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	04/11/2025

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

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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 - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to ensure the residents and/or responsible party (RP) were informed in advance, of the risks and benefits of psychoactive medication (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) for two of two sampled residents (Residents 21 and 3) reviewed for informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure: 1. Resident 21's lorazepam (also known as Ativan, a drug that is used to treat anxiety and certain seizure disorders), mirtazapine (also known as Remeron, an antidepressant medicine), escitalopram (also known as Lexapro, a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest] and generalized anxiety disorder [mental health conditions characterized by excessive and persistent worry, fear, and unease that can interfere with daily life]), and gabapentin (also known as Neurontin, a medication that works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system) had informed consents from the resident or representative. 2. Resident 3's escitalopram had informed consent from the resident or representative. These deficient practices violated the residents' right to make an informed decision regarding the use of psychoactive medications. Findings: 1. During a review of Resident 21's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/30/2023. During a review of Resident 21's History and Physical (H&P), dated 11/26/2024, the H&P indicated the resident was awake, alert, pleasant, and cooperative. The H&P indicated the resident had a history of depression, insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), and atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time). (continued on next page)

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 2/14/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate impaired cognition (a person is experiencing significant, noticeable difficulties with thinking and memory, which starts to affect their daily activities). The MDS indicated the resident was taking the following high-risk drug class medications: antianxiety (medications or treatments that help reduce feelings of excessive worry, fear, or anxiety), antidepression (medications used to treat symptoms of depression and other mental health conditions), and anticonvulsant (A type of drug that is used to prevent or treat seizures or convulsions by controlling abnormal electrical activity in the brain) medications. During a review of Resident 21's Active Orders, the Active Orders indicated Resident 21 was ordered the following: On 5/9/2024, gabapentin 600 milligrams (mg - a unit of measurement for mass). Give 600 mg (one [1] tablet) by mouth at bedtime. Indication: anxiety. Monitor for behavior manifested by (m/b) insomnia. On 5/31/2024, escitalopram oxalate 10 mg. Give 10 mg (1 tablet) by mouth at bedtime. Indication: depression m/b verbalize sadness. On 1/6/2025, mirtazapine 15 mg. Give 15 mg (1 tablet) by mouth at bedtime. Indication: depression m/b insomnia and oral intake less than 40 percent (% - a unit of measurement). On 3/20/2025, lorazepam 0.5 mg. Give 0.5 mg (1 tablets) by mouth at bedtime. Please hold if resident is sleepy. Indication: anxiety m/b insomnia. During a review of Resident 21's Plan of Care (POC), dated 11/30/2023, regarding medical conditions, the POC indicated the following interventions: escitalopram oxalate 10 mg by mouth at bedtime, mirtazapine 15 mg by mouth at bedtime, lorazepam 0.5 mg by mouth at bedtime, and gabapentin 600 mg by mouth at bedtime. During a concurrent interview and record review, on 4/10/2025, at 9:31 a.m., with Registered Nurse (RN) 2, Resident 21's Active Orders, Medication Administration Record (MAR), Consents, and POC were reviewed. RN 2 stated she cannot find the consents for psychotropic medications Lexapro, Remeron, Ativan, and Neurontin used for anxiety and sleep. RN 2 stated before administering the medications they need a physician's order, obtain an informed consent from the resident or resident representative discussing the risk and benefits of taking the medications, monitor for adverse effects (an unwanted and harmful result, often caused by a medication, treatment, or procedure) of the medication, and develop and implement a care plan on its use. RN 2 stated it was important to obtain a consent from the resident or representative before administering the medications to honor the resident or representative's right to informed consents and to afford them an opportunity to accept or decline the use of the medications. During an interview, on 4/11/2025, at 3:23 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated the licensed staff should have ensured Resident 21 had a written consent for each psychotropic medications to ensure the resident's right to informed consent is honored. The DLTC stated there should be a physician's order, an informed consent indicating the resident was presented with the risk and benefit, monitoring for adverse effects, and a care plan on psychotropic medication use. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled, Psychotherapeutic Medication/Monitoring/Informed Consent, last approved on 12/5/2024, the P&P indicated when psychotherapeutic drugs are used: 2. Residents will be monitored to determine the drug's effectiveness for the treatment of the stated condition and any adverse reaction. f. Documentation of obtaining informed consent (if new medication or higher dose of current medication). With the exception of antidepressants, written informed consent will be obtained from the resident of the resident's representative after disclosure of the following information: a. Possible nonpharmacologic approaches that could address the resident's needs. b. Whether the drug has a current boxed warning label along with a summary of, and information about how to find, the contraindications, warnings, and precautions required by the United States Food and Drug Administration (FDA). c. Whether the proposed drug is being prescribed for a purpose that has or has not been approved by the United States FDA. d. Possible interactions with other drugs the resident is receiving. e. How the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects. Before prescribing a psychotherapeutic drug: c. The consent requires the signature of the healthcare professional declaring the required material information has been provided. Medical Records: a. The signed written consent must be recorded in the resident's medical record. Renewals of Informed Consent: a. The written informed consent will be renewed every six months. 2. During a review of Resident 3's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/18/2024. During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate impaired cognition. The MDS indicated the resident was on a high-risk drug class antianxiety and antidepressant medications. The MDS indicated the resident had anxiety disorder, depression, and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Active Orders, dated 12/5/2024, the Active Orders indicated an order of escitalopram oxalate 20 mg. Give 20 mg (1 tablet) by mouth daily. Indication: depression m/b anxious behavior. During a review of Resident 3's POC regarding the use of psychotropic drug use, dated 11/18/2024, the POC indicated an intervention of escitalopram oxalate (Lexapro) 20 mg daily for depression. During a concurrent interview and record review, on 4/10/2025, at 10:39 a.m., with RN 2, Resident 3's Active Orders, MAR, Consents, and POC were reviewed. RN 2 stated she cannot find the consent for psychotropic medication Lexapro. RN 2 stated before administering the medications they need a physician's order, obtain an inform consent from the resident or resident representative discussing the risk and benefits of taking the medications, monitor for adverse effects of the medication, and develop and implement a care plan on its use. RN 2 stated it was important to obtain a consent from the resident or representative before administering the medications to honor the resident or representative's right to informed consents and to afford them an opportunity to accept or decline the use of the medications. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated the licensed staff should have ensured Resident 3 had a written consent for psychotropic medication to ensure their right to informed consent is honored. The DLTC stated there should be a physician's order, an informed consent indicating the resident was presented with the risk and benefit, monitoring for adverse effects, and a care plan on psychotropic medication use. During a review of the facility's recent P&P titled Psychotherapeutic Medication/Monitoring/Informed Consent, last approved on 12/5/2024, the P&P indicated when psychotherapeutic drugs are used: 2. Residents will be monitored to determine the drug's effectiveness for the treatment of the stated condition and any adverse reaction. f. Documentation of obtaining informed consent (if new medication or higher dose of current medication). With the exception of antidepressants written informed consent will be obtained from the resident of the resident's representative after disclosure of the following information: a. Possible nonpharmacologic approaches that could address the resident's needs. b. Whether the drug has a current boxed warning label along with a summary of, and information about how to find, the contraindications, warnings, and precautions required by the United States Food and Drug Administration (FDA). c. Whether the proposed drug is being prescribed for a purpose that has or has not been approved by the United States FDA. d. Possible interactions with other drugs the resident is receiving. e. How the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before prescribing a psychotherapeutic drug: c. The consent requires the signature of the healthcare professional declaring the required material information has been provided. Medical Records: a. The signed written consent must be recorded in the resident's medical record. Renewals of Informed Consent: a.The written informed consent will be renewed every six months.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43988 Based on interview and record review, the facility failed to ensure the physician or medical provider and resident's responsible party (RP) were notified for one (1) of 1 sampled resident (Resident 20) reviewed under change of condition when Resident 20 had an episode of hypoxia (low level of oxygen [O2 - a colorless and odorless gas that the body needs to work properly] in the body). This deficient practice violated Resident 20's right (including RP) to be informed and a had the potential to result in the delay of care, services and further decline of Resident 20 by failing to notify the provider. Findings: During a review of Resident 20's Face Sheet, the Face Sheet indicated the facility admitted the resident on 9/6/2023. During a review of Resident 20's Clinical Record Abstract, the Clinical Record Abstract indicated Resident 20's diagnoses including dementia (a type of progressive dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 20's History and Physical (H&P) dated 9/6/2024, the H&P indicated the resident was alert and oriented to full name and location, and was unable to tell the date. During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool) dated 2/25/2025, the MDS indicated Resident 20 had severely impaired cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) and usually understands others and usually able to make needs known. The MDS indicated Resident 20 required substantial/maximal assistance with bed mobility; total assistance from staff with all other activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 20's physician's order, the physician's order indicated an order dated 6/27/2024 for oxygen via nasal cannula (NC - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) every eight (8) hours as needed at two (2) liters per minute (L/min - a unit of measurement) for hypoxia. During a review of Resident 20's Nursing Note LTC form completed by Registered Nurse (RN) 4 dated 4/4/2025, the Nursing Note LTC form indicated Resident 20 seen to assess for staff report of hypoxia with O2 saturation level (02 sat- a measurement of how much oxygen the blood is carrying as a percentage) 83 to 85 percent (% - a unit of measurement) on room air and respirations of 30 per minute. The Nursing Note LTC further indicated nasal O2 was applied to resident and titrated (adjusting a dose to achieve a desired outcome) to 1 L/min with O2 sat at 93%. The Nursing Note LTC did not indicate the medical provider and resident's RP were notified of Resident 20's change in condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/11/2025 at 9:16 a.m., reviewed Resident 20's Nursing Note LTC form dated 4/4/2025, physician's orders, and nursing progress notes with RN 4. RN 4 stated she was called to Resident 20's room to assess for staff report of hypoxia with 02 sat 83 to 85 % on room air and respirations of 30 per minute. RN 2 stated she applied nasal O2 to the resident and she was able to titrate down to 1 L/min with O2 sat at 93%. RN 4 stated the Nursing Note LTC did not indicate the medical provider and resident's RP were notified of Resident 20's change in condition. RN 4 stated she did not have to notify the medical provider as Resident 20 had an existing physician's order for oxygen as needed for hypoxia. RN 4 stated the staff are supposed to notify the medical provider or resident's RP for any change in condition. RN 4 stated it violated the Resident 20's RP's right to be notified of the change in condition. RN 4 stated the medical provider should have been notified for further instructions to prevent delay in the care the resident needed. During a concurrent interview and record on 4/11/2025 at 2:05 p.m., reviewed Resident 20's physician's orders, Nursing Note LTC form dated 4/4/2025 and other nursing notes or progress notes with the Director of Long-Term Care (DLTC). The DLTC stated Resident 20 had an order for O2 via NC as needed for hypoxia. The DLTC stated the Nursing Note LTC dated 4/4/2025 indicate Resident 20 had an episode of hypoxia and O2 was applied according to the physician's order but did not indicate the medical provider and resident's responsible party were notified of Resident 20's change in condition. The DLTC stated there was no documentation anywhere in the other nurses' notes that the medical provider and Resident 20's RP were made aware of the change in condition. The DLTC stated if any residents had any change in condition, the medical provider and RP should have been notified so they can be made of the resident's current medical condition per facility policy. The DLTC stated Resident 20's episode of hypoxia was still considered a change in condition, therefore, the medical provider and Resident 20's RP should have been notified as it violated Resident 20's RP right to be informed of the resident's current condition and a possible delay in the provision of care and services the resident need if the medical provider was not notified. During a review of the facility's policy and procedure (P&P) titled, Change in Patient-Resident Status, Notification of Medical Provider, last reviewed on 12/5/2025, the P&P indicated: - The medical provider shall be notified in the event of an incident involving the patient/resident or other significant change in patient's resident's physical, mental, or emotional status. - The patient's/resident's Durable Power of Attorney for Healthcare (DPOAH) or other responsible person(s) shall also be notified. - The medical provider is to be notified of any sudden and/or marked adverse change in signs, symptoms and behavior exhibited by a patient/resident. - Necessary documentation with regard to medical provider notification such as time of attempt to notify, method of notification, name of physician/general nurse practitioner (GNP), reason for the attempt to notify, and the physician/GNP response.

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	055034	A. Building B. Wing	04/11/2025

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Motion Picture and T.V. Hosp D/P Snf	23388 Mulholland Dr. Woodland Hills, CA 91364

