN 2 stated after 9/18/2024, there was no more documentation about the IV's and it is unknown when the IV on the right forearm was removed. RN 2 stated it is important for the nurses to document if they remove an IV or place a new IV because this is how you communicate to the other nurses what happened on the shift, and each documentation can tell the reader useful reader important information regarding the resident.</p> <p>During a review of the facility's policy and procedure titled Charting and Documentation, dated 7/2017, it indicated all services provided to the resident shall be documented in the resident's medical record. It also indicated treatments or services performed is to be documented and must be objective, complete, and accurate.</p>

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 02/21/2025
NAME OF PROVIDER OR SUPPLIER Marina Pointe Healthcare & Subacute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure two out of six sampled residents (Resident 67 and 147) nasal cannulas (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) were not dated and labeled. <p>This deficient practice of not dating and labeling the nasal cannulas placed Residents 67 and 147 at risk for respiratory infection (an infection affecting the nose, throat, sinuses, airways, and lungs).</p> <ol style="list-style-type: none"> 2. Ensure there were not two bags of opened and emptied bottles of water, sparkling water, iced coffee, fruit juice, and energy drinks in the laundry room next to a washing machine. <p>This deficient practice had the potential for attracting pests to the laundry room.</p> <p>a. During a review of Resident 67's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 67 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 67's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 67's History and Physical (H&P), dated 1/30/2025, the H&P indicated, Resident 67 had the d capacity to understand and make decisions.</p> <p>During a review of Resident 67's Minimum Data Set ([MDS] a resident assessment tool), dated 1/3/2025, the MDS indicated Resident 67's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 67 required moderate assistance on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 67 required respiratory treatment with oxygen therapy (providing a patient with supplemental oxygen, which is extra oxygen beyond what they can breathe from the air).</p> <p>During an observation on 2/18/2025 at 12:40 p.m., in Resident 67's room, the nasal cannula was attached to an oxygen tank on the wheelchair. The nasal cannula was not dated and labeled.</p> <p>During a concurrent observation and interview on 2/19/2025 at 12:29 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 67's room, Resident 67 had a nasal cannula not dated and labeled attached to an oxygen tank on his wheelchair.</p> <p>LVN 3 stated the nasal cannula was not dated and labeled. LVN 3 stated when the nasal cannula is not dated and labeled it places the resident at risk for an infection. LVN 3 stated Resident 67 at risk for inhaling dust or dirt which could build up over time and could put him at risk for respiratory infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b. During a review of Resident 147's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 147 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 147's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and pneumonia (an infection/inflammation in the lungs).</p> <p>During a review of Resident 147's History and Physical (H&P), dated 2/13/2025, the H&P indicated, Resident 147 could make needs known but cannot make medical decisions.</p> <p>During a review of Resident 147's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 147's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 147 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 147 required respiratory treatment with oxygen therapy.</p> <p>During an observation on 2/18/2025 at 12:45 p.m. in Resident 147's room, the nasal cannula was not dated and labeled.</p> <p>During a concurrent observation and interview on 2/19/2025 at 12:39 p.m. with Licensed Vocational Nurse (LVN) 3, in Residents 147's room, Resident 147's nasal cannula was not dated and labeled. LVN 3 stated Resident 147's nasal cannula had condensation (water which collects as droplets) build up inside the nasal cannula. LVN 3 stated the condensation trapped in the nasal cannula could potentially create trapped bacteria and place the resident at risk for a respiratory infection.</p> <p>During a review of facility's policy and procedure (P&P) titled, Oxygen administration (Mask, Cannula, Catheter), dated 12/2016, the P&P indicated the purpose of the oxygen therapy was to provide sufficient oxygen to the blood stream and tissues. The P&P indicated oxygen tubing is to be replaced every seven days.</p> <p>49131</p> <p>c. During a review of Resident 147's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 147 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 147's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), respiratory failure (when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly), and pneumonia (an infection/inflammation in the lungs).</p> <p>During a review of Resident 147's History and Physical (H&P), dated 2/13/2025, the H&P indicated, Resident 147 could make needs known but cannot make medical decisions.</p> <p>During a review of Resident 147's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 147's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 147 was dependent on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 147 required respiratory treatment with oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 2/18/2025 at 12:45 p.m. in Resident 147's room, the nasal cannula was not dated and labeled.</p> <p>During a concurrent observation and interview on 2/19/2025 at 12:39 p.m. with Licensed Vocational Nurse (LVN) 3, in Residents 147's room, Resident 147's nasal cannula was not dated and labeled. LVN 3 stated Resident 147's nasal cannula had condensation (water which collects as droplets) build up inside the nasal cannula. LVN 3 stated the condensation trapped in the nasal cannula could potentially create trapped bacteria and place the resident at risk for a respiratory infection.</p> <p>During a review of facility's policy and procedure (P&P) titled, Oxygen administration (Mask, Cannula, Catheter), dated 12/2016, the P&P indicated the purpose of the oxygen therapy was to provide sufficient oxygen to the blood stream and tissues. The P&P indicated oxygen tubing is to be replaced every seven days.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Ensure residents in rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 23, 34, 35, 36, 38, and 40 had at least 80 sqft of living space.</p> <p>This deficient practice had the potential to result in residents not being able to move around freely or store personal items. Staff may also have difficulty providing care due to a lack of space.</p> <p>Findings:</p> <p>During a review of the Client Accommodation Analysis, dated 2/19/2025, the analysis indicated the facility had the following room measurements:</p> <p>Room # # of beds Floor square footage</p> <p>1 3 235</p> <p>2 3 235</p> <p>3 3 235</p> <p>4 3 235</p> <p>5 3 235</p> <p>6 3 235</p> <p>7 3 235</p> <p>8 3 235</p> <p>9 3 235</p> <p>10 3 235</p> <p>11 3 235</p> <p>12 3 235</p> <p>13 3 235</p> <p>14 3 235</p> <p>(continued on next page)</p>

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F 0912	15 3 235
Level of Harm - Potential for minimal harm	16 3 235
Residents Affected - Some	17 3 235
	18 3 235
	19 3 235
	20 2 245
	21 3 235
	22 2 245
	23 3 235
	24 2 245
	25 2 245
	26 2 245
	27 2 245
	28 2 245
	29 2 245
	30 2 245
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	34 3 235
	35 3 235
	36 3 235
	37 1 244
	38 2 235
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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>39 3 244</p> <p>40 3 244</p> <p>During a review of the Room Variance Waiver request letter, dated 2/20/2025, the letter indicated rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 23, 34, 35, 36, 38, and 40 measure 235 sqft. The letter indicated the required room size is 240 sqft.</p> <p>During an observation on 2/21/2025 at 11:00 a.m., rooms [ROOM NUMBERS] were noted to contain 3 beds.</p> <p>During an interview on 2/21/2025 at 11:16 a.m. with the Administrator (Adm), the Adm stated the smaller room size could have a psychosocial effect on the resident. A smaller room can affect resident safety and comfort.</p>