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	04/24/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure informed consent was completed with all required elements for two of six sampled residents (Resident 2 and Resident 30).This deficient practice has the potential to result in residents receiving treatments or interventions without understanding the risks, benefits, or alternatives.Findings:During a review of Resident 2's admission record, the admission record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included anoxic brain damage (brain damage happens when the brain does not get any oxygen at all causing the brain cells to become injured or die), Type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (too much fat in the blood).During a review of Resident 2's History and Physical (H&P) dated 4/18/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 1/20/2026, the MDS indicated Resident 2's cognition (thought process) was severely impaired and never/rarely made decisions. The MDS indicated Resident 2 was dependent (helper does all of the effort) on staff for all activities of daily living and mobility.During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses including heart failure (heart is too weak or too stiff to pump blood the way it should), pneumonia (an infection, inflammation in the lungs), and epilepsy (condition where a person has repeated seizures caused by sudden bursts of abnormal electrical activity om the brain).During a review of Resident 30's H&P dated 3/31/2026, the H&P indicated Resident 30 had the capacity to understand and make decisions.During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 was able to sometimes understand and be understood by others. The MDS indicated Resident 30's cognition was severely impaired. The MDS indicated Resident 30 was dependent on staff for activities of daily living such as dressing and toileting hygiene and mobility.During a concurrent interview and record review on 4/21/2026 at 2:12 p.m. with Licensed Vocation Nurse (LVN) 1, Resident 2's and Resident 30's medical records were reviewed. LVN 1 stated the informed consent forms for ventilator (a medical device to help support or replace breathing), tracheostomy (a surgically created hole in the windpipe to create a direct airway for breathing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) lacked the physician's name and date.During a concurrent interview and record review on 4/24/2026 at 10:05 a.m. with the Director of Nursing (DON), Resident 2's and Resident 30's consent forms were reviewed. The DON stated Resident 2's and Resident 30's informed consent forms were incomplete and missing the physician's name and date, however staff changed the consent forms by adding the physician's signature and backdated to 4/16/2026. The DON stated completed informed consent forms are necessary to inform Resident 2 and Resident 30 and their responsible parties of the risks and benefits of the recommended treatment. The DON stated an incomplete informed consent fails to provide this information and may place Resident 2 and Resident 30 at risk if treatment was given without the physician's knowledge and understanding.During a review of the facility's policy and procedure (P&P) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Informed Consent, undated, indicated it was the responsibility of the healthcare professional who proposes any medical intervention or treatment that required informed consent to provide information to the resident/resident representative regarding the resident's condition and circumstances that are pertinent to a decision to accept or refuse the proposed intervention treatment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of four sampled residents' (Residents 95 and 109) call light was placed within reach.This deficient practice had the potential for Residents 95 and 109 not to be able to call for assistance and delay the assistance needed.Findings: During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 95's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis affecting one side of the body), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities.)During a review of Resident 95's History and Physical (H&P) dated 12/1/2025, the H&P indicated Resident 95 did not have the capacity to understand and make medical decisions.During a review of Resident 95's Minimum Data Set (MDS, a resident assessment tool) dated 2/3/2026, the MDS indicated Resident 95 had the ability to make self-understood and the ability to understand others. The MDS indicated Resident 95 was dependent on a helper for oral hygiene, toileting hygiene, showering/bathing, and upper and lower body dressingDuring a review of Resident 95's Care Plan Report dated 4/15/2025, the care plan indicated to ensure the resident's call light was within reach. During a review of Resident 109's admission Record, the admission record indicated Resident 109 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a chronic lung disease causing difficulty in breathing), Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia.During