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44376 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (CP - is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting): 1. For two of three sampled residents (Residents 21 and 77) reviewed for care plans by failing to ensure identified problems were specific, grouped together, with individual goals and interventions. 2. For one of seven sampled residents (Resident 19) reviewed under the accidents care area by failing to ensure a comprehensive person-centered Care Plan for smoking was developed and implemented when the smoking CP did not include the use of an apron (a safety device that prevent burns from dropped ashes or smoking materials). These deficient practices had a potential for delay in the delivery of necessary care and services and miscommunication among healthcare providers. Findings: 1. During a review of Resident 21's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/30/2023. During a review of Resident 21's History and Physical (H&P), dated 11/26/2024, the H&P indicated the resident was awake, alert, pleasant, and cooperative. The H&P indicated the resident had dyslipidemia (means too many lipids [fats] in the blood), chronic recurrent pneumonia (two or more episodes of pneumonia in 12 months or three episodes altogether with radiographic clearance in between), and atrial fibrillation (a common heart condition where the heart's upper chambers [atria] beat irregularly, sometimes too fast, creating a quivering or fluttering sensation). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 2/14/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate impaired cognition (a noticeable but not severe decline in a person's ability to think, remember, and make decisions). The MDS indicated the resident had multiple active diagnoses. During a review of Resident 21's Plan of Care (POC), dated 11/30/2023, the POC indicated a list of all of Resident 21's medical conditions on the first column, and a list of goals on the second column. The list on the second column was not specific to the problems identified as there were multiple problems listed on the first column. The third column contained the interventions, with 89 interventions not organized according to identified problems. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/10/2025, at 9:07 a.m., with Registered Nurse (RN) 2, Resident 21's POC, dated 11/30/2023, was reviewed. RN 2 stated the POC written for Resident 21 was complicated to sort out. RN 2 stated the problems/medical diagnosis identified were all on the same column and the interventions were all mixed up with other identified problem interventions. RN 2 stated they have to scroll through multiple pages to check for interventions for a specific problem. RN 2 stated the POC should have one problem per care plan with specific goals and interventions. RN 2 stated the POC written for Resident 21 was disorganized and had the potential for delayed treatment and miscommunication with other healthcare providers. During an interview, on 4/11/2025, at 3:23 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated the POC of Resident 21 should be organized in such a way that it can communicate the problem and interventions to healthcare workers effectively. The DLTC stated a POC should have one problem, with a goal, and interventions specific to the problem. The DLTC stated Resident 21's POC was disorganized, and it will take time for a healthcare worker to go through which interventions will be appropriate for a specific problem as it is mixed in with other problems of the resident which leads to delay of care. During a review of the facility's recent policy and procedure (P&P) titled Care Plan - Resident, last reviewed on 12/5/2024, the P&P indicated to ensure a coordinated and comprehensive written plan is developed based on the resident assessment and the individual needs and preferences of the resident. The care plan will include the start date, goals, interventions and target date for the next review. 2. During a review of Resident 77's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/27/2023. During a review of Resident 77's H&P, dated 12/17/2024, the H&P indicated the resident was alert and unable to converse. The H&P indicated the resident had Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), frontal lobe dementia (an umbrella term for a group of brain diseases that mainly affect the frontal and temporal lobes of the brain), and major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has significant difficulty with thinking, memory, and reasoning, to the point where they struggle with everyday activities and may be unable to live independently). The MDS indicated the resident had multiple active diagnoses. During a review of Resident 77's POC, dated 12/27/2023, indicated a list of all of Resident 77's medical conditions on the first column, and a list of goals on the second column. The list on the second column was not specific to the problems identified as there were multiple problems listed on the first column. The third column contained 28 interventions not organized according to identified problem. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/10/2025, at 9:07 a.m., with RN 2, Resident 77's POC, dated 12/27/2023, was reviewed. RN 2 stated Resident 77's POC was complicated to sort out. RN 2 stated the problems identified were all on the same column and the interventions were all mixed up with other identified problem interventions. RN 2 stated they have to scroll through multiple pages to check for interventions for a specific problem. RN 2 stated the POC should be one problem per care plan with specific goals and interventions. RN 2 stated the POC written for Resident 77 was disorganized and had the potential for delayed treatment and miscommunication with other healthcare providers. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated the POC of Resident 77 should be organized in such a way that it can communicate the problem and interventions to healthcare workers effectively. The DLTC stated a POC should have one problem, with a goal, and interventions specific to the problem. The DLTC stated the care plan of Resident 77 was disorganized and it will take time for a healthcare worker to go through which interventions will be appropriate for the problem as it is mixed in with other problems of the resident which leads to delay of care. During a review of the facility's recent P&P titled Care Plan- Resident, last reviewed on 12/5/2024, the P&P indicated to ensure a coordinated and comprehensive written plan is developed based on the resident assessment and the individual needs and preferences of the resident. The care plan will include the start date, goals, interventions, and target date for the next review. 44244 3. During a review of Resident 19's Face Sheet, the Face Sheet indicated the facility admitted the resident on 8/7/2024. During a record review of Resident 19's Patient Diagnosis Information, the Patient Diagnosis Information indicated the resident had diagnoses that included dementia, diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (high cholesterol [a waxy substance that can build up in the blood resulting in stroke or heart issues]). During a review of Resident 19's MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required partial/moderate assistance for oral hygiene and dressing and required substantial/maximal assistance from staff for toileting, bathing, personal hygiene, and transferring from the bed to chair. During a review of Resident 19's Resident Smoking Assessment, dated 11/15/2024, the Resident Smoking Assessment indicated the resident expressed a desire to smoke small cigars again and was assessed by the interdisciplinary team (IDT). The IDT indicated the resident planned to smoke a few times a week with a caregiver present and Resident 19 would need to wear an apron. During a review of Resident 19's CP titled, Smokes Cigars, initiated 11/15/2025, the CP indicated a goal that the resident would comply with the smoking policy and would be assisted with lighting and extinguishing cigars. (continued on next page)

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	04/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/9/2025, at 3:58 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 19's Care Plans and Resident Smoking Assessment, dated 11/15/2024, were reviewed. The MDSC stated Resident 19 expressed a desire to smoke after being admitted to the facility. The MDSC stated when a resident expresses a desire to smoke, an initial smoking assessment is completed by the Social Worker (SW) and a personalized CP is developed. The MDSC stated a smoking CP identifies resident specific interventions to ensure the resident complies with the smoking policy. The MDSC stated Resident 19's smoking assessment indicated the resident needs to wear a smoking apron, but Resident 19's CP did not include the use of a smoking apron. The MDSC stated it is important that Resident 19's CP include the intervention of wearing an apron because the CP is used to communicate the resident specific interventions with all the staff. During a concurrent interview and record review, on 4/10/2025, at 9:18 a.m., with the SW, Resident 19's Care Plans and Resident Smoking Assessment, dated 11/15/2024, were reviewed. The SW stated a smoking CP is completed for staff to be able to follow to keep a resident safe while smoking. The SW stated Resident 19 should wear a smoking apron while smoking. The SW stated a smoking CP should include the intervention of wearing an apron, but the SW forgot to add it to Resident 19's CP. The SW stated when the SW forgot to include the use of an apron in Resident 19's CP, there was a potential that the staff may take the resident out to smoke without an apron resulting in a burn injury to Resident 19. During an interview, on 4/11/2025, at 11:15 a.m., with the DLTC, the stated CPs are an individualized plan of care for each resident with different interventions used as guides for the appropriate care to provide. The DLTC stated the smoking apron is important for Resident 19's safety while smoking to prevent burns from falling ashes. The DLTC stated the apron is an intervention that should be in Resident 19's CP, but it was not. The DLTC stated when the use of an apron was not included in Resident 19's CP, the facility P&P were not followed and could have potentially resulted in burns to the resident. During a review of the facility provided P&P titled, Care Plan - Resident, last reviewed 10/2024, the P&P indicated the purpose of the P&P was to ensure a coordinated and comprehensive written plan is developed based on the resident assessment and the individual needs and preferences of the resident. The CP will be person-centered and reflect the needs of the resident. The CP will include the start date, goals, interventions and target date for the next review. During review of the facility provided P&P titled, Resident Smoking, last reviewed 3/6/2025, the P&P indicated any resident that smokes will be assessed to ensure resident is able to smoke safely and to determine if supervision is needed. The smoking assessment will be completed on admission, annually, and with change of condition.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards of practice by: 1. Failing to ensure residents' scheduled medications were administered as ordered at the scheduled time for two of five sampled residents (Resident 66 and Resident 19) who were reviewed under the Medication Administration facility task. 2. Failing to check a resident's gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems) placement and patency before administering medications for one of five sampled residents (Resident 86) reviewed under Medication Administration facility task. 3. Failing to flush water in between medications for a resident when g-tube medications were administered for one of five sampled residents (Resident 86) reviewed under Medication Administration facility task. 4. Failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites for one (1) of 1 sampled resident (Resident 10) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) These deficient practices had the potential for Resident 86 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have); for Residents 66 and 19's health and well-being to be negatively impacted; and for Resident 10 to experience adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat), and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference: F755, F759, and F760 Findings: 1. During a review of Resident 66's Face Sheet (FS- front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted the resident on 8/18/2023. During a review of Resident 66's Clinical Record Abstract (CRA), the CRA indicated Resident 66 had diagnoses including dementia (a progressive state of decline in mental abilities), paraplegia (loss of movement and/or sensation, to some degree, of the legs), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66's Minimum Data Set (MDS-a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 66 had adequate hearing, clear speech, had the ability to make self understood, and usually understand others. The MDS indicated Resident 66 required substantial assistance with eating and was dependent on staff on functional abilities in mobility. During a review of Resident 66's Orders (physician's orders), the Orders indicated: - carboxymethylcellulose sodium (Refresh Tears-eye drops) 0.5 percent (%-a unit of measurement), take two drops twice a day, indication for irritation or dry eye, dated 9/29/2023. - cetirizine hydrochloride (HCL) (Zyrtec-antihistamine helps relieve allergies), give 10 milligrams (mg-a unit of measurement), give 10 mg (1 tablet) by mouth daily, indication for pruritus (itching), dated 4/9/2024. - Eyelid cleanser (Ocusoft lid scrub), instill one pad into both eyes, twice a day, indication for blepharitis (inflammation of the eyelid), dated 12/6/2024. - lacosamide (Vimpat-antiseizure medication) give 150 mg, one tablet by mouth, twice a day, indication for seizure disorder, dated 8/31/2023. - levetiracetam (Keppra- antiseizure) 500 mg, give 750 mg (1.5 tablets) by mouth, twice a day, indication for seizure disorder, dated 2/8/2024. During a review of Resident 66's Medication Administration Record (MAR-a record of medications administered to residents), for April 2025, the MAR indicated the scheduled time for Resident 66's medications to be given at 9 a.m. included carboxymethylcellulose sodium, cetirizine hydrochloride, eyelid cleanser, lacosamide, and levetiracetam. During a concurrent observation and interview on 4/10/2025 at 7:27 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following medications for Resident 66: lacosamide, one tablet (tab); levetiracetam 500 mg, 1.5 tabs; cetirizine 10 mg, one tab; carboxymethylcellulose eye drops; and eyelid cleanser. LVN 1 stated she has a total of 3.5 tablets and one eye drops to give. During an observation and interview on 4/10/2025 at 7:31 a.m. with LVN 1, at Resident 66's bedside, LVN 1 administered 3.5 tablets, and one eye drop medications to Resident 66. LVN 1 stated she completed medication administration for Resident 66. During a concurrent interview and record review on 4/10/2025 at 7:34 a.m. with LVN 1, reviewed Resident 66's MAR for 4/10/2025. LVN 1 stated she cannot sign Resident 66's MAR with the actual time she gave the medications because the system will not allow her until 8 a.m. LVN 1 stated the medications she gave were scheduled at 9 a.m. LVN 1 stated she will continue to pass (administer) medications. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Residents 66's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurses) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. LVN 1 stated she gave the medications earlier because when Resident 66 was up in the chair, it was difficult to administer the eye drops compared to when the resident is was still on bed. LVN 1 stated she also asked Resident 66 if he would like to receive his medications before the scheduled time and Resident 66 stated he would like to take his medications if they were ready. LVN 1 stated she gives the medications to Resident 66 outside the scheduled time about three times a week but not all the time. During an interview on 4/11/2025 at 11:26 a.m. with the Employee Health Manager ([NAME]), the [NAME] stated medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early for Resident 66. During an interview on 4/11/2025 at 1:18 p.m. with the Director of Pharmacy (DP), the DP stated their MARs have a built-in one hour before and one hour after (time frames to record medication administration). The DP stated if the medication nurse was unable to sign the MAR of Resident 66, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated medications should be given at the scheduled time. The DLTC stated when medications are not given at the scheduled time, Resident 66 may not get the full effect and may have potential drug interactions. The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication of Resident 66 and document the communication with the provider. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. 2. During a review of Resident 19's FS, the FS indicated the facility admitted the resident on 8/7/2024. During a review of Resident 19's CRA, the CRA indicated Resident 19 had diagnoses including dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and constipation (a problem with passing stool). During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had minimal difficulty hearing, clear speech, had the ability to make self understood and understand others. The MDS indicated Resident 19 required staff assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 19's Orders, the Orders indicated the following: - donepezil HCL (Aricept-used to treat dementia), give 5 mg, one tablet by mouth daily, indication for dementia, dated 8/7/2024. - gabapentin (Neurontin- nerve pain medication), give 100 mg, one capsule by mouth, twice a day, indication for depression m/b refusing and resistance to care, dated 12/24/2024. - metformin extended release (Glucophage Extended Release- medication that helps lower high blood sugar) 500 mg, give 1000 mg (two tablets) by mouth, twice a day, indication for diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dated 8/7/2024. - pantoprazole (Protonix- decreases amount of acid produced in the stomach) 40 mg, give 40 mg, one tablet by mouth, daily, indication for gastroesophageal reflux disease (GERD- a condition in which the stomach contents move up into the esophagus), dated 8/7/2024. - polyethylene glycol 3350 (Miralax- used to treat constipation) 15 grams (g-a unit of measurement)/dose, give 17 g (one powder) by mouth daily, mix with eight (8) ounces (oz- a unit of measurement) of liquid or juice, indication for constipation, dated 8/7/2024. - solifenacin succinate (Vesicare- used to treat overactive bladder [OAB- a problem with bladder (organ that stores urine before leaving the body) function that causes the sudden need to urinate]) 5 mg, give 5 mg (one tablet) by mouth, daily, indication for OAB, dated 2/21/2025. During a review of Resident 19's MAR, for April 2025, the MAR indicated the scheduled time for Resident 19's medications to be given at 9 a.m. on 4/10/2025 included donepezil HCL, gabapentin, metformin extended release, pantoprazole, polyethylene glycol 3350, and solifenacin. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/10/2025 at 7:37 a.m. with LVN 1, LVN 1 prepared Resident 19's including medications: pantoprazole 40 mg, one tab; metformin 500 mg, two tabs; gabapentin 100 mg, one capsule; solifenacin 5 mg, one tab; donepezil 5 mg, one tab; polyethylene glycol 17 g. LVN 1 stated she will administer a total of eight medications with seven tablets and one powder. LVN 1 stated she will separate buspirone and gabapentin into a separate medication cup because Resident 19 usually does not want to take all the medications. During a concurrent interview and record review on 4/10/2025 at 7:44 a.m. with LVN 1, reviewed Resident 19's MAR for 4/10/2025. LVN 1 stated she cannot sign at 7:44 a.m. the medications administered because the electronic MAR will not save the date and time she gave the medications. LVN 1 stated she will have to wait until 8 a.m. to sign Resident 19's medications. During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Resident 19's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurse) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. During an interview on 4/11/2025 at 11:26 a.m. with the [NAME], the [NAME] stated Resident 19's medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early. During an interview on 4/11/2025 at 1:18 p.m. with the DP, the DP stated their (facility) MARs have a built-in one hour before and one hour after time frames to record medication administration. The DP stated if the medication nurse was unable to sign Resident 19's MAR, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the DLTC, the DLTC stated Resident 19's medications should have been given at the scheduled time. The DLTC stated when medications are not given at the scheduled time the resident may not get the full effect and may have potential drug interactions.The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication and document the communication with the provider. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. 3. During a review of Resident 86's FS, the FS indicated the facility admitted Resident 86 on 3/5/2025. During a review of Resident 86's CRA, the CRA indicated Resident 86 had diagnoses including epilepsy (a condition that affects the brain and causes frequent seizures, muscle spasm (a sudden, involuntary movement in one or more muscles), neuralgia (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve), and neuritis (inflammation of a nerve). During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 had unclear speech, adequate hearing, rarely/never made self understood, and rarely/never understands others. The MDS indicated Resident 86 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 86 required assistance from staff with ADLs and mobility. The MDS indicated the resident had a feeding tube (a flexible tube inserted into the stomach or intestines to deliver liquid nutrition) while a resident of the facility. During a review of Resident 86's Orders, the Orders indicated: - gabapentin 300 mg, give 300 mg (one tablet) via g-tube three times a day, administer through the percutaneous endoscopic gastrostomy (PEG- a procedure for placing a feeding tube directly into the stomach through the abdominal wall, bypassing the mouth and esophagus) tube, indication for neuralgia and neuritis, dated 3/5/2025. - quetiapine fumarate (Seroquel- drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) 100 mg, give 100 mg (one tablet) via g-tube three times a day via PEG tube, indications for encephalopathy (a disease that affects the function or structure of the brain) secondary to hypoxic brain injury (low levels of oxygen in the brain causing irreversible damage) m/b agitation, dated 3/6/2025. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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Motion Picture and T.V. Hosp D/P Snf	23388 Mulholland Dr. Woodland Hills, CA 91364

