

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Motion Picture and T.V. Hosp D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 23388 Mulholland Dr. Woodland Hills, CA 91364	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident rights for one resident (Resident 1), were upheld and ensured their right to receive care in a safe environment. This failure resulted in physical harm to Resident 1 by a facility staff employee with the potential to have resulted in serious injury to Resident 1. Findings: During a review of Resident 1's History and Physical (H&P), dated 4/16/2025, the H&P indicated, Resident 1 admitted to the facility on [DATE] due to dementia (a progressive state of decline in mental abilities). Resident 1 had a past medical history of multiple Venous thromboembolism (VTE - is a medical condition where a blood clot forms in blood vessel), chronic kidney disease (CKD - condition where kidneys are damaged progressively and irreversibly), fibromyalgia (a chronic condition characterized by widespread muscle pain and fatigue) and spinal stenosis (a painful condition where the spaces within spine narrow). During an interview on 8/4/2025 at 11:55 AM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, he had witnessed on 6/30/2025 at approximately 11:05 PM, Certified Nurse Assistant 2 (CNA 2), forcefully assist Resident 1 to the commode. CNA 1 stated he witnessed CNA 2 become frustrated while assisting Resident 1 to the commode, in which he witnessed CNA 2 manhandle Resident 1 in her armpits and slam her to the commode with aggressive and excessive force. During an interview on 8/4/2025 at 1:39 PM with the Director of Risk Management and Regulatory Affairs (DRM), the DRM stated the facility found CNA 2's behavior to have raised to a level of misconduct due to the rough handling of Resident 1. During a review of Resident 1's document titled California Standard admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities, dated 4/18/2025, the document indicated, Your Rights as a Resident[:] Residents of this Facility keep all their basic rights and liberties as a citizen or resident of the United States when, and after, they are admitted. Attachment F, entitled Resident [NAME] of Rights, lists your rights, as set forth in State and Federal law. During a review of the facility's document titled, Attachment F Resident [NAME] of Rights, undated, indicated, Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. Patients shall have the right. To be free from mental and physical abuse. To be treated with consideration, respect.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055034
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to enforce for one resident (Resident 1), their own policy and procedures regarding abuse prevention and reporting. This failure resulted in Resident 1 to be in an unsafe environment due to continued exposure to an alleged perpetrator. Findings: During a review of Resident 1's History and Physical (H&P), dated 4/16/2025, the H&P indicated, Resident 1 admitted to the facility on [DATE] due to dementia (a progressive state of decline in mental abilities). Resident 1 had a past medical history of multiple Venous thromboembolism (VTE - is a medical condition where a blood clot forms in blood vessel), chronic kidney disease (CKD - condition where kidneys are damaged progressively and irreversibly), fibromyalgia (a chronic condition characterized by widespread muscle pain and fatigue) and spinal stenosis (a painful condition where the spaces within spine narrow). During an interview on 8/4/2025 at 11:55 AM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, he had witnessed on 6/30/2025 at approximately 11:05 PM, Certified Nurse Assistant 2 (CNA 2), forcefully assist Resident 1 to the commode. CNA 1 stated he witnessed CNA 2 become frustrated while assisting Resident 1 to the commode, in which he witnessed CNA 2 manhandle Resident 1 in her armpits and slam her to the commode with aggressive and excessive force. During a review of Resident 1's medical record titled Nursing Note, dated 7/8/2025, the record indicated Resident 1 had a physical assessment completed with no injuries or discoloration noted on her body. During an interview on 8/4/2025 at 1:39 PM with the Director of Risk Management and Regulatory Affairs (DRM), the DRM stated the facility found CNA 2's behavior to have raised to a level of misconduct due to the rough handling of Resident 1. During a concurrent interview and record review, on 8/4/2025 at 12:29 PM with the DON, CNA 2's Employee Timecards, dated multiple dates was reviewed. The timecard indicated, CNA 2 had worked:- On 6/30/2025, from 11:00 PM to 