a review of Resident 109's H&P dated 4/19/2026, the H&P indicated Resident 109 did not have the capacity to understand and make decisions.During a review of Resident 109's MDS dated [DATE], the MDS indicated Resident 109 rarely/never made self-understood or had the ability to understand others.During a review of Resident 109's Care Plan Report dated 4/7/2026, the care plan indicated to ensure the resident's call light was within reach.During a concurrent observation and interview on 4/21/2026 at 9:39 am, in Resident 109's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the call light is not within reach for the resident if it is on the floor. Resident 109 could fall out of bed reaching for it or be in distress and we might not hear him call.During a concurrent observation and interview on 4/21/2026 at 9:41 am, in Resident 95's room with CNA 1, CNA 1 stated the call light is not within reach for the resident if it is on the floor. We would not be able to assist her if she cannot call for help.During a review of the facility's Policy and Procedure (P&P) titled Call Lights: Accessibility and Timely Response revised 10/2025, the P&P indicated staff should facilitate call light placement within reach of resident and secure it as needed.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 5) had a completed Physician Orders for Life-Sustaining Treatment (POLST) form, when the POLST form did not include a resident or responsible party signature.This failure had the potential to result in the resident's treatment preferences and wishes not being known or honored in the event of an emergency.Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 5's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 5's History and Physical (H&P), dated [DATE], the H&P indicated Resident 5 did not have the capacity to understand and make decisions.During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 5's cognition (process of thinking) was moderately impaired.During a review of Resident 5's physician's order dated [DATE], the physician order indicated do not resuscitate (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR-an emergency lifesaving procedure performed when the heart stops beating or breathing ceases] if breathing stops or the heart stops beating).During a review of Resident 5's POLST form dated [DATE], the POLST form indicated there were no signatures by the resident or responsible party. The POLST form indicated there were two initials at the bottom of the form.During an interview on [DATE] at 10:43 a.m. with Resident 5 in her room, Resident 5 stated she did not have knowledge of POLST form and had not seen such form. Resident 5 stated her family member (FM 1) oversaw her care.During a concurrent interview and record review on [DATE] at 10:50 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 5's POLST form, dated [DATE], was reviewed. LVN 1 stated there was no resident or responsible party signature on the POLST form. LVN 1 stated FM 1 consents and signs forms for Resident 5. LVN 1 stated if residents are found pulseless, facility staff looks in the chart for a POLST form to determine whether to perform CPR or not.During a concurrent interview and record review on [DATE] at 10:59 a.m. with Registered Nurse (RN) 2, Resident 5's POLST form, dated [DATE], was reviewed. RN 2 stated resident's responsible party may sign POLST form if the resident was not able to sign. RN 2 stated verbal consent was obtained via phone, and the POLST form was initialed by two licensed staff in place of the responsible party's signature.During a phone interview on [DATE] at 11:12 a.m. with FM 1, FM 1 stated Resident 5 spoke about becoming DNR but did not sign a POLST form. FM 1 stated the resident does not sign paperwork unless she (FM 1) is present. FM 1 reported she had not signed the POLST and denied having any phone discussion with facility staff regarding DNR options. FM 1 stated she did not give verbal consent for staff to sign the POLST on behalf of herself or Resident 5, adding this is a sensitive topic and she only signs documents in person.During an interview on [DATE] at 12:31 p.m. with the Social Services Assistant (SSA), the SSA stated the POLST form is a legal document and should be signed by the resident or responsible party to confirm accuracy.During a concurrent interview and record review on [DATE] at 1:08 p.m. with Director of Nursing (DON), Resident 5's POLST dated [DATE] was reviewed. The Completing POLST instructions indicated to be valid, a POLST form must be signed by the patient or decisionmaker. The DON stated POLST and DNR status are reviewed upon admission, and without a resident or responsible party signature, the POLST is incomplete and the resident is treated as full code (full life-saving measure in case of an emergency). The DON stated phone consent and having two nurses sign the POLST is not allowed, and there is no facility policy permitting this.During a review of the facility's policy and procedure (P&P) titled, Informed Consent, dated 2023, the P&P indicated, When (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated

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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 ensure care plans were developed for two of four sampled residents (Resident 73 and 97) when there were no care plans for Resident 73's diagnoses of anxiety (persistent and excessive worry that interferes with daily activities), Alzheimer's Disease (progressive mental deterioration) major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly) and Resident 97's diagnoses of anxiety, major depressive disorder, and bipolar disorder.These deficient practices had the potential to result in delayed care and services for Resident 73's and Resident 97's health.Findings:During a review of Resident 73's admission Record, the admission record indicated Resident 73 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 73's diagnoses included anxiety, Alzheimer's Disease, and bipolar disorder.During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) dated 2/2/2026, the MDS indicated Resident 73's cognition (process of thinking) was severely impaired. The MDS indicated Resident 73 required substantial/maximal assistance (helper does more than half the effort) for showering/bathing, lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 97's admission Record, the admission record indicated Resident 97 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 97's diagnoses included anxiety, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder.During a review of Resident 97's H&P dated 11/12/2025, the H&P indicated Resident 97 had the capacity to understand and make decisions.During a review of Resident 97's MDS dated [DATE], the MDS indicated Resident 97's cognition was moderately impaired. The MDS indicated Resident 97 required setup or clean-up assistance from staff for eating, oral hygiene, toileting hygiene, and personal hygiene.During a concurrent interview and record review on 4/23/2026 at 12:07 p.m. with the Director of Nursing (DON), the care plans for Resident 73 and Resident 97 were reviewed. The DON stated the residents should have care plans for behavioral diagnoses. The DON stated without a care plan, the interventions for the diagnoses would be delayed and staff would not know what the goals for that resident were. The DON stated staff needed to know what non-pharmacological interventions to try.During a review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated the comprehensive, person-centered care plan would incorporate identified problem areas and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a humidifier to the oxygenator machine for one out of one sampled resident (Resident 49).This failure had the potential to allow mucous to thicken, dry, and create a mucous plug and block oxygen to the lungs.Findings:During a review of Resident 49's admission Record, the admission Record indicated Resident 49 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 49's diagnoses included chronic respiratory failure with hypoxia (long term, gradual, progressive condition where the lungs cannot adequately transfer oxygen to the blood, resulting in persistently low blood oxygen levels), tracheostomy (a surgical procedure that creates an opening in the neck for a tube to be inserted directly into the windpipe to help with breathing), and dysphagia (difficulty swallowing).During a review of Resident 49's History & Physical (H&P), dated 3/5/2026, the H&P indicated Resident 49 did not have the capacity to understand and make decisions.During a review of Resident 49's physician orders, dated 3/3/2026, the physician orders indicated to change the humidifier every night shift every Monday, Wednesday, Friday, and place on humidified O2 (oxygen) at 2 liters per minute via T-piece (a T shaped medical device connected to tracheostomy tubes to deliver oxygen to spontaneously breathing patients) every day and night shift.During a review of Resident 49's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 49's cognition (process of thinking) was severely impaired. The MDS indicated Resident 49 was dependent (helper does all of the effort) on staff for all activities of daily living and mobility.During a concurrent observation and interview on 4/21/2026 at 11:17 a.m., in Resident 49's room with the Respiratory Therapist (RT 1), Resident 49's oxygenator did not have a humidifier attached. RT 1 stated the resident has been at the facility since 10/2025 and there was no order for a humidifier. RT 1 stated that if the air from the oxygenator was not humidified, the secretions could dry up and if the resident was unable to cough up the secretions, a mucous plug could develop.During an interview with the Director of Nursing (DON) on 4/24/2026 at 11:35 a.m., the DON stated a humidifier should be used when residents are on an oxygenator and if a humidifier was not used, the secretions would thicken and can become stuck. The DON stated the dryness can cause discomfort.During a review of the facility's policy and procedure (P&P) titled Oxygen Concentrator, dated 2022, the P&P indicated oxygen was administered under orders of the attending physician, except in the case of an emergency and to attach disposable humidifier to the concentrator, if indicated.