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- baclofen 10 mg, give 15 mg (1.5 tablets) via g-tube, three times a day, indication for muscle spasticity of cerebral (brain) origin, dated 4/6/2025. During a review of Resident 86's MAR, for April 2025, the MAR indicated the scheduled time for Resident 86's medications to be given at 2 p.m. included gabapentin, quetiapine, and baclofen. During a concurrent observation and interview on 4/10/2025 at 1 p.m. with LVN 1, LVN 1 prepared Resident 86's medications: quetiapine 100 mg, one tab; gabapentin 300 mg, one capsule; baclofen 10 mg, 1.5 tablets. LVN 1 stated she will administer three medications, total 3.5 tablets to give. LVN 1 crushed each tablets separately in a plastic pouch and poured separately into each medication cup. Observed LVN 1 poured five to 10 ml of water into each medication cup and stirred the medications. During an observation on 4/10/2025 at 1:10 p.m. with LVN 1, at Resident 86's bedside, LVN 1 informed Resident 86 that she (LVN 1) prepared the resident's medications to administer. LVN 1 located Resident 86's g-tube and checked g-tube residual (the amount aspirated from the stomach following administration of enteral feed) which was zero (0) ml. LVN 1 flushed Resident 86's g-tube with 30 ml of water by gravity. LVN 1 administered all three medications with no flushing of water in between medications then flushed with 30 ml of water afterwards. LVN 1 stated she had completed medication pass for Resident 86. During an interview on 4/10/2025 at 1:24 p.m. with LVN 1, LVN 1 stated she prepared Resident 86's medications then she went inside Resident 86's room. LVN 1 stated she checked Resident 86's g-tube residual and there was none. LVN 1 stated she flushed the g-tube with 30 ml and gave the medications then flushed the g-tube another 30 ml afterwards. LVN 1 stated she did not check for patency during the medication pass because in the morning before the night shift nurse left, she (LVN 1) checked Resident 86's g-tube and it was patent. LVN 1 stated she uses a stethoscope to check for patency. LVN 1 stated her supervisor has told her that she did not need to check for patency every medication pass (medication administration). LVN 1 stated she checks for g-tube patency once per day at the beginning of her shift. LVN 1 stated she did not flush the g-tube in between medications because she follows the physician's order which was to flush the g-tube before and after medication administration. LVN 1 stated there was no order to flush the g-tube in between medications. During a concurrent interview and record review on 4/10/2025 at 2:15 p.m. with the DLTC, reviewed the facility's policy and procedure (P&P) titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024. The DLTC stated the P&P for g-tube medication administration is to check placement, patency, and residual before every scheduled medication administration time. The DLTC stated the P&P indicated #10 administer prepared medication separately (Do not mix medication) and flush with 15 ml to 30 ml (unless otherwise ordered) of water between each med (prevent air from entering the tube and follow feeding procedure). The DLTC stated medication nurses are expected to flush 15 to 30 ml between every medication unless there is an order to administer specific amount of water to flush. The DLTC stated if there is no physician's order; the standard of practice applicable to residents including Resident 86 is to flush 15 ml to 30 ml of water between medications. During a concurrent interview and record review on 4/10/2025 at 2:47 p.m. with LVN 1, reviewed Resident 86's MAR. LVN 1 stated there was a physician's order to flush Resident 86's g-tube with 30 ml of water before and after medication administration which she did. LVN 1 stated she did not give water flush in between medications because there was no order to flush in between medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/10/2025 at 2:55 p.m. with LVN 1, reviewed the facility's P&P titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024. LVN 1 stated she did not follow their P&P to flush in between medications and did not check Resident 86's g-tube placement and patency at every scheduled medication administration. LVN 1 stated the [NAME] provided the instructions that there is no need to check for g-tube placement and patency at every scheduled medication administration, and that checking for g-tube placement and patency once at the beginning of the shift or the first scheduled medication during her shift was good. During an interview on 4/11/2025 at 11:26 a.m. with the [NAME], the [NAME] stated the standard of practice for g-tube administration is to check for placement, patency, residual, flush with water before medication administration, in between medications, and after medication administration. The [NAME] stated she did not provide instruction to LVN 1 to only checking placement and patency at the beginning of the shift during the first scheduled medication. The [NAME] stated their policy is to check for placement, patency, and residual done before administering every scheduled medication to be administered. The [NAME] stated flushing in between medications is done as to not mix the medications. The [NAME] stated when flushing in between medications is not done, then it is the same as mixing the medications in the same cup. The [NAME] stated LVN 1 should have followed their policy when LVN 1 administered medications to Resident 86. During an interview on 4/11/2025 at 1:25 p.m. with the DP, the DP stated medications given through the g-tube should not be mixed and should be flushed in between medications to maintain g-tube patency and to ensure Resident 86 received the whole dose. The DP stated there is a potential for medication interactions and clogging of the g-tube. During an interview on 4/11/2025 at 5:17 p.m. with the DLTC, the DLTC stated it is important for the medication nurse to flush in between medications because they would not know what the drug interaction for Resident 86 and this is to ensure the patency of the g-tube and that the resident receives the medications as ordered. The DLTC stated the purpose of checking for patency and placement is to ensure the g-tube is in the right place. The DLTC stated when this is not done the resident could potentially not receive the medications or the medication could go to a different area of the body and would not be properly absorbed. During a review of the facility's P&P titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024, the P&P indicated the purpose of the policy is to provide medication administration when unable to take orally and to monitor for signs and symptoms of infection, irritation at the stoma (a surgically created opening on the abdomen) site. The P&P indicated procedure for medication administration: 1. Check doctor's order. 2. Wash hands and prepare equipment. 3. Identify patient and explain procedure. 4. Position patient; semi-Fowler's position. 5. [NAME] (put on) gloves and check feeding tube for placement, patency, and residual. (continued on next page)

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	04/11/2025

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. For GT/JT placement check: air auscultation (a method used to listen to the sounds of the body by using a stethoscope [medical device), stomach secretions, aspiration . 7. Check gastric residual before giving medication (unless otherwise ordered). 8. If residual is greater than 100 ml, hold medication for one hour and repeat check . 9. Flush tube with 30 ml of water prior to administering medication unless physician orders different amount for flush. 10. Administer prepared medication separately (Do not mix medication) and flush with 15 ml to 30 ml (unless otherwise ordered) of water between each med (Prevent air from entering the tube and follow feeding procedure). 11. After medication is administered, instill 30 mls of water to clear the tube or as GNP/ General Nurse Practitioner (GNP)/Physician order indicates. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. 43988 4. During a review of Resident 10's Face Sheet, the Face Sheet indicated the facility admitted the resident on 6/30/2021 with diagnoses including type 2 diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life), and chronic pain syndrome. During a review of Resident 10's History and Physical (H&P) dated 9/27/2024, the H&P indicated Resident 10 was alert and oriented to full name, exact date, and location. During a review of Resident 10's MDS, dated [DATE], the indicated Resident 10 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 10 received insulin. During a review of Resident 10's physician's order, the physician's order dated 10/2/2024 indicated liraglutide (Victoza - a long-acting insulin) 0.6 milligrams (mg - a unit of measurement) per 0.1 milliliter (ml - a unit of measurement), inject 1.8 mg (0.3 ml) subcutaneously daily at eight (8) a.m. for DM 2. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's care plan (CP) titled Medical Condition: related to DM2, initiated on 6/30/2021, the CP indicated to administer liraglutide (Victoza) as one of the interventions to prevent complications or problems with medical conditions. During a concurrent interview and record review on 4/11/2025 at 8:57 am., reviewed Resident 10's physician's order, subcutaneous administration sites for Victoza from 1/8/2025 to 4/11/2025, and the MDS with Registered Nurse (RN) 1. RN 1 stated Resident 10 received insulin, had a physician's order for Victoza, and were administered as follows: - 3/19/2025 9:26 a.m. left middle mid-thigh - 3/20/2025 9:10 a.m. left middle mid-thigh - 1/27/2025 9:21 a.m. right lower back of arm - 1/28/2025 8:43 a.m. right lower back of arm - 1/5/2025 8:59 a.m. right lower quadrant - 1/6/2025 8:22 a.m. right lower quadrant RN 2 stated administration sites for insulin should be rotated per standards of practice and manufacturer's guideline to prevent hardening or lumps in the skin. RN 2 stated the location of administration sites for Resident 10's insulin was not rotated. RN 2 stated Resident 10's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin which can affect the absorption of the insulin. During an interview on 4/11/2025 at 4 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated the nurses are supposed to rotate insulin administration sites according to standards of practice, and as indicated in the manufacturer's guideline. The DLTC stated the location of administration sites for Resident 10's insulin was not rotated. The DLTC stated Resident 10's administration sites for the Victoza should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. During a review of the facility-provided manufacturer's guideline for Victoza dated 11/2024, the manufacturer's guideline indicated: - Inject Victoza SQ in the abdomen, thigh, or upper arm. - Rotate injection sites within the same region in order to reduce the risk of cutaneous amyloidosis.

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	055034	A. Building B. Wing	04/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure resident received care consistent with professional standards of practice to prevent pressure injury (PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for one (1) of 1 sampled resident (Resident 9) reviewed for pressure injury by failing to perform an accurate assessment of Resident 9's PI on the right buttock. This deficient practice placed Resident 9 at risk for developing pressure injuries and worsening of the current PI. Findings: During a review of Resident 9's Face Sheet, the Face Sheet indicated the facility admitted the resident on 3/30/2022. During a review of Resident 9's Clinical Record Abstract printed on 4/11/2025, the Clinical Record Abstract indicated Resident 39's diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and abnormalities of gait and mobility. During a review of Resident 9's History and Physical (H&P) dated 3/6/2025, the H&P indicated the resident was alert. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool) dated 3/11/2025, the MDS indicated Resident 9 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) but able to understand others and make needs known. The MDS indicated Resident 9 required partial/moderate assistance with eating; total assistance with toileting/hygiene, bathing, and transfers; substantial/maximal assistance with all other activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 9's Wound Care assessment dated [DATE], 4/2/2025, and 4/9/2025, the Wound Care Assessments indicated: - 3/26/2025: Stage 2 PI (partial-thickness loss of skin, presenting as a shallow open sore or wound) right gluteus (also known as buttock). - 4/2/2025: Unstageable PI (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone obscured with yellow or black dead tissue on the wound base) right gluteus. - 4/9/2025: Stage 2 PI right gluteus. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/11/2025 at 8:45 a.m., reviewed Resident 9's Wound Care Assessments with Registered Nurse (RN) 2. RN 2 stated the Wound Care Assessments indicated Resident 9's PI on the right gluteus dated 3/26/2025 indicated stage 2, 4/2/2025 indicated unstageable PI, and 4/9/2025 indicated stage 2. RN 2 stated wound assessments are completed by the RN weekly and documented in the Wound Care Assessment form. RN 2 stated all wounds should be assessed properly and reverse staging (the practice of incorrectly assigning a lower classification to a wound as it heals) is not an acceptable practice. RN 2 stated Resident 9's Wound Care assessment dated [DATE] should have classified the PI on the right gluteus as healing unstageable PI instead of reverse staging to stage 2. RN 2 stated the purpose of properly assessing a wound was for the facility to ensure that the proper treatments and interventions will be provided to the resident to continue healing the wound and prevent worsening. During a concurrent interview and record review on 4/11/2025 at 9:09 a.m., reviewed Resident 9's Wound Care Assessments with RN 4. RN 4 stated the Wound Care Assessments indicated Resident 9's PI on the right gluteus dated 3/26/2025 indicated stage 2, 4/2/2025 indicated unstageable PI, and 4/9/2025 indicated stage 2. RN 4 stated wound assessments are completed by the RN weekly and documented in the Wound Care Assessment form. RN 4 stated PIs should be assessed properly, and staging cannot be reversed. RN 4 stated she did not see that the Wound Care assessment dated [DATE] indicated that Resident 9's PI was unstageable. RN 4 stated she completed Resident 9's Wound Care assessment dated [DATE] and indicated the PI as classified the PI as stage 2. RN 4 stated she should have classified Resident 9's PI on the right gluteus in the Wound Care assessment dated [DATE] as stage healing unstageable PI instead of stage 2 for the facility to ensure Resident 9 will continue to receive the proper treatments and interventions needed to continue healing the wound and prevent worsening. During a concurrent interview and record review on 4/11/2025 at 3:51 p.m. reviewed Resident 9's Wound Care Assessments with RN 2 and the Director of Long-Term Care (DLTC). The DLTC stated Wound Care Assessments are completed by the RNs weekly for any type of wounds such as PI and should be completed accurately. The DLTC stated the Wound Care Assessments indicated Resident 9's PI on the right gluteus dated 3/26/2025 indicated stage 2, 4/2/2025 indicated unstageable PI, and 4/9/2025 indicated stage 2. The DLTC stated classifying of PIs cannot be reversed. The DLTC stated if a PI is healing, the wound remains at its pervious stage and will just be classified as healing. The DLTC stated Resident 9's Wound Care Assessment should have been completed accurately on 4/9/2025 to indicate that the resident's unstageable PI on the right gluteus as healing instead of reverse staging to a stage 2. The DLTC stated it was important to accurately assess the wounds so the proper treatments and interventions will continue to be provided to the resident for continued healing of the PI and prevent worsening. During a review of the facility's policy and procedure (P&P) titled, LTC Standards of Care Nursing Protocol, last reviewed 3/6/2025, the P&P indicated good documentation practices provide an integrated, real-time method of informing the healthcare team about the resident's status and the care provided. The P&P further indicated that two of the six principles of nursing documentation are accuracy to ensure all documentation is precise and reflects the actual care provided, and completeness to include all the necessary information to provide a comprehensive view of the resident's care. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Pressure Injury Monitoring, last reviewed on 3/6/2025, the P&P indicated a purpose to provide a comprehensive evaluation for individuals with pressure injury. The P&P further indicated to complete the Initial Pressure Injury/Vascular Wound Record in the electronic health record (EMR), initiate Weekly/Vascular Injury Record and short-term care plan, and include documentation in the weekly summary.