7:30 AM- On 7/2/2025, from 11:00 PM to 7:30 AM- On 7/3/2025, from 11:00 PM to 7:30 AM- On 7/4/2025, from 11:00 PM to 7:30 AM- On 7/6/2025, from 3:00 PM to 11:30 PM and 11:30 PM to 7:23 AM. The DON stated CNA 2 should have been suspended the same day the incident occurred with Resident 1 on 6/30/2025 without any delay. The DON stated that by waiting the facility left Resident 1 exposed to the possibility of further abuse from CNA 2. During a review of the facility's document titled Code of Conduct, undated, the document indicated, Patients and residents shall be treated at all times with care, concern and respect. During a review of CNA 2's document titled Code of Conduct Employee Acknowledgement, dated 12/15/2017, the document indicated, CNA 2 received a copy of the facility's Code of Conduct and acknowledged an understanding to adhere to the Code of Conduct. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Reporting (Suspected Elder and Dependent Adult Abuse and Neglect, dated 3/6/2025, indicated, VIII. Protection[.] During the course of an investigation, the patient and/or resident will be protected from possible harm by the suspected abused. If the suspected abused is an employee, that employee will be suspended. During a review of the facility's P&P titled, Corrective Action Disciplinary Procedures, dated 9/4/2020, indicated, Investigatory Suspension[.] An employee may be placed on a n investigatory leave, with or without notice, to permit [name of facility] to review or investigate actions including . acts endangering patients or others, or other conduct which warrants removing the employee from the work site.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the alleged abuse incident of one resident (Resident 1), in accordance with facility policy. This failure resulted in delayed investigation of the incident by the state agency and law enforcement that may have a negative impact on the care and treatment received by patient. Findings: During a review of Resident 1's History and Physical (H&P), dated 4/16/2025, the H&P indicated, Resident 1 admitted to the facility on [DATE] due to dementia (a progressive state of decline in mental abilities). Resident 1 had a past medical history of multiple Venous thromboembolism (VTE - is a medical condition where a blood clot forms in blood vessel), chronic kidney disease (CKD - condition where kidneys are damaged progressively and irreversibly), fibromyalgia (a chronic condition characterized by widespread muscle pain and fatigue) and spinal stenosis (a painful condition where the spaces within spine narrow). During an interview on 8/4/2025 at 11:55 AM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, he had witnessed on 6/30/2025 at approximately 11:05 PM, Certified Nurse Assistant 2 (CNA 2), forcefully assist Resident 1 to the commode. CNA 1 stated he witnessed CNA 2 become frustrated while assisting Resident 1 to the commode, in which he witnessed CNA 2 manhandle Resident 1 in her armpits and slam her to the commode with aggressive and excessive force. During a review of Resident 1's medical record titled Nursing Note, dated 7/8/2025, the record indicated Resident 1 had a physical assessment completed with no injuries or discoloration noted on her body. During an interview on 8/4/2025 at 1:39 PM with the Director of Risk Management and Regulatory Affairs (DRM), the DRM stated the facility found CNA 2's behavior to have raised to a level of misconduct due to the rough handling of Resident 1. During a concurrent interview and record review, on 8/4/2025 at 12:29 PM with the Director of Nursing (DON), the facility's document titled, Fax, dated 7/8/2025 was reviewed. The document indicated the facility had reported the incident to licensing agency, local law enforcement and ombudsman via fax message on 7/8/2025. The DON stated the facility reported the incident late; she stated the report should have been made to the licensing agency within 24 hours of the incident occurring on 6/30/2025. The DON also stated the facility should have reported this incident to law enforcement via telephone call within 24 hours of the incident occurring on 6/30/2025, in addition to, the faxed written report sent to law enforcement. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Reporting (Suspected Elder and Dependent Adult Abuse and Neglect, dated 3/6/2025, indicated, VI. Reporting/Response . If the suspected abuse does not result in serious bodily injury: 1. A telephone report shall be made to the local law enforcement within 24 hours. 2. Within 24 hours, a written report shall be made to local ombudsman, corresponding licensing agency (CDPH) and local law enforcement.</p>		