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient numbers of nursing aides were available on weekends to provide nursing care to 10 out of 10 sampled residents in accordance with resident care plans and assessed needs.This deficient practice has the potential to result in delayed or missed care, including delays in assistance with activities of daily living (ADL, activities such as bathing, dressing and toileting a person performs daily), timely response to call lights, increased risk for falls, skin breakdown, and decreased psychosocial well-being. Findings: During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 8's diagnoses included hemiplegia and hemiparesis following cerebral infarction (loss of strength and paralysis on one side of a body following a stroke [death of brain tissue caused by a sudden lack of oxygen and nutrients]), a stage 4 pressure ulcer at the sacral region (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and is dependent on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 8's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 8 was dependent (helper does all of the effort) on staff for toileting hygiene, standing, sitting, and transferring from bed to chair. During an interview on 4/21/2026 at 11:06 a.m., with Resident 8, Resident 8 stated the facility is always short staffed on the weekend. During an interview and record review on 4/23/2026 at 2:34 p.m. with the Certified Nurse Assistant (CNA) 9, the CNA 9 stated the CNAs call out on weekends because they do not receive support from the licensed vocational nurses (LVNs). CNA 9 stated the Charge LVN and Desk LVN, who function in supervisory roles, do not respond when CNAs request assistance with patient care and instead defer all call lights to the CNAs. CNA 9 stated management is not visible on weekends, and when staffing is very low, management does not come in to assist. During an interview and record review on 4/24/2026 at 11:01 a.m. with the Director of Nursing (DON), the California Department of Public Health (CDPH) staffing waiver, 6/25/2025, was reviewed. The staffing waiver indicated the facility shall continue to provide a minimum of 2.4 direct care service hours per patient day. The DON stated the facility has been meeting the minimum staffing of 2.4 direct care service hours per patient day. The DON reviewed the Census and Direct Care Service Hours per Patient Day (DHPPD) for December, January, February, March and April 2026 and acknowledged the facility did not meet the minimum of 2.4 direct care service hours per patient day for CNAs on the following dates: Wednesday, 12/31/2025: CNA hours 2.37 Thursday, 1/1/2026: CNA hours 2.3 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sunday, 1/11/2026: CNA hours 2.01 Friday, 2/13/2026: CNA hours 2.25 Sunday, 2/22/2026: CNA hours 2.25 Sunday, 3/1/2026: CNA hours 2.09 Thursday, 3/19/2026: CNA hours 2.22 Saturday, 3/28/2026: CNA hours 2.23 Sunday, 4/5/2026: CNA hours 2.15 Friday, 4/17/2026: CNA hours 2.25 Sunday, 4/19/2026 CNA hours 2.22 The DON stated the facility had a pattern of low staffing on weekends and did not meet the minimum requirement of 2.4 direct care service hours per patient day. The DON stated the RNs and LVNs are expected to assist CNAs with patient care and was unaware of the LVNs unwillingness to help CNAs. The DON stated she and her leadership team do not go to the facility when staffing is very low to assist with patient care. The DON stated low staffing resulted in delayed resident care, delayed responses to call lights, and resident complaints about sub-par or delay care. During a review of the facility's policy and procedure (P&P) titled, Staffing, dated 10/2017, indicated, the facility provided sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. The P&P indicated licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services and staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure two of four trash bins were covered.This failure has the potential to attract pests, such as rodents and flies, to the area.Findings:During an observation on 4/21/2026 at 8:57 a.m., at the outside area where trash bins are stored, two trash bins were uncovered.During an observation and interview on 4/21/2026 at 9:25 a.m., with the Dietary Supervisor (DS), two open trash bins were uncovered. The DS stated the trash bins should be covered. The DS stated if the bins were not covered, pests, such as rodents or flies, could come into the facility, and land on the residents' food.During an interview on 4/24/2026 at 11:35 a.m. with the Director Of Nursing (DON), the DON stated the trash bins should be covered. The DON stated if the bins are not covered, flies would be attracted by the smell, and it would not be safe for the staff, residents, or visitors.During a review of the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal, dated 10/2017, the P&P indicated all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use.