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	055034	A. Building B. Wing	04/11/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observations, interviews, and record reviews, the facility failed to provide appropriate treatments and services to prevent a decline in joint range of motion (ROM, full movement potential of a joint) and mobility for four out of nine sampled residents (Residents 73, 19, 23, and 4) who had limited ROM and mobility by failing to: 1a. Ensure Resident 73's Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) order for ambulation was updated after Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) recommended RNA to ambulate with a platform walker (a type of walking assistive device with forearm supports to provide extra support during walking) for stability. 1b. Ensure Resident 73 received quarterly PT and Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) joint mobility screens (JMS, assessment of joints to monitor joint range of motion) in 2/2025. 2a. Ensure Resident 19 received RNA treatments after PT recommended RNA for ambulation upon discharge on 11/12/2024. RNA treatment was not ordered until 2/2/2025 (about three months later). 2b. Ensure Resident 19 received a quarterly PT JMS in 1/2025. 3. Ensure Resident 23 received quarterly PT and OT JMS in 3/2025. 4. Ensure Resident 4 received quarterly PT and OT JMS in 2/2025. These deficient practices had the potential for residents to have a further decline in Residents' 73, 19, 23, and 4's ROM and mobility due to delayed treatments and a potential for delayed identification of ROM and mobility decline. Findings: 1. During a review of Resident 73's Face Sheet (FS), the FS indicated Resident 73 was admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia (weakness to one side of the body) following cerebral infarction (bleeding in the brain) affecting left non dominant side and contracture (loss of motion of a joint) of the left hand. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) dated 2/18/2025, the MDS indicated Resident 73 was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 15 had functional limitations in ROM on one side of the upper extremity (UE, shoulder, elbow, wrist/hand) and both sides of the lower extremity (LE, hip, knee, ankle/foot). The MDS indicated Resident 15 required supervision assistance for eating. The MDS indicated Resident 15 required substantial assistance for upper body dressing, toileting hygiene, sit and stand, and chair to bed transfers. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 73's quarterly OT JMS dated 11/12/2024, the OT JMS indicated Resident 73 had full ROM in both shoulders, elbows, and right wrist and hand. The OT JMS indicated Resident 73 had minimal ROM limitation in the left wrist and severe ROM limitations in the left hand. During a review of Resident 73's quarterly PT JMS dated 11/12/2024, the PT JMS indicated Resident 73 had full ROM in both hips, knees, and ankles. During a review of Resident 73's Orders, the Orders indicated an order dated 5/15/2024 for RNA for active range of motion (AROM, movement at a given joint when the person moves voluntarily) to lower and right UE extremities, passive range of motion (PROM, movement at a given joint with full assistance from another person) to left UE, and ambulation with front-wheeled walker (FWW, type of mobility aid with wide base of support and two wheels in the front) three to five days a week as tolerated. 1a. During an observation on 4/9/2025 at 1:08 p.m., Restorative Nursing Aide (RNA 1) walked with Resident 73 using a FWW during RNA treatment. Resident 73 walked from Resident 73's room to the hallway past the nursing station before sitting down for a rest break. During a review of Resident 73's PT Evaluation dated 8/13/2024, the PT Evaluation indicated a recommendation for PT treatment one time a week and a platform walker for improved stability and increased weightbearing (putting one's weight through an extremity) through the upper extremity. During a review of Resident 73's PT Discharge Note (PT DC) dated 9/7/2024, the PT DC indicated Resident 73 demonstrated improved ambulation with platform walker in therapy treatments and to continue RNA for ambulation and ROM exercises to help maintain strength and mobility performance and equipment needed were a platform walker and wheelchair. During an interview and record review on 4/9/2025 at 2:51 p.m., the Registered Nurse Supervisor (RN 1) stated she was the RNA program coordinator. RN 1 stated the RNA program was recommended by PT and OT after the therapists completed their evaluation and treatments with each resident. RN 1 stated the RNA programs were recommended to help maintain the resident's mobility and ROM so the residents could be as mobile as they could and not develop contractures or prevent contractures from getting worse. RN 1 stated once a resident was discharged from PT and OT, the Therapy Manager/Occupational Therapist (TM/OT) would inform RN 1 what the RNA recommendations were and RN 1 would implement the RNA program the therapists recommended. RN 1 reviewed Resident 73's PT DC dated 9/7/2024 and stated the PT recommended Resident 73 to walk with a platform walker during RNA ambulation. RN 1 stated the current RNA order indicated for Resident 73 to ambulate with a FWW. RN 1 stated the RNA order should have been revised for RNA to ambulate with platform walker after 9/7/2024. RN 1 stated the facility was not providing the quality of mobility that was determined by PT. During an interview on 4/10/2025 at 2:06 p.m., the Director of Long-Term Care (DLTC) stated the PT and OT recommended all RNA programs for the residents. DLTC stated the RNA orders and treatments should reflect the recommendations that PT indicated at discharge. During a review of the facility's policy and procedure (P&P) reviewed 4/2024, titled Restorative Nursing Program, indicated the RNP is designed to promote/improve/maintain strength, endurance, balance and mobility. Generally, RNPs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A RN will review at least every month to ensure that orders are appropriate and are being provided to the residents. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. During an interview on 4/9/2025 at 2:51 p.m., RN 1 stated the PT and OT JMS were completed quarterly when the MDS was completed. RN 1 stated the JMS was completed to see if the resident's ROM stayed the same, improved, or declined. RN 1 stated it was important to monitor the ROM closely in case the resident's stiffened up or if the resident developed a contracture, the facility would need to know that immediately. During an interview and record review of Resident 73's JMS on 4/9/2025 at 3:43 p.m., Physical Therapist (PT 1) and TM/OT, PT 1 and TM/OT stated there was no PT or OT JMS completed after 11/12/2024. TM/OT stated Resident 73 should have a quarterly PT and OT JMS completed in 2/2025 and it was not completed. PT 1 stated the PT and OT JMS were completed quarterly for all joints to monitor a resident's ROM. PT 1 stated the purpose was to identify any changes in function or if a resident was developing contractures and see if a resident needed any skilled therapy interventions. TM/OT stated a resident could decline and contractures could get worse if therapy did not complete quarterly JMS, because the declines could be missed. During an interview on 4/10/2025 at 2:06 p.m., the DLTC stated the PT and OT JMS should be completed quarterly for all residents to monitor ROM and joint mobility. During an interview on 4/10/2025 at 1:32 p.m., DLTC stated there was no facility policy and procedure for PT and OT joint mobility screening or to monitor ROM. 2. During a review of Resident 19's Face Sheet (FS), the FS indicated Resident 19 admitted to the facility on [DATE] with diagnoses including but not limited to dementia (a progressive state of decline in mental abilities) and Type 2 Diabetes Mellitus (condition in which the body does not metabolize blood sugar correctly). During a review of Resident 19's MDS dated [DATE], the MDS indicated had moderate cognitive impairment. The MDS indicated Resident 19 had no impairment in ROM on the upper extremity and had functional limitation impairments in ROM on one side of the lower extremity. The MDS indicated Resident 19 required setup with eating, partial assistance with sit to stand, oral hygiene. The MDS indicated Resident 19 required substantial assistance with bed to chair transfers, toileting, and walking 10 feet. 2a. During a review of Resident 19's PT Evaluation dated 11/16/2024, the PT Evaluation indicated a PT recommendation for PT evaluation only and for nursing for ambulation three to five times a week per week. During a review of Resident 19's Orders indicated an order dated 2/2/2025 for RNA for ambulation with FWW three to five days per week as tolerated. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 4/9/2025 at 2:51 p.m., RN 1 stated the RNA program was recommended by PT and OT after the therapists completed their evaluation and treatments with each resident. RN 1 stated the RNA programs were recommended to help maintain the resident's mobility and ROM so the residents could be as mobile as they could and not develop contractures or prevent contractures from getting worse. RN 1 stated once a resident was discharged from PT and OT, the TM/OT would inform RN 1 what the RNA recommendations were, and RN 1 would implement the RNA program the therapists recommended. RN 1 reviewed Resident 19's PT records and stated the PT evaluation dated 11/16/2024 recommended RNA for ambulation three to five times a week. RN 1 stated the RNA program should have started soon after PT discharged the resident on 11/16/2024. RN 1 confirmed RNA order for ambulation was not ordered until 2/2/2025. RN 1 stated Resident 19 could have a decline in function and muscle atrophy with a long delay in starting an RNA program that PT recommended. During an interview and record review on 4/10/2025 at 10:56 a.m., the TM/OT stated PT discharged Resident 19 in 11/2024 and PT recommended RNA for ambulation three to five times a week, but the RNA program was not ordered until 2/2/2025. TM/OT stated the RNA program should not have been delayed this long. TM/OT stated it was important to start an RNA program right after PT and OT was completed to maintain the resident's level of function and that the resident could decline if the resident did not start a recommended RNA program right away. During an interview on 4/10/2025 at 2:06 p.m., the DLTC stated once a resident was discharged from PT or OT and therapists recommend an RNA program, the RNA order should be completed right away. During a review of the facility's policy and procedure (P&P) reviewed 4/2024, titled Restorative Nursing Program, indicated the RNP is designed to promote/improve/maintain strength, endurance, balance and mobility. Generally, RNPs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A RN will review at least every month to ensure that orders are appropriate and are being provided to the residents. 2b. During a review of Resident 19's quarterly OT JMS dated 1/28/2025, the OT JMS indicated Resident 19 had full range of motion in both shoulders, elbows, wrists, and hands. During an interview on 4/9/2025 at 2:51 p.m., RN 1 stated the PT and OT JMS were completed quarterly when the MDS was completed. RN 1 stated the JMS was completed to see if the resident's ROM stayed the same, improved, or declined. RN 1 stated it was important to monitor the ROM closely in case the resident's stiffened up or if the resident developed a contracture, the facility would need to know that immediately. During an interview on 4/9/2025 at 3:43 p.m., PT 1 and TM/OT stated the PT and OT JMS were completed quarterly for all joints to monitor a resident's ROM. PT 1 stated the purpose was to identify any changes in function or if a resident was developing contractures and see if a resident needed any skilled therapy interventions. TM/OT stated a resident could decline and contractures could get worse if therapy did not complete quarterly JMS, because the declines could be missed. During an interview and record review on 4/10/2025 at 10:56 a.m., the TM/OT reviewed Resident 19's medical records and stated Resident 19 was due for a quarterly PT JMS in 1/2025, but it was not completed. (continued on next page)

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	04/11/2025

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 2:06 p.m., the DLTC stated the PT and OT JMS should be completed quarterly for all residents to monitor ROM and joint mobility. During an interview on 4/10/2025 at 1:32 p.m., DLTC stated there was no facility policy and procedure for PT and OT JMS or to monitor ROM. 3. During a review of Resident 23's Face Sheet (FS), the FS indicated Resident 23 admitted to the facility on [DATE] with diagnoses including but not limited to multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and functional quadriplegia (paralysis from the neck down, including legs, and arms) and contracture of right and left hand, right and left foot. During a review of Resident 23's MDS dated [DATE], the MDS indicated Resident 23 had intact cognition. The MDS indicated Resident 23 had functional limitation impairments in ROM on both sides of the upper extremities and both sides of the lower extremities. The MDS indicated Resident 23 required dependent assistance for eating, toileting, bathing, dressing, and bed to chair transfers. During a review of Resident 23's Orders, the Orders indicated an order dated 3/12/2025 for RNA for active ROM to upper extremities, passive ROM to lower extremities as tolerated three to five times a week. During an interview and record review of Resident 23's medical records on 4/9/2025 at 3:43 p.m., PT 1 and TM/OT stated Resident 23 should have received a quarterly PT and OT JMS on 3/2025, but the quarterly PT and OT JMS were not completed. PT 1 and TM/OT stated the PT and OT JMS were completed quarterly for all joints to monitor a resident's ROM. PT 1 stated the purpose was to identify any changes in function or if a resident was developing contractures and see if a resident needed any skilled therapy interventions. TM/OT stated a resident could decline and contractures could get worse if therapy did not complete quarterly JMS, because the declines could be missed. During an interview on 4/10/2025 at 2:06 p.m., the DLTC stated the PT and OT JMS should be completed quarterly for all residents to monitor ROM and joint mobility. During an interview on 4/10/2025 at 1:32 p.m., DLTC stated there was no facility policy and procedure for PT and OT joint mobility screening or to monitor ROM. 4. During a review of Resident 4's Face Sheet (FS), the FS indicated Resident 4 admitted to the facility on [DATE] with diagnoses including, but not limited to congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and polyarthritis (swelling and tenderness of multiple joints causing pain and stiffness). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had moderate cognitive impairment. The MDS indicated Resident 4 had no functional limitations in range of motion in both upper extremities and had impairments in range of motion on both sides of the lower extremities. The MDS indicated Resident 4 required supervision for eating, substantial assistance with toileting, bathing, sit to stand, and bed to chair transfers. (continued on next page)

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	04/11/2025

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Motion Picture and T.V. Hosp D/P Snf	23388 Mulholland Dr. Woodland Hills, CA 91364

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/2025 at 3:43 p.m., PT 1 and TM/OT stated the PT and OT JMS were completed quarterly for all joints to monitor a resident's ROM. PT 1 stated the purpose was to identify any changes in function or if a resident was developing contractures and see if a resident needed any skilled therapy interventions. TM/OT stated a resident could decline and contractures could get worse if therapy did not complete quarterly JMS, because the declines could be missed. During an interview and record review of Resident 4's medical records on 4/10/2025 at 11:04 a.m., TM/OT stated Resident 4 should have received a quarterly PT and OT JMS in 2/2025, but the quarterly PT and OT JMS were not completed. During an interview on 4/10/2025 at 2:06 p.m., the DLTC stated the PT and OT JMS should be completed quarterly for all residents to monitor ROM and joint mobility. During an interview on 4/10/2025 at 1:32 p.m., DLTC stated there was no facility policy and procedure for PT and OT joint mobility screening or to monitor ROM.

