STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055034	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Motion Picture and T.V. Hosp D/P Snf	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to complete an inventory of one of one sampled resident's (Resident 1) home medication. This deficient practice resulted in Resident 1's home medication mismanagement; in addition, failure to inventory a patient's home medication upon admission to a facility creates a high risk of lost belongings, medication omissions, and discrepancies in treatment.During a review of Resident 1's History and Physical (H&P, a comprehensive assessment of a patient's medical history and physical examination), dated 12/11/2025, the H&P indicated Resident 1 was admitted to the Skilled Nursing Facility (SNF, a licensed facility that provides 24/7 high-level nursing and rehabilitative care for short-term recovery or chronic conditions) 1 on 12/11/2025, having been diagnosed with dementia (a progressive syndrome characterized by a decline in memory, thinking, behavior, and functional ability). The H&P also indicated Resident 1 was prescribed Norco (a prescription combination medication containing hydrocodone, a potent opioid pain reliever and acetaminophen, a non-opioid pain reliever, and is used to treat moderate to severe pain) and Klonopin (a prescription benzodiazepine used to treat panic disorder and certain seizure disorders).During a review of Resident 1's Resident Belongings/ Valuables - admission Inventory (a document used by SNF to inventory and safeguard a resident's personal effects and property), dated 12/11/2025, the admission Inventory did not reflect any inventory of Resident 1's home medications. The form was unsigned and noted that Resident 1 was unable/refused to sign.During an interview on 3/12/2025 at 11:55 A.M. with the Chief Nursing Officer (CNO1), CNO1 stated that Resident 1 was a transfer from an assisted facility last December. Resident 1 came with his belongings and valuables, including his home medications. CNO1 stated Resident 1's daughter came by a couple of days after, and Resident 1's home medications were returned to Resident 1's daughter. CNO1 stated Resident 1's daughter, a day or two afterward, made claims that Resident 1's medications were not returned to her. CNO1 added that the Nurse Practitioner who admitted Resident 1 reviewed Resident 1's home medication and took them to the pharmacy. CNO1 stated the facility did this to check if there was any medication not available in the pharmacy to dispense so they could temporarily use residents' home medication if ordered. CNO1 further stated none of Resident 1's home medication was needed as it was all available in the pharmacy; the pharmacy kept Resident 1's home medication and the home medication was later given back to Resident 1's daughter a few days later. CNO1 stated none of Resident 1's home medications were inventoried or documented.During an interview on 3/12/2025 at 12:10 A.M. with the Director of Risk Management (DRM1), DRM1 stated that the typical practice when a resident arrives with home medication was that it went to nursing staff and pharmacy for review, then it be given back to family. DRM1 stated the facility did not keep home medication; in the case of Resident 1, Resident 1's daughter came by, and all the home medication was handed back to her by the social worker. DRM1 stated Resident 1's home medications were kept in pharmacy for storage and the pharmacy did not inventory or document Resident 1's home medication. DRM1 added that it was not the facility's practice to include and document residents' home medication in the Resident Belongings and valuables form (a document used by SNF1 to inventory and safeguard a resident's personal effects and property). At that time, the facility had no separate process in place to track, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inventory, or document patient home medication. During a review of the facility's policy and procedures (P&P), titled Use of Patient-Supplied Medications, with last revised date of 12/2025, the P&P indicated, When medications are brought in at admission: (a) they will be returned to the family/responsible party whenever possible; (b) if no responsible party is present, the medications will be transferred in a tamper-evident bag to Pharmacy, where unit staff and the pharmacist will jointly verify and count, document receipt in a log, and secure the medications until return to family or destruction is authorized.During a review of the facility's P&P, titled Inventory of Personal Effects, with last revised date of 7/2019, the P&P indicated the following: When a resident is admitted to the facility, an inventory of the resident's personal effects shall be done by a staff member of the facility. The inventory should include the recording of all personal clothing, valuable articles, etc. which are brought into the facility with the resident and retained by the resident. These personal effects shall be recorded on the Resident Belongings and valuables form or in EHR (Electronic Health Record). When any personal item which may have a direct or indirect bearing on the resident's health and safety is brought into the facility for a resident after admission, the item shall be recorded in resident belonging list.