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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 staff followed proper infection control when:a) Certified Nurse Assistant (CNA 9) and Licensed Vocational Nurse (LVN 3) did not implement appropriate use of personal protective equipment (PPE, special clothing or gear to wear to protect the body from getting sick) during care of two out of 10 sampled residents (Resident 18 and 65).b) Rehabilitative Nurse Assistant (RNA) 1 walked in the hallways wearing a disposable gown.c) Laundry Staff (L1) did not use a gown when folding clean linen or loading dirty linen and attended to the clean and dirty linen at the same time.These failures had the potential to result in residents being exposed to infectious agents and becoming ill. Findings: a) During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 18's diagnoses included sepsis (a life-threatening blood infection), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). During a review of Resident 18's History and Physical (H&P), dated 3/20/2026, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS- a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 18's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 18 was dependent (helper does all of the effort) on staff for toileting hygiene and required partial or moderate assistance (helper does less than half the effort) from staff for eating. During a review of Resident 18's lab results dated 4/1/2026, the lab results indicated the resident had Escherichia coli (E. coli- bacteria that causes infection) in the urine. During an observation on 4/21/2026 at 1:25 p.m., an Enhanced Barrier Precautions (EBP- rules and steps used to stop the spread of germs and bacteria) sign was posted outside of Resident 18's room. The sign indicated staff must wear a gown and gloves while feeding the resident. During an observation on 4/21/2026 at 1:25 p.m. in Resident 18's room, Certified Nurse Assistant (CNA 9) was observed feeding the resident without wearing a gown or gloves. During a concurrent interview and record review on 4/21/2026 at 1:59 p.m. outside of Resident 18's room, the EBP sign posted outside of the room was reviewed. CNA 9 stated the sign indicated to wear a gown and gloves when feeding the resident. CNA 9 stated he did not wear a gown and gloves while feeding the resident and this could have caused cross contamination of infections between residents. During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses including sepsis and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). During a review of Resident 65's H&P, dated 7/29/2025, the H&P indicated Resident 65 did not have (continued on next page)

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	04/24/2026

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the capacity to understand and make decisions. During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65's cognition was moderately impaired. The MDS indicated Resident 65 required substantial or maximal assistance (helper does more than half the effort) from staff for personal hygiene. During a review of Resident 65's lab results dated 3/22/2026, the lab results indicated the resident had proteus mirabilis (bacteria that causes infection) in a wound. During an observation on 4/23/2026 at 8:36 a.m., outside of Resident 65's room, an EBP sign was posted outside of the resident's room. During a concurrent observation and interview on 4/23/2026 at 8:36 a.m. outside of Resident 65's room, Licensed Vocational Nurse (LVN) 3 was observed putting on a gown and gloves. LVN 3 stated she was going to take Resident 65's respiratory rate prior to administering medications. LVN 3 removed her gloves and performed hand hygiene but did not remove the gown. LVN 3 proceeded to prepare Resident 65's medications on the medication cart located outside of the resident's room while wearing the same gown. LVN 3 administered Resident 65's medications without putting on a new gown. During an interview on 4/23/2026 at 8:42 a.m. with LVN 3, LVN 3 stated she did not remove the gown after taking Resident 65's respirations and before touching the medication cart and preparing the resident's medications. LVN 3 stated gowns are to be removed inside the room and not doing so could cause cross-contamination between residents. During an interview on 4/23/2026 at 3:24 p.m. with Infection Preventionist (IP), the IP stated EBP precautions help protect residents from infections. IP stated personal protective equipment (PPE-masks, gowns, gloves) must be worn while feeding residents on EBP, and PPE must be discarded while inside residents' rooms and before starting a new task to help avoid cross-contamination. The IP stated failing to follow EBP could increase the spread of infection. During an interview on 4/24/2026 at 1:08 p.m. with the Director of Nursing (DON), the DON stated EBP precautions were in place to help protect residents from illness and to stop germs from moving from one person to another. The DON stated EBP precautions must be followed while feeding a resident and in between tasks such as taking vital signs and preparing medications. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated 6/20/24, the P&P indicated, Gowns and gloves shall be removed and hand hygiene will be performed before leaving the room and avoid touching potentially contaminated environmental surfaces with clothing after contaminated PPEs are removed and discarded. b) During a concurrent observation and interview on 4/21/2026 at 11:05 a.m., Rehabilitative Nurse Assistant (RNA) 1 was walking in the hallway wearing a disposable gown. RNA 1 stated although she had donned the gown, she had not entered or exited a resident room and believed it was acceptable to walk in the hallway while wearing a gown. RNA 1 stated the gown should have been removed and discarded in a trash can. RNA 1 stated she had not disinfected her hands before applying gloves. RNA 1 stated staff needed to don a gown before entering a room and remove the gown before exiting the room. RNA 1 stated staff must disinfect their hands before donning gloves. (continued on next page)