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	04/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to ensure residents' environment was free of accident hazards for five of seven sampled residents (Residents 21, 338, 77, 20, and 2) reviewed for accidents by failing to ensure: 1. Resident 21, who was on a swallow precaution (steps to help someone swallow without choking or having food/liquid go down the wrong way), was sitting 90 degrees while eating her breakfast and was completely supervised on 4/8/2025. 2. Resident 338's bottle of Daikin's solution (a strong topical antiseptic widely used to clean infected wounds, ulcers, and burns) was not left at the bedside drawer mixed in with food items. 3. Resident 77's call light's (a device used to summon healthcare workers for assistance, typically found near a resident's bed or within reach of a resident) cord was free from exposed/frayed wires. 4. Resident 77 and Resident 20's bilateral fall mat (a cushioned mat that reduces the risk of injury from a fall) did not have furniture or equipment on top of them. 5. Resident 2 did not have an unattended clear medication cup containing ointment left at the bedside accessible and readily available for self-administration. These deficient practices increased the risk of accidents such as falls with injuries, electrocution, ingestion of harmful chemicals, and choking. Findings: 1. During a review of Resident 21's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/30/2023. During a review of Resident 21's History and Physical (H&P), dated 11/26/2024, the H&P indicated the resident was awake, alert, pleasant, and cooperative. The H&P indicated the resident had history of stroke (a loss of blood flow to part of the brain, which damages brain tissue) with chronic left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and chronic recurrent pneumonia (two or more episodes of pneumonia in twelve (12) months or three episodes altogether) associated with bed-bound status with hypostasis aspiration (refers to the accumulation of fluid or blood in a dependent part of the body, especially after death, due to gravity and lack of circulation, and the subsequent aspiration [breathing in] of this fluid) and general debilitation (being in a weakened or frail state, characterized by a general lack of energy and strength). (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 2/14/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (having noticeable difficulties with thinking, learning, and remembering things, but still able to manage some daily activities with assistance or strategies). The MDS indicated the resident was dependent to needing partial to moderate assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was on a mechanically altered diet (modifying food textures to make them easier to chew and swallow). During a review of Resident 21's Active Orders, dated 8/14/2024, the Active Order indicated an order of Regular diet with meals three times a day (TID). Consistency: Regular, liquid consistency: honey. Comments: She requests only breakfast items that are not cooked, for example fruit, yogurt, muffins, oatmeal. 2/20/2024: Swallow Precautions - head of bed (HOB) elevated at 90 degrees during meals and for half hour following meals. Supervision during meal, no straw, single cup sips, ensure she is eating drinking slowly. Indication: resident complaint of difficulty with nectar thick. During a review of Resident 21's Plan of Care (POC) regarding medical conditions, dated 11/30/2023, the POC indicated an intervention of Regular, liquid consistency: honey. Comments: She requests only breakfast items that are not cooked, for example fruit, yogurt, muffins, oatmeal. 2/20/2024: Swallow Precautions - HOB elevated at 90 degrees during meals and for half hour following meals. Supervision during meal, no straw, single cup sips, ensure she is eating drinking slowly. Indication: resident complaint of difficulty with nectar thick. During a concurrent observation and interview, on 4/8/2025, at 9:22 a.m., with Restorative Nursing Aide (RNA) 3 and Resident 21, inside Resident 21's room, Resident 21 laid in bed with the HOB elevated 75 to 80 degrees, with an empty breakfast tray on top of the side table, eating a cup of yogurt by herself. Resident 21 stated she ate by herself and was just assisted by RNA 3, who cut the food into bite sized pieces and left the room. Resident 21 stated RNA 3 does not stay with her while she eats her breakfast. RNA 3 stated she assisted the resident by placing the breakfast tray on the resident's side table, adjusting the head of the bed up, setting up the food for the resident, cutting the food into bite sized pieces, leaving the room and checking on the resident occasionally while the resident is eating. RNA 3 stated the sign on the resident's wall indicated swallow guidelines, head of bed at 90-degree angle during meals and for 30 minutes following meals, and supervision during meals. RNA 3 stated the sign on the door indicated to please keep this door open while eating and risk for aspiration. RNA 3 stated her responsibility was to keep an eye on the resident, make sure the resident is sitting at a 90-degree angle, make sure the resident's mouth was clear of food, and ensure the resident was not falling asleep. RNA 3 stated she should not have left the room while the resident was eating as the resident can aspirate or choke. RNA 3 stated she was stepping out of the room because the private sitter for the resident was not in yet and she must assist other residents too. During a concurrent interview and record review, on 4/10/2025, at 9:42 a.m., with Registered Nurse (RN) 2, Resident 21's Active Orders, Posted Signage, and POC were reviewed. RN 2 stated there was an order for swallow precautions for Resident 21, head of bed at 90-degree angle during meals and for 30 minutes following meals, and supervision during meals. RN 2 stated RNA 3 should not have left the resident's room as the resident had swallowing problems and the resident can aspirate or choke on the food. (continued on next page)

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	04/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/11/2025, at 3:23 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated RNA 3 should have not left Resident 21 while eating her breakfast. The DLTC stated when a resident is on a swallow precaution, the staff should be always present while the resident is eating so they can supervise and intervene right away if the resident is experiencing aspiration and choking. During a review of the facility-provided Skills Inventory/Competency/Orientation Validation Tool for RNA, undated, the Skills Inventory/Competency/Orientation Validation Tool for RNA indicated safety during meals, observes residents for symptoms of dysphagia (difficulty swallowing): coughing, choking, wet voicing (refers to a voice that sounds gurgly, bubbling, or liquidy, often heard after swallowing or during a meal that is a potential sign that something, like mucus, saliva, or even food, is sitting on the vocal cords or isn't being cleared properly, possibly indicating a swallowing problem), reflux, and complaints of discomfort. Demonstrates knowledge of swallowing precautions/positioning. Observes for food pocketing during meals and provides good oral care after meals. 2. During a review of Resident 338's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/20/2024. During a review of Resident 338's H&P, dated 12/21/2024, the H&P indicated the resident was difficult to communicate with, alert, crying at times, sometimes calm, and quiet. The H&P indicated the resident had multi-infarct state (a loss of mental skills caused by a series of small strokes) with cognitive deficits (problems with mental abilities like thinking, learning, remembering, and making decisions), and chronic neuropathic pain (a long-lasting pain (lasting more than 3 months) that arises from damage or dysfunction of the nervous system). During a review of Resident 338's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and usually understands others and had impaired cognition (a decline in mental abilities that affects a person's thinking, memory, reasoning, judgment, and other cognitive functions). The MDS indicated the resident had diabetic foot ulcer (a slow-healing sore or wound, often on the bottom of the foot, that develops in people with diabetes [a disorder characterized by difficulty in blood sugar control and poor wound healing)]) and moisture associated skin damage (MASD - skin inflammation or breakdown caused by prolonged exposure to wetness, such as urine, feces, sweat, or wound drainage) with application of ointments/medications and application of dressings to feet. During a review of Resident 338's Discontinued Orders, dated 4/10/2025, the Discontinued Orders indicated sodium hypochlorite (Daikin's 1/2 Strength) 0.25%, take 30 milliliters (ml - a unit of measure for volume) twice a day, cleanse coccyx (the last bone at the bottom [base] of the spine) before application of clotrimazole/betamethasone ointments (a topical medicine used to treat fungal skin infections, like jock itch, ringworm, and athlete's foot). Indication: Stage two (2) pressure injury (PI - partial-thickness loss of skin, presenting as a shallow open sore or wound) with fungal component. During a review of Resident 338's POC regarding medical conditions, dated 12/20/2024, the POC indicated an intervention of sodium hypochlorite (Daikin's 1/2 Strength) 0.25%, take 30 ml twice a day cleanse coccyx before application of clotrimazole/betamethasone ointments. Indication: Stage 2 PI with fungal component. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/8/2025, at 10:13 a.m., with Licensed Vocational Nurse (LVN) 3, inside Resident 338's room, the top of the bedside drawer contained a bottle of Daikin's Solution labeled with the resident's name mixed with food items. LVN 3 stated there should be no medications left at the bedside as the residents can accidentally ingest them causing harm. LVN 3 stated the Daikin's solution should be placed back in the medication cart after it was administered. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated the Daikin's Solution should not have been left at Resident 338's bedside to prevent accidental chemical ingestion by the resident which can cause harm to residents. The DLTC stated the Daikin's solution should have been kept in the medication cart. During a review of the facility's recent policy and procedure (P&P) titled Accident Prevention, last reviewed on 3/6/2025, the P&P indicated to ensure the environment is as free as possible from accidents hazards and identify residents who require supervision and/or assistive devices to prevent accidents. Conduct routine rounding to identify and mitigate environmental hazards including: -Electrical safety -Other Environmental Hazards as identified During a review of the facility's recent P&P titled Medication Administration, last reviewed on 12/5/2024, the P&P indicated do not leave medications unattended with the patient/resident. 3. During a review of Resident 77's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/27/2023. During a review of Resident 77's H&P, dated 12/17/2024, the H&P indicated the resident was alert, but unable to converse. The H&P indicated the resident had Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), frontal lobe dementia (a group of conditions where the frontal and temporal lobes of the brain are damaged, leading to changes in thinking, behavior, and sometimes language or movement), and major depression (mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was dependent on mobility and ADLs. During a review of Resident 77's Fall Risk Evaluation, dated 3/18/2025, the Fall Risk Evaluation indicated the resident was high risk for fall. During a review of Resident 77's Active Orders, dated 5/2/2024, the Active Orders indicated beveled floor mat LTC every(q) shift During a review of Resident 77's POC regarding cognitive/communication/falls/ ADL's/Incontinence/Skin Integrity problem, dated 12/27/2023, the POC indicated a goal of the resident wanting to be free of fall and complications and to place beveled floor mat when the resident is in bed and store mat when not in use with an indication for major injury prevention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/8/2025, at 9:07 a.m., with Certified Nursing Assistant (CNA) 6, inside Resident 77's room, Resident 77's call light cord had exposed/frayed wires and the bilateral fall mats had two wheels of the side table and the staff chair resting on top of the right fall mat of the resident's bed while feeding the resident breakfast. CNA 6 stated there should be no exposed/frayed wires on the resident's call light cord because the resident can be electrocuted and there should be no furniture or medical equipment on the fall mat of the resident to prevent the fall mat from sustaining permanent dents that can lessen the cushioning effect of the mat when the resident falls on them, sustaining an injury. CNA 6 stated the side table could also tip over the resident and cause injury. During a concurrent interview and record review, on 4/10/2025, at 10:13 a.m., with RN 2, Resident 77's Fall Risk Assessment, dated 3/18/2025, and POC, dated 12/27/2023, were reviewed. RN 2 confirmed and stated Resident 77 was at risk for falls. RN 2 further stated there should be no frayed/exposed wires on the resident's call light cord to prevent the resident from electrocution. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated there should be no exposed/frayed wires to prevent accidental electrocution of Resident 77. The DLTC further stated no furniture, or medical equipment should be on top of Resident 77's fall mat to prevent injury to residents when they slide down on them. During a review of the facility's recent P&P titled, LTC [Long Term Care] Standard of Care Nursing Protocol, last reviewed on 3/6/2025, the P&P indicated to keep the environment free of clutter. During a review of the facility's recent P&P titled, Falls, last reviewed on 12/5/2024, the P&P indicated to keep the environment free of clutter and floors dry. Keep floor clutter/obstacles in pathway between bed and bathroom/commode. Remove excess equipment/supplies, furniture from rooms and hallways. During a review of the facility's recent P&P titled, Bed Maintenance, last reviewed on 3/1/2024, the P&P indicated to check all electrical outlets, including accessory outlets that may be mounted on resident beds, for cleanliness, physical integrity, and functionality. 43988 4. During a review of Resident 20's Face Sheet, the Face Sheet indicated the facility admitted the resident on 9/6/2023. During a review of Resident 20's Clinical Record Abstract, the Clinical Record Abstract indicated Resident 20's diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 20's H&P, dated 9/6/2024, the H&P indicated the resident was alert and oriented to full name and location, and unable to tell the date. (continued on next page)

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	04/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had severely impaired cognition and usually understands others and usually to make needs known. The MDS indicated Resident 20 required substantial/maximal assistance with bed mobility and total assistance from staff with all other ADLs. During a review of Resident 20's physician's order, dated 10/25/2024, the physician's order indicated an order for beveled floor mat as directed for risk of fall with injury. During a review of Resident 20's care plan (CP) titled, Cognitive/Vision/Falls/ADL/Incontinence/Skin integrity, initiated on 9/6/2023, the CP indicated beveled floor mat as directed for risk of fall with injury as one of the interventions for Resident 20's safety and will have no falls or injury. During a concurrent observation and interview, on 4/9/2025, at 7:26 a.m., inside Resident 20's room, with CNA 7, CNA 7 stated Resident 20 had bilateral floor mats with an overbed table placed on top of each floor mat on both sides and in front of the resident. CNA 7 stated Resident 20's overbed tables should have not been placed on top of the floor mat as it places the resident at risk for getting injured when he tries to get out of bed unassisted. CNA 7 stated Resident 20 had a few incidents of falls in the past. CNA 7 stated the integrity of the floor mat can get affected if there are indentation from placing equipment or table on top of floor mat and cannot protect the resident. During an interview, on 4/10/2025, at 10:13 a.m., with RN 2, RN 2 stated Resident 20 is a risk for falls and had a few incidents of falls in the past. RN 2 stated there should be no overbed table on top of the floor mat as it can tip over and fall on the resident and residents can hit the table when they try to get out of bed unassisted which could lead to injury. RN 2 stated placing the overbed tables on top of the floor mat can affect the integrity of the floor mat and reduce the ability of the floor mat to protect the resident during a fall incident. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated there should be no furniture or medical equipment on top of the residents' floor mats. The DLTC stated the overbed tables should not have been placed on top of Resident 20's bilateral floor mats to prevent the resident from incurring injury when Resident 20 tries to get out of bed unassisted and hit the overbed table. During a review of the facility's P&P titled, Falls, last reviewed on 12/5/2024, the P&P indicated interventions will be implemented in accordance with the resident's needs which include but not limited to keeping the environment free of clutter and floors dry. The P&P further indicated to keep floor clutter free/obstacle free especially in pathway between bed and bathroom/commode as one of the general safety interventions During a review of the facility's P&P titled, Accident Prevention, last reviewed on 3/6/2025, the P&P indicated the facility will ensure the environment is as free as possible from accident hazards and identify residents who requires supervision and/or assistive devices to prevent accidents. The P&P further indicated to conduct routine rounding to identify and mitigate environmental hazards including assistive devices/equipment hazards. 44244 5. During a review of Resident 2's Face Sheet, the Face Sheet indicated the facility admitted the resident on 9/12/2020. (continued on next page)

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	04/11/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Patient Diagnosis Information, the Patient Diagnosis Information indicated the resident had diagnoses including Alzheimer's Disease, dementia, xerosis (condition characterized by rough, dry, and itchy skin), infection reaction of the left knee prosthesis (artificial replacement of the knee), and diabetes mellitus. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the facility most recently admitted the resident on 4/16/202. The MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required substantial/maximal assistance from staff for toileting, dressing, personal hygiene, and mobility. The MDS indicated the resident was dependent on staff for bathing and putting on footwear. During a review of Resident 2's Care Plan (CP) titled, . [Resident 2] has forgetfulness, short term memory loss related to dementia .has impaired safety judgement ., initiated 9/12/2022, the CP indicated the resident wanted to be safe and remain safely within the facility. The CP indicated the resident had an intervention of petrolatum, white (a moisturizer to treat or prevent dry, rough, scaly, itchy skin) 41 percent (%, a unit of measurement), apply ointment topically every eight hours as needed to affected areas for xerosis that was discontinued on 4/2/2024. During a concurrent observation and interview, on 4/8/2025, at 10:20 a.m., Resident 2 laid wake in bed with no staff were present in the room. Resident 2's nightstand had a clear plastic medication cup with a light-yellow ointment on top of it. Resident 2 stated she needed staff assistance with a spill. Resident 2 pressed the call light (a device used to summon health care workers). During a concurrent observation and interview, on 4/8/2025, at 10:25 a.m., RNA 2 entered Resident 2's room and walked past the clear plastic cup containing ointment. RNA 2 stated the resident had a spill and RNA 2 would get the CNA to help the resident. RNA 2 exited the room and did not remove the ointment. CNA 2 entered Resident 2's room and walked past the cup with ointment. The resident requested to have the breakfast tray reheated and CNA 2 exited the room without removing the ointment. LVN 2 entered Resident 2's room and walked past the ointment. LVN 2 stated Resident 2 had a spill on the shirt that would be cleaned after the resident finished breakfast. LVN 2 exited the room. The ointment remained in Resident 2's room. During an observation, on 4/8/2025, at 10:40 a.m., CNA 2 entered Resident 2's room with clean linens. The ointment remained on Resident 2's nightstand. During a concurrent observation and interview, on 4/8/2025, at 11 a.m., CNA 2 stood at the doorway to Resident 2's room and stated there was ointment in a cup left on the resident's nightstand. CNA 2 stated somebody from nightshift must have left the ointment on the nightstand. CNA 2 stated she did not previously see the ointment but had been in the resident's room about four times since the beginning of the shift at 7 a. m. CNA 2 stated Resident 2 should not have any ointments left in the room unattended. CNA 2 stated she was not sure why ointments should not be left in resident rooms. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/8/2025, at 11:05 a.m., with LVN 2, LVN 2 stated Resident 2 did not have an order for the topical ointment left in Resident 2's room and was not safe for self-administration of medication. LVN 2 stated she did not see the ointment while in Resident 2's room, but she should have. LVN 2 stated medications should never be left in a resident's room because of safety issues. LVN 2 stated all the residents on the unit had dementia, confusion, and some resident's wandered. LVN 2 stated any resident could get the ointment when the ointment was left unattended in the room, potentially resulting in the resident eating the topical medication. During a concurrent interview and record review, on 4/11/2025, at 11:15 a.m., with the DLTC, In-services titled, Plan of Correction for April 2-4, 2024, Survey Findings, dated 4/2/2024 to 4/4/2024, were reviewed. The DLTC stated all staff complete walking rounds to residents' rooms at the beginning and end of every shift. The DLTC stated every time staff enters a resident's room, the staff should assess the environment for safety. The DLTC stated the residents on Resident 2's unit have dementia. The DLTC stated for the safety of all residents on the unit, medications should never be left unattended in a resident's room. The DLTC stated staff had an in-service in 4/2024 regarding not leaving medications at bedside and staff know that medication should not be left in a resident's room. The DLTC stated when the topical medication was left out in Resident 2's room, a confused resident could put the topical medication on their body causing an allergic reaction or ingest the topical medication causing illness from poisoning. The DLTC stated the facility P&P was not followed when medication was left unattended in Resident 2's room. During a review of the facility provided In-service titled, Plan of Correction for April 2-4, 2024 Survey Findings, dated 4/2/2024 to 4/4/2024, the In-service indicated medications or treatments should never be left at the bedside without a medical provider order. This includes over the counter medications and creams. Medications or treatments left at the bedside could present a danger to the resident. Always make sure all supplies are removed from the bedside after completing a treatment or medication pass. During a review of the facility provided P&P titled, Medication Administration, last reviewed 11/2024, the P&P indicated medications shall be accurately and safely administered to facility residents by authorized personnel. Remain with the resident until the medication has been administered. Do not leave medications unattended with the resident. During a review of the facility provided P&P titled, Accident Prevention, last revised 1/2025, the P&P indicated the purpose of the P&P was to ensure the environment is as free as possible from accident hazards and to identify residents who require supervision. Conduct routine rounding to identify and mitigate environmental hazards.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43988 Based on observation, interview, and record review, the facility failed to ensure a residents with a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for one (1) of 1 sampled resident (Resident 40) reviewed for urinary catheter or UTI by failing to ensure Resident 40's urinary catheter tubing was anchored to the statlock (a device that secures the catheter in place preventing it from being pulled out or moving around). This deficient practice had the potential for the resident's urinary catheter to be pulled out or move around which may lead to pain, trauma, and catheter blockage. Findings: During a review of Resident 40's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 9/27/2023 and readmitted the resident on 2/4/2024. During a review of Resident 40's Clinical Record Abstract, the Clinical Record Abstract indicated Resident 40's diagnoses including unspecified dementia (a progressive state of decline in mental abilities), presence of suprapubic catheter (a hollow tube inserted into the bladder through a small incision in the lower abdomen to drain or collect urine), and hypertension (HTN-high blood pressure). During a review of Resident 40's History and Physical (H&P) dated 8/28/2024, the H&P indicated Resident 40 was alert and oriented. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 3/14/2025, the MDS indicated Resident 40 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; partial/moderate assistance with oral hygiene, bed mobility, and ambulation; substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 40 had indwelling catheter (a type of urinary catheter). During a review of Resident 40's physician's order dated 10/4/2023, the physician's order indicated: - Suprapubic catheter French (FR - a unit of measurement) 16 per 10 milliliters (ml - a unit of measurement). - Suprapubic catheter: Monitor suprapubic catheter site daily every eight hours for any signs and symptoms of infection: redness drainage, fever, increase warmth, feeling of malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well), increased pain, swelling, and document and notify provider. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Suprapubic catheter every two (2) months: Change every 2 months and as needed for dislodgement, blockage, and bypassing (leaking). During an observation on 4/7/2025 at 9:20 a.m. inside Resident 40's room, observed Resident 40 lying on bed alert, answers appropriately and with the urinary catheter on the right leg attached to a leg bag (a type of urine collection bag that can be attached to the leg for use during the day). Observed statlock attached on the resident's right thigh and the suprapubic catheter was not anchored to the statlock. During a concurrent observation and interview on 4/7/2025 at 9:32 a.m. inside Resident 40's room with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 40 has a statlock on the right thigh and the suprapubic catheter was not anchored to the statlock. LVN 3 stated any type of urinary catheter should be anchored securely to the statlock to keep the catheter stable and prevent from being pulled out or moving causing pain, or trauma. LVN 3 stated Resident 40's suprapubic catheter should have been anchored to the statlock as it placed Resident 40's catheter at risk from being move around and/or pulled causing pain and trauma to the insertion site which may lead to development of UTI. During an interview on 4/11/2025 at 4:30 p.m. with the Director of Long Term Care (DLTC), the DLTC stated the staff are supposed to place a statlock on residents with any type of urinary catheters to keep the catheter stable and prevent form being pulled out or moving which can cause trauma and pain to the resident. The DLTC stated Resident 40's suprapubic catheter should have been anchored securely to the statlock to prevent Resident 40's catheter to be moving around and accidentally pulled out due to movements causing pain and trauma. The DLTC if the catheter is not anchored securely, the movement and pulling out may lead to development of urine infection. During a review of the facility's policy and procedure (P&P) titled, Urinary Catheterization, last reviewed 10/2024, the P&P indicated indwelling catheters should be properly secured after insertion to minimize movement and urethral traction.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to ensure residents were administered medications according to facility's policy and procedure for three of five sampled residents (Resident 66, 19, and 86) reviewed under Medication Administration facility task and for one of three sampled residents (Resident 39) reviewed under the Pressure Ulcer / Injury (PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) care area, by: 1. Failing to ensure Licensed Vocational Nurse (LVN) 1 did not administer mupirocin (a topical medication that treats skin infections caused by bacteria) without a physician's order to Resident 39. This deficient practice placed Resident 39 at risk for a delay in the necessary care and services for the prevention and healing of PIs. 2. Failing to ensure two of five sampled residents' (Residents 66 and Resident 19) scheduled medications were administered as ordered at the scheduled time. 3. Failing to check Resident 86's gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems) placement and patency before administering the resident's medications. 4. Failing to flush water in between medications for Resident 86 when LVN 1 administered the resident's g-tube medications. These deficient practices had the potential for Resident 86 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and for Residents 66 and 19's health and well-being to be negatively impacted. (Cross reference: F658, F759, F760, F761) Findings: 1. During a review of Resident 39's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/18/2018. During a review of Resident 39's Patient Diagnosis Information, the Patient Diagnosis Information indicated the resident had diagnoses including neurocognitive disorder with Lewy bodies (a progressive disorder characterized by the gradual decline of thinking and reasoning abilities, often accompanied by movement and sleep disturbances, and visual hallucinations) and PI of the sacral region (lower back at the base of the spine) stage two (partial-thickness loss of skin, presenting as a shallow open sore or wound). (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 39's Minimum Data Set (MDS - resident assessment tool), dated 3/14/2025, the MDS indicated the facility most recently admitted the resident on 8/21/2018. The MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make himself understood. The MDS further indicated the resident was dependent on assistance from staff for eating, toileting, bathing, dressing, personal and oral hygiene, and mobility. During a review of Resident 39's Care Plan (CP) titled, Pressure Injury Stage Two (2) on sacrum related to previous pressure injury on area, incontinence, impaired mobility, initiated 11/25/2024, the CP indicated a goal that the area would heal without complications in the next 120 days. During a review of Resident 39's physician orders, the physician orders indicated the following treatment orders: - Dated 3/26/2025, cleanse PI of the sacrum with wound cleansing spray, gently pat dry, apply maxorb plus silver (an antimicrobial wound dressing), cut to fit wound, cover with opti foam (a type of dressing), change dressing daily. - Dated 1/30/2025 and discontinued (DC'd) on 2/12/2025, mupirocin 2 percent (% - a unit of measure), apply ointment 1 dose topically twice a day. cleanse PI of the sacrum with warm cleansing wipes, gently pat dry, apply mupirocin ointment prior to application of moisture barrier cream. Indication: stage 2 pressure injury. During a concurrent observation and interview, on 4/10/2025, at 11:30 a.m., with LVN 1, LVN 1 performed Resident 39's wound care treatment. LVN 1 stated the LVNs provide daily wound care for facility residents. LVN 1 gathered the following wound care supplies from the One [NAME] Treatment Cart: mupirocin ointment placed in a clear medication cup, an opti foam dressing, cleansing spray, and the maxorb dressing. LVN 1 entered Resident 39's room with the supplies, cleansed Resident 39's wound, applied the mupirocin ointment to cover the wound, placed the maxorb dressing on top of the mupirocin ointment, then applied the opti foam dressing. Upon completion of the treatment, LVN 1 exited the resident's room. During a concurrent interview and record review, on 4/10/2025, at 11:55 a.m., with LVN 1, Resident 39's physician orders were reviewed. LVN 1 stated she applied mupirocin ointment to Resident 39. LVN 1 stated she always applies the mupirocin when providing Resident 39's wound care treatment. LVN 1 reviewed Resident 39's treatment orders and stated Resident 39 did not have an active order to apply mupirocin. LVN 1 stated prior to administering mupirocin, LVN 1 reviewed Resident 39's treatment order. LVN 1 stated she thought there was an order for mupirocin, but there was not. LVN 1 stated she should have read the order more carefully. During a concurrent interview and record review, on 4/10/2025, at 12:15 p.m., with Registered Nurse (RN) 3, Resident 39's physician orders were reviewed. RN 3 stated the medication and treatment administration process is to review the physician's treatment orders, remove the medication from the treatment cart, compare the medication with the order, and then apply the medication to the resident. RN 3 stated if there is no order for the mupirocin, the nurse should contact the nurse practitioner or physician to clarify if they would like to continue with the treatment. RN 3 stated there must be a physician's order prior to applying medication to a resident. RN 3 stated Resident 39 did not have an active order for mupirocin when LVN 1 applied the mupirocin to Resident 39. RN 3 stated Resident 39 previously had an order for mupirocin that was discontinued on 2/12/2025. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/10/2025, at 1:13 p.m., with RN 2, Resident 39's physician orders were reviewed. RN 2 stated when a medication is discontinued, the pharmacy and the nurse receive a notification to remove the medication from the cart. RN 2 stated Resident 39's mupirocin order was discontinued on 2/12/2025 and the medication should have been removed immediately from the One [NAME] Treatment Cart to ensure the medication was not administered by mistake. During an interview, on 4/10/2025, at 2:02 p.m., with LVN 1, LVN 1 stated it is important to carefully review the treatment order prior to providing the treatment to ensure errors are avoided like administering the wrong medication to the resident. LVN 1 stated Resident 39's discontinued mupirocin ointment remained in the One [NAME] Treatment Cart and LVN 1 administered the discontinued medication to Resident 39 every day that she worked this week including 4/10/2025, 4/9/2025, 4/8/2025, and 4/7/2025. LVN 1 stated she thought Resident 39 had an order for mupirocin when LVN 1 applied the medication, but there was no order. LVN 1 stated she just saw the mupirocin ointment in the cart, grabbed it, and applied it to Resident 39. During an interview, on 4/10/2025, at 2:12 p.m., with RN 3, RN 3 stated during medication and treatment administration, nurses should follow the rights of safe medication administration by comparing the physician's order to the actual medication label to ensure the right resident gets the right medication at the right time and no errors are made. RN 3 stated LVN 1 did not follow the rights of safe medication administration, and it resulted in LVN 1 administering a discontinued medication to Resident 39. RN 3 stated when the discontinued mupirocin was administered to Resident 39 there was the potential that the PI healing process would be affected causing a delay in healing or a decline in the resident's condition. During an interview, on 4/11/2025, at 11:15 a.m., with the Director of Long-Term Care (DLTC), the DLTC stated medications are discontinued for a reason. The DLTC stated discontinued medication may not be an effective treatment, or a different treatment may be more appropriate. The DLTC stated when a discontinued medication was left in the treatment cart and administered to Resident 39, there was a potential that the mupirocin would have a negative effect on the resident's healing process. During a review of the facility policy and procedure (P&P) titled, Pharmacy: General Administrative, last reviewed 3/2024, the P&P indicated all medications dispensed to residents must be ordered by a prescriber. A system of controlling nursing medication stock items and replacement is maintained with transaction records to maintain control and accountability of all drugs. All medications administered to residents must be first ordered by a physician or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the resident's medical record. Residents administered medications shall be carefully monitored to determine whether the medication results in the therapeutically intended benefit, and to allow for early identification of adverse effects and timely initiation of appropriate corrective action. During a review of the facility P&P titled, Medication Administration, last reviewed 11/2024, the P&P indicated medication shall be accurately and safely administered to residents, by authorized personnel. The procedure includes: - Access the resident's Medication Administration Record (eMAR) via the Electronic Medical Record (EMR). a. Compare the label of the unit of medication with the individual resident eMAR. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Place medications for individual resident in a small disposable cup, tray or medication cup according to need. c. Identify the resident using two identifiers (never by room number). d. Assess/monitor a patient/resident who requires checking prior to administering medication, and those for whom PRN/as needed medications have been prescribed. Check for and document effectiveness in the PRN EMR. e. Remain with the patient/resident until medication has been administered. f. Discard medication packages and other waste in the mandated receptacles. g. Sign the eMAR after administration or non-administration of all medications. - Medication Safety Practices for Medication Administration include: - The 6 Rights of Safe Medication Administration are: i. The Right Medication ii. The Right Dose iii. The Right Patient/Resident iv. The Right Route v. The Right Time vi. The Right Documentation - A physician's order must include: o Date and time of the order o Name of the medication o Dose o Frequency o Route o Indication o Duration, if applicable o Diagnosis (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38552 2. During a review of Resident 39's Face Sheet (FS- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted the resident on 4/18/2018. During a record review of Resident 39's Patient Diagnosis Information, the Patient Diagnosis Information indicated the resident had diagnoses that included neurocognitive disorder with Lewy bodies (a progressive disorder characterized by the gradual decline of thinking and reasoning abilities, often accompanied by movement and sleep disturbances, and visual hallucinations) and PI of the sacral region (lower back at the base of the spine) stage two (partial-thickness loss of skin, presenting as a shallow open sore or wound). During a review of Resident 39's Minimum Data Set (MDS - resident assessment tool) dated 3/14/2025, the MDS indicated the facility most recently admitted the resident on 8/21/2018. The MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make himself understood. The MDS further indicated the resident was dependent on assistance from staff for eating, toileting, bathing, dressing, personal and oral hygiene, and mobility. During a review of Resident 39's Care Plan (CP) titled, Pressure Injury Stage 2 on sacrum related to previous pressure injury on area, incontinence, impaired mobility, initiated 11/25/2024, the CP indicated a goal that the area would heal without complications in the next 120 days. During a review of Resident 39's physician orders, the physician orders indicated the following treatment orders: - Dated 3/26/2025, cleanse PI of the sacrum with wound cleansing spray, gently pat dry, apply maxorb plus silver (an antimicrobial wound dressing), cut to fit wound, cover with opti foam (a type of dressing), change dressing daily. - Dated 1/30/2025 and discontinued (DC'd) on 2/12/2025, mupirocin 2 %, apply ointment 1 dose topically twice a day. cleanse PI of the sacrum with warm cleansing wipes, gently pat dry, apply mupirocin ointment prior to application of moisture barrier cream. Indication: stage 2 pressure injury. During a concurrent observation and interview on 4/10/2025 at 11:30 a.m. with LVN 1, observed Resident 39's wound care treatment in the resident's room. LVN 1 stated the LVNs provide daily wound care for facility residents. LVN 1 gathered the following wound care supplies from the One [NAME] Treatment Cart: mupirocin ointment placed in a clear medication cup, an opti foam dressing, cleansing spray, and the maxorb dressing. LVN 1 entered Resident 39's room with the supplies, cleansed Resident 39's wound, applied the mupirocin ointment to cover the wound, placed the maxorb dressing on top of the mupirocin ointment, then applied the opti foam dressing. Upon completion of the treatment, LVN 1 exited the resident's room. (continued on next page)