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	555340	A. Building B. Wing	04/24/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2026 at 11:00 a.m. with the Infection Preventionist (IP), the IP stated RNA1 had previously performed perineal care (keeping the private areas of the body clean) without wearing the required PPE. The IP stated she was notified about RNA1 wearing a gown in the hallway and failed to disinfect her hands prior to donning gloves. The IP stated staff must remove PPE inside the resident's room before exiting, and hand hygiene was required before donning gloves. During an interview on 4/24/2026 at 10:05 a.m. with the DON, the DON stated staff must wear PPE (gown, mask, gloves) while providing resident care. The DON stated staff must dispose of PPE inside the resident room or in the designated large trash bins in the hallway. The DON stated staff should not exit a resident room or walk in the hallway while wearing PPE. During a review of the facility's P&P titled, Enhanced Barrier Precaution, dated 6/20/2024, the P&P indicated, facility staff shall perform hand hygiene and don gown and gloves before performing high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, and changing briefs or assisting with toileting. The P&P indicated gowns and gloves shall be removed and hand hygiene will be performed before leaving the room and avoid touching potentially contaminated environmental surfaces with clothing after contaminated PPEs are removed and discarded. c) During a concurrent observation and interview on 4/24/2026 at 8:05am with Laundry Staff (L1), a bin with wet linen was propped on the wall and window seal. L1 stated the linen was washed but not clean anymore because the window was dusty. During a concurrent observation and interview on 4/24/2026 at 8:07 a.m., with the Laundry Staff (L1), L1 did not use a gown when folding clean linen or loading dirty linen and L1 left the clean linen area to load dirty linen. L1 stated they should wear an apron when folding clean linen and they should not load dirty linen and attend to clean linen at the same time because the clean linen will be contaminated. L1 stated if the residents were given contaminated linen, they would be exposed to dirty linen. During an interview on 4/24/2026 at 11:35 a.m. with the DON, the DON stated linen would not be clean if it was leaning on the wall or window. The DON stated staff could not attend to clean and dirty linen at the same time and staff were supposed to use the apron when they wash linen because staff must protect themselves from dirty linen. During a review of the facility's P&P titled, Departmental (Environmental Services) – Laundry and Linen, dated 1/2014, the P&P indicated all soiled linen must be placed directly into covered laundry hamper which can contain the moisture. The P&P indicated employees sorting or washing linen must wear a gown and gloves and a mask may be worn if aerosolization is expected. The P&P indicated to use heavy-duty rubber gloves for sorting laundry and always wash hands after completing the task and removing gloves.

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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	555340	A. Building B. Wing	04/24/2026

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Marina Pointe Healthcare & Subacute	5240 Sepulveda Blvd Culver City, CA 90230

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 sq ft of living space.This deficient practice had the potential to prevent residents from moving around the room freely or store personal items. Staff may also have difficulty providing care due to limited space.Findings:During a review of the Client Accommodation Analysis, dated 3/18/2026, the analysis indicated the facility's rooms had the following room measurements:room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 square (sq) feet (ft) per resident)room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident)room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) 3 room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 3 beds (78.3 sq ft per resident) room [ROOM NUMBER] is 235 sq ft with 2 beds (117.5 sq ft per resident) room [ROOM NUMBER] is 244.2 sq ft with 3 beds (81.4 sq ft per resident) During an interview on 4/24/2026 at 11:15 am with the Administrator (ADM), the ADM stated the rooms that do not have at least 80 sq ft of living space could have the potential to not feel like a home-like environment for those residents.During a review of the Room Variance Waiver request letter dated April 29, 2026, 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 measured 235 sq ft, The letter indicated the required room size is 240 sq ft.During observations and interviews conducted from 4/21/2026 to 4/24/2026, there were no concerns observed as a result of the facility not providing residents with at least 80 sq. ft. of living space. Quality of care was not affected, and no complaints or concerns were reported by facility staff or residents.