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	04/11/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up observation, interview, and record review on 4/10/2025 at 11:55 a.m. with LVN 1, LVN 1 reviewed Resident 39's physician orders. LVN 1 stated LVN 1 applied mupirocin ointment to Resident 39. LVN 1 stated LVN 1 always applies the mupirocin when providing Resident 39's wound care treatment. LVN 1 then reviewed Resident 39's treatment orders and noted Resident 39 did not have an active order to apply mupirocin. LVN 1 stated prior to administering mupirocin, LVN 1 reviewed Resident 39's treatment order. LVN 1 stated LVN 1 thought there was an order for mupirocin, but there was not. LVN 1 stated LVN 1 should have read the order more carefully. During a concurrent interview and record review on 4/10/2025 at 12:15 p.m. with Registered Nurse (RN) 3, RN 3 reviewed Resident 39's physician orders. RN 3 stated the medication and treatment administration process it to review the physician's treatment orders, remove the medication from the treatment cart, compare the medication with the order, and then apply the medication to the resident. RN 3 stated if there is no order for the mupirocin, the nurse should contact the nurse practitioner or physician to clarify if they would like to continue with the treatment. RN 3 stated there must be a physician's order prior to applying medication to a resident. RN 3 stated Resident 39 did not have an active order for mupirocin when LVN 1 applied the mupirocin to Resident 39. RN 3 stated Resident 39 previously had an order for mupirocin that was discontinued on 2/12/2025. During a concurrent interview and record review on 4/10/2025 at 1:13 p.m. with RN 2, RN 2 reviewed Resident 39's physician orders. RN 2 stated when a medication is discontinued, the pharmacy and the nurse receive a notification to remove the medication from the cart. RN 2 stated Resident 39's mupirocin order was discontinued on 2/12/2025 and the medication should have been removed immediately from the One [NAME] Treatment Cart to ensure the medication was not administered by mistake. During an interview on 4/10/2025 at 2:02 p.m. with LVN 1, stated it is important to carefully review the treatment order prior to providing the treatment to ensure errors are avoided like administering the wrong medication to the resident. LVN 1 stated Resident 39's discontinued mupirocin ointment remained in the One [NAME] Treatment Cart and LVN 1 administered the discontinued medication to Resident 39 every day that she worked this week including 4/10/2025, 4/9/2025, 4/8/2025, and 4/7/2025. LVN 1 stated LVN 1 thought Resident 39 had an order for mupirocin when LVN 1 applied the medication, but there was no order. LVN 1 stated LVN 1 just saw the mupirocin ointment in the cart, grabbed it, and applied it to Resident 39. During a follow up interview on 4/10/2025 at 2:12 p.m. with RN 3, RN 3 stated during medication and treatment administration nurses should follow the rights of safe medication administration by comparing the physician's order to the actual medication label to ensure the right resident gets the right medication at the right time and no errors are made. RN 3 stated LVN 1 did not follow the rights of safe medication administration, and it resulted in LVN 1 administering a discontinued medication to Resident 39. RN 3 stated when the discontinued mupirocin was administered to Resident 39 there was the potential that the PI healing process would be affected causing a delay in healing or a decline in the resident's condition. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/11/2025 at 11:15 a.m. with the Director of Long Term Care (DLTC), the DLTC reviewed the facility policy and procedure regarding medication administration and medication storage. The DLTC stated medications are discontinued for a reason. The DLTC stated discontinued medication may not be an effective treatment, or a different treatment may be more appropriate. The DLTC stated when a discontinued medication was left in the treatment cart and administered to Resident 39, there was a potential that the mupirocin would have a negative effect on the resident's healing process. A review of the facility policy and procedure (P&P) titled, Pharmacy: General Administrative, last reviewed 3/2024, the P&P indicated all medications dispensed to patients must be ordered by a prescriber. A system of controlling nursing medication stock items and replacement is maintained with transaction records to maintain control and accountability of all drugs. All medications administered to patients must be first ordered by a physician or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. Patients administered medications shall be carefully monitored to determine whether the medication results in the therapeutically intended benefit, and to allow for early identification of adverse effects and timely initiation of appropriate corrective action. A review of the facility policy and procedure (P&P) titled, Medication Administration, last reviewed 11/2024, the P&P indicated medication shall be accurately and safely administered to residents, by authorized personnel. The procedure includes: - Access the resident's Medication Administration Record (eMAR) via the Electronic Medical Record (EMR). a. Compare the label of the unit of medication with the individual resident eMAR. b. Place medications for individual resident in a small disposable cup, tray or medication cup according to need. c. Identify the resident using two identifiers (never by room number). d. Assess/monitor a patient/resident who requires checking prior to administering e. medication, and those for whom PRN/as needed medications have been prescribed. Check for and document effectiveness in the PRN EMR. f. Remain with the patient/resident until medication has been administered. g. Discard medication packages and other waste in the mandated receptacles. h. Sign the eMAR after administration or non-administration of all medications. - Medication Safety Practices for Medication Administration include: - The 6 Rights of Safe Medication Administration are: i. The Right Medication (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. The Right Dose iii. The Right Patient/Resident iv. The Right Route v. The Right Time vi. The Right Documentation - A physician's order must include: o Date and time of the order o Name of the medication o Dose o Frequency o Route o Indication o Duration, if applicable o Diagnosis 3. During a review of Resident 66's FS, the FS indicated the facility admitted the resident on 8/18/2023. During a review of Resident 66's Clinical Record Abstract (CRA), the CRA indicated Resident 66 had diagnoses including dementia (a progressive state of decline in mental abilities), paraplegia (loss of movement and/or sensation, to some degree, of the legs), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had adequate hearing, clear speech, had the ability to make self understood, and usually understand others. The MDS indicated Resident 66 required substantial assistance with eating and was dependent on staff on functional abilities in mobility. During a review of Resident 66's Orders (physician's orders), the Orders indicated: - carboxymethylcellulose sodium (Refresh Tears-eye drops) 0.5 percent (%-a unit of measurement), take two drops twice a day, indication for irritation or dry eye, dated 9/29/2023. (continued on next page)

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	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- cetirizine hydrochloride (HCL) (Zyrtec-antihistamine helps relieve allergies), give 10 milligrams (mg-a unit of measurement), give 10 mg (1 tablet) by mouth daily, indication for pruritus (itching), dated 4/9/2024. - Eyelid cleanser (Ocusoft lid scrub), instill one pad into both eyes, twice a day, indication for blepharitis (inflammation of the eyelid), dated 12/6/2024. - lacosamide (Vimpat-antiseizure medication) give 150 mg, one tablet by mouth, twice a day, indication for seizure disorder, dated 8/31/2023. - levetiracetam (Keppra- antiseizure) 500 mg, give 750 mg (1.5 tablets) by mouth, twice a day, indication for seizure disorder, dated 2/8/2024. During a review of Resident 66's Medication Administration Record (MAR-a record of medications administered to residents), for April 2025, the MAR indicated the scheduled time for Resident 66's medications to be given at 9 a.m. included carboxymethylcellulose sodium, cetirizine hydrochloride, eyelid cleanser, lacosamide, and levetiracetam. During a concurrent observation and interview on 4/10/2025 at 7:27 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following medications for Resident 66: lacosamide, one tablet (tab); levetiracetam 500 mg, 1.5 tabs; cetirizine 10 mg, one tab; carboxymethylcellulose eye drops; and eyelid cleanser. LVN 1 stated she has a total of 3.5 tablets and one eye drops to give. During an observation and interview on 4/10/2025 at 7:31 a.m. with LVN 1, at Resident 66's bedside, LVN 1 administered 3.5 tablets, and one eye drop medications to Resident 66. LVN 1 stated she completed medication administration for Resident 66. During a concurrent interview and record review on 4/10/2025 at 7:34 a.m. with LVN 1, reviewed Resident 66's MAR for 4/10/2025. LVN 1 stated she cannot sign Resident 66's MAR with the actual time she gave the medications because the system will not allow her until 8 a.m. LVN 1 stated the medications she gave were scheduled at 9 a.m. LVN 1 stated she will continue to pass (administer) medications. During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Residents 66's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurses) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. LVN 1 stated she gave the medications earlier because when Resident 66 was up in the chair, it was difficult to administer the eye drops compared to when the resident is was still on bed. LVN 1 stated she also asked Resident 66 if he would like to receive his medications before the scheduled time and Resident 66 stated he would like to take his medications if they were ready. LVN 1 stated she gives the medications to Resident 66 outside the scheduled time about three times a week but not all the time. (continued on next page)

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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/2025 at 11:26 a.m. with the Employee Health Manager ([NAME]), the [NAME] stated medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early for Resident 66. During an interview on 4/11/2025 at 1:18 p.m. with the Director of Pharmacy (DP), the DP stated their MARs have a built-in one hour before and one hour after (time frames to record medication administration). The DP stated if the medication nurse was unable to sign the MAR of Resident 66, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated medications should be given at the scheduled time. The DLTC stated when medications are not given at the scheduled time, Resident 66 may not get the full effect and may have potential drug interactions. The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication of Resident 66 and document the communication with the provider. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. 4. During a review of Resident 19's FS, the FS indicated the facility admitted the resident on 8/7/2024. During a review of Resident 19's CRA, the CRA indicated Resident 19 had diagnoses including dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and constipation (a problem with passing stool). (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had minimal difficulty hearing, clear speech, had the ability to make self understood and understand others. The MDS indicated Resident 19 required staff assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 19's Orders, the Orders indicated the following: - donepezil HCL (Aricept-used to treat dementia), give 5 mg, one tablet by mouth daily, indication for dementia, dated 8/7/2024. - gabapentin (Neurontin- nerve pain medication), give 100 mg, one capsule by mouth, twice a day, indication for depression m/b refusing and resistance to care, dated 12/24/2024. - metformin extended release (Glucophage Extended Release- medication that helps lower high blood sugar) 500 mg, give 1000 mg (two tablets) by mouth, twice a day, indication for diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dated 8/7/2024. - pantoprazole (Protonix- decreases amount of acid produced in the stomach) 40 mg, give 40 mg, one tablet by mouth, daily, indication for gastroesophageal reflux disease (GERD- a condition in which the stomach contents move up into the esophagus), dated 8/7/2024. - polyethylene glycol 3350 (Miralax- used to treat constipation) 15 grams (g-a unit of measurement)/dose, give 17 g (one powder) by mouth daily, mix with eight (8) ounces (oz- a unit of measurement) of liquid or juice, indication for constipation, dated 8/7/2024. - solifenacin succinate (Vesicare- used to treat overactive bladder [OAB- a problem with bladder (organ that stores urine before leaving the body) function that causes the sudden need to urinate]) 5 mg, give 5 mg (one tablet) by mouth, daily, indication for OAB, dated 2/21/2025. During a review of Resident 19's MAR, for April 2025, the MAR indicated the scheduled time for Resident 19's medications to be given at 9 a.m. on 4/10/2025 included donepezil HCL, gabapentin, metformin extended release, pantoprazole, polyethylene glycol 3350, and solifenacin. During a concurrent observation and interview on 4/10/2025 at 7:37 a.m. with LVN 1, LVN 1 prepared Resident 19's including medications: pantoprazole 40 mg, one tab; metformin 500 mg, two tabs; gabapentin 100 mg, one capsule; solifenacin 5 mg, one tab; donepezil 5 mg, one tab; polyethylene glycol 17 g. LVN 1 stated she will administer a total of eight medications with seven tablets and one powder. LVN 1 stated she will separate buspirone and gabapentin into a separate medication cup because Resident 19 usually does not want to take all the medications. During a concurrent observation and interview on 4/10/2025 at 7:43 a.m. with LVN 1, at Resident 19's bedside, LVN 1 stated Resident 19 does not want to take all the medications. LVN 1 offered buspirone and gabapentin to Resident 19 which the resident took. LVN 1 offered the rest of the medications but Resident 19 refused. (continued on next page)

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	04/11/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/10/2025 at 7:44 a.m. with LVN 1, reviewed Resident 19's MAR for 4/10/2025. LVN 1 stated she cannot sign at 7:44 a.m. the medications administered because the electronic MAR will not save the date and time she gave the medications. LVN 1 stated she will have to wait until 8 a.m. to sign Resident 19's medications. During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Resident 19's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurse) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. During an interview on 4/11/2025 at 11:26 a.m. wi [TRUNCATED]

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	055034	A. Building B. Wing	04/11/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by failing to: 1. Ensure the antibiotic medications had monitoring for adverse effect (unwanted undesirable effects that are possibly related to a drug) for two of three sampled residents (Residents 21 and 4) reviewed for antibiotic use. 2. Ensure the antiplatelet (medications that prevent blood clots from forming) had monitoring for adverse effect for one of three sampled residents (Resident 338) reviewed for anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) use. This deficient practice placed the residents at risk for unnecessary medication and undetected adverse/side effects. Findings: 1. During a review of Resident 21's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/30/2023. During a review of Resident 21's History and Physical (H&P), dated 11/24/2024, the H&P indicated the resident was awake, alert, pleasant, and cooperative. The H&P indicated the resident had dyslipidemia (having too much or too little of certain fats [lipids] in the blood, like cholesterol or triglycerides), chronic recurrent pneumonia (two or more episodes of pneumonia [lung infection] in 12 months or three episodes altogether), and atrial fibrillation (a common heart condition where the heart's upper chambers [atria] beat irregularly, sometimes too fast, creating a quivering or fluttering sensation). The H&P indicated per primary medical doctor (PMD) the resident will continue twice weekly azithromycin (an antibiotic medicine) life-long, and daily prednisone (a corticosteroid medicine used to decrease inflammation). During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool), dated 2/14/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (having noticeable difficulties with thinking and memory that start to impact daily life). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 21's Active Orders, dated 11/25/2024, the Active Orders indicated an order for azithromycin (Zithromax) 250 milligrams (mg - a unit of measure for mass). Give 250 mg (one [1] tablets) by mouth Monday and Friday per prescriber. Indication: pneumonia prophylaxis (measures taken to prevent pneumonia, a lung infection). The orders did not indicate an order for monitoring for adverse/side effects on the use of azithromycin. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/10/2025, at 9:07 a.m., with Registered Nurse (RN) 2, Resident 21's Active Orders, Medication Administration Record (MAR), and Care Plan were reviewed. RN 2 stated there was no order for monitoring for adverse effects of the medication azithromycin as prophylaxis for pneumonia on Resident 21. RN 2 stated it was important for Resident 21 to have a monitoring for the adverse effect on the use of antibiotic to intervene when a complication arises and to prevent antibiotic resistance (occurs when bacteria develop defenses against the antibiotics designed to kill them). During an interview, on 4/10/2025, at 2:55 p.m., with the Director of Pharmacy (DP), the DP stated there should be monitoring for adverse effect on the use of azithromycin for pneumonia prophylaxis to ensure its safe use. The DP stated it is a standard of practice to monitor the adverse effect of antibiotic medication administration on residents. During an interview, on 4/11/2025, at 3:23 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated the staff should have obtained an order from the physician for monitoring of adverse effects on the use of Resident 21's antibiotic azithromycin. The DLTC stated it is important for Resident 21 to be monitored for adverse effect on the use of antibiotic to mitigate the negative reaction of the medication in a timely manner. During a review of the facility-provided Summary of Product Characteristics of Azithromycin dihydrate 200 mg/5 milliliters (ml - a unit of measure for volume) Powder for Oral Suspension, dated 5/2024, the Summary of Product Characteristics indicated for treatment of upper and lower respiratory tract infections, skin and soft tissues infections and odontostomatological (referring to the field of study and practice related to teeth, their structure, and diseases) infections 500 mg per day taken once daily, for 3 consecutive days. The same dosage regimen can be applied to elderly patients. Since elderly patients are more susceptible to developing cardiac arrythmia, particular caution is recommended due to the risk of developing cardiac arrhythmia (a problem with the rate or rhythm of the heartbeat) and torsade de pointes (a type of very fast heart rhythm [tachycardia] that starts in your heart's lower chambers [ventricles]). 2. During a review of Resident 4's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/8/2022. During a review of Resident 4's H&P, dated 9/23/2024, the H&P indicated the resident was awake, alert, coherent, oriented to place, time, and person. The H&P indicated the resident had periprosthetic fracture (a broken bone that occurs near a metal implant, often a joint replacement) of the right femur (the long bone in the upper leg, also known as the thigh bone), heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), and chronic kidney disease (long-term condition where the kidneys do not work as well as they should). During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment. The MDS indicated the resident was on a high-risk drug class antibiotic. (continued on next page)

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	04/11/2025

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Active Orders, dated 9/17/2024, the Active Orders indicated amoxicillin (Amoxil) 500 mg. Give 2000 mg (four [4] capsules) by mouth as needed (PRN). Administer two hours prior to the scheduled dental procedure. Indication: prophylaxis (measures designed to preserve health) for dental procedures etc. The Active Orders did not indicate an order for monitoring for adverse/side effects on the use of amoxicillin. During a concurrent interview and record review, on 4/10/2025, at 10:24 a.m., with RN 2, Resident 4's Active orders, MAR, and Care Plan were reviewed. RN 4 stated there was no monitoring for adverse effect on the use of amoxicillin on the resident. RN 4 stated the amoxicillin was given only once last year. RN 4 stated the order can just be made as a one-time order as opposed to having the order as PRN. RN 4 stated placing the order as PRN increases the risk of staff administering the medication for other indications increasing the risk of medication error. RN 4 stated not monitoring for adverse effect on the use of amoxicillin predisposes Resident 4 to its adverse effect. During an interview, on 4/10/2025, at 1:20 p.m., with Nurse Practitioner (NP) 1, NP 1 stated the antibiotic amoxicillin for Resident 4 should have been written as a one-time order as opposed to PRN to reduce the risk of medication error of nurse administering the medication for other indication. NP 1 also stated there should be monitoring for adverse effect on the use of amoxicillin to mitigate possible side effects of the medication. During an interview, on 4/10/2025, at 2:55 p.m., with the DP, the DP stated there should be monitoring for adverse effect on the use of amoxicillin for dental prophylaxis to ensure its safe use. The DP stated it is a standard of practice to monitor for adverse effect of antibiotic medication administration. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated the amoxicillin order of Resident 4 should have a monitoring for adverse effect to ensure the safe use of the drug and to timely mitigate the negative effects of the medication. The DLTC also stated the order should have been written as a one-time order instead of a PRN to prevent medication error. During a review of the facility-provided Highlights of Prescribing Information on the use of Amoxil (amoxicillin) capsules, tablets, or powder for oral suspension, with initial U.S. approval in 1974, the Highlights of Prescribing Information indicated an adverse reaction of Amoxil, capsules, tablets, or oral suspension were diarrhea, rash, vomiting, and nausea. Prescribing Amoxil in the absence of a proven strongly suspected bacterial infection is unlikely to provide benefit to the patient an increase the risk of the development of drug-resistant bacteria. 3. During a review of Resident 338's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/20/2024. During a review of Resident 338's H&P, dated 12/21/2024, the H&P indicated the resident was difficult to communicate with, alert, crying at times, sometimes calm and quiet. The H&P indicated the resident had multi-infarct state (someone has experienced several small strokes, often called mini-strokes or silent strokes, which cause damage to different parts of the brain) with cognitive deficits (a problem with a person's ability to think, learn, remember, and make decisions), hypertension (HTN - a condition where the force of blood pushing against your artery walls is consistently too high) and chronic neuropathic pain (nerve pain that can happen if your nervous system malfunctions or gets damaged). (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 338's MDS, dated [DATE], the MDS indicated the resident sometimes make self-understood and usually understand others and had impaired cognition (difficulty with thinking and memory functions, including remembering things, concentrating, and making decisions). The MDS indicated the resident was on a high-risk drug class antiplatelet. During a review of Resident 338's Active Orders, dated 3/29/2025, the Active Orders indicated an order for aspirin (medication used to prevent blood clots) 81 mg. Give 81 mg (1 tablet) by mouth daily. Indication: cerebrovascular accident (CVA, also known as a stroke, medical emergency that occurs when the blood supply to the brain is interrupted, either by a blockage or a rupture of a blood vessel) prophylaxis and clopidogrel bisulfate (also known as Plavix, medication used to prevent blood clots) 75 mg. Give 75 mg (1 tablet(s)) by mouth daily. Indication: CVA prophylaxis. During a concurrent interview and record review, on 4/10/2025, at 9:58 a.m., with RN 2, Resident 338's Active Orders, MAR, and Care Plan were reviewed. RN 2 stated there was no order for monitoring of adverse effect on the use of aspirin and Plavix on Resident 338. RN 2 stated it was important to monitor for Resident 338's use of aspirin and Plavix's adverse effect to prevent undue bleeding on the resident. During an interview, on 4/11/2025, at 3:23 p.m., with the DLTC, the DLTC stated the staff should have monitored for adverse effect on the use of ASA and Plavix on Resident 338 to intervene timely to its adverse effect and prevent bleeding. During a review of the facility-provided Professional Information on the use of [NAME] Aspirin Tablets, last revised on 4/19/2013, the Professional Information indicated side effects of hemorrhage (an acute loss of blood from a damaged blood vessel), hypersensitivity, anaphylactic shock (a sudden, severe and life-threatening allergic reaction that involves the whole body), rash , urticaria (the medical term for hives), dizziness, and tinnitus (when a person experiences ringing or other noises in one or both of the ears). During a review of the facility-provided Highlights of Prescribing Information on the use of Plavix (clopidogrel tablets) for oral use, with initial approval in 1997, the Highlights of Prescribing Information indicated adverse reactions such as bleeding, including life-threatening and fatal bleeding, is the most commonly reported adverse reaction.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent, when seven (7) medication errors out of 28 opportunities contributed to an overall medication error rate of 25%. The medication error rate are as follows: 1. For Residents 66 and 19, Licensed Vocational Nurse (LVN) 1 failed to administer 9 a.m. scheduled medications at the scheduled time. 2. For Resident 86, LVN 1 failed to flush the resident's gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems) with water in between medications when LVN 1 administered the resident's g-tube medications. These deficient practices had the potential to result in Resident 86 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 66 and 19's health and well-being to be negatively impacted. Cross reference: F658, F755, and F760 Findings: 1. During a review of Resident 66's Face Sheet (FS- front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted the resident on 8/18/2023. During a review of Resident 66's Clinical Record Abstract (CRA), the CRA indicated Resident 66 had diagnoses including dementia (a progressive state of decline in mental abilities), paraplegia (loss of movement and/or sensation, to some degree, of the legs), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 66's Minimum Data Set (MDS-a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 66 had adequate hearing, clear speech, had the ability to make self understood, and usually understand others. The MDS indicated Resident 66 required substantial assistance with eating and was dependent on staff on functional abilities in mobility. During a review of Resident 66's Orders (physician's orders), the Orders indicated: - carboxymethylcellulose sodium (Refresh Tears-eye drops) 0.5 percent (%-a unit of measurement), take two drops twice a day, indication for irritation or dry eye, dated 9/29/2023. - cetirizine hydrochloride (HCL) (Zyrtec-antihistamine helps relieve allergies), give 10 milligrams (mg-a unit of measurement), give 10 mg (1 tablet) by mouth daily, indication for pruritus (itching), dated 4/9/2024. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Eyelid cleanser (Ocusoft lid scrub), instill one pad into both eyes, twice a day, indication for blepharitis (inflammation of the eyelid), dated 12/6/2024. - lacosamide (Vimpat-antiseizure medication) give 150 mg, one tablet by mouth, twice a day, indication for seizure disorder, dated 8/31/2023. - levetiracetam (Keppra- antiseizure) 500 mg, give 750 mg (1.5 tablets) by mouth, twice a day, indication for seizure disorder, dated 2/8/2024. During a review of Resident 66's Medication Administration Record (MAR-a record of medications administered to residents), for April 2025, the MAR indicated the scheduled time for Resident 66's medications to be given at 9 a.m. included carboxymethylcellulose sodium, cetirizine hydrochloride, eyelid cleanser, lacosamide, and levetiracetam. During a concurrent observation and interview on 4/10/2025 at 7:27 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following medications for Resident 66: lacosamide, one tablet (tab); levetiracetam 500 mg, 1.5 tabs; cetirizine 10 mg, one tab; carboxymethylcellulose eye drops; and eyelid cleanser. LVN 1 stated she has a total of 3.5 tablets and one eye drops to give. During an observation and interview on 4/10/2025 at 7:31 a.m. with LVN 1, at Resident 66's bedside, LVN 1 administered 3.5 tablets, and one eye drop medications to Resident 66. LVN 1 stated she completed medication administration for Resident 66. During a concurrent interview and record review on 4/10/2025 at 7:34 a.m. with LVN 1, reviewed Resident 66's MAR for 4/10/2025. LVN 1 stated she cannot sign Resident 66's MAR with the actual time she gave the medications because the system will not allow her until 8 a.m. LVN 1 stated the medications she gave were scheduled at 9 a.m. LVN 1 stated she will continue to pass (administer) medications. During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Residents 66's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurses) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. LVN 1 stated she gave the medications earlier because when Resident 66 was up in the chair, it was difficult to administer the eye drops compared to when the resident is was still on bed. LVN 1 stated she also asked Resident 66 if he would like to receive his medications before the scheduled time and Resident 66 stated he would like to take his medications if they were ready. LVN 1 stated she gives the medications to Resident 66 outside the scheduled time about three times a week but not all the time. During an interview on 4/11/2025 at 11:26 a.m. with the Employee Health Manager ([NAME]), the [NAME] stated medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early for Resident 66. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/2025 at 1:18 p.m. with the Director of Pharmacy (DP), the DP stated their MARs have a built-in one hour before and one hour after (time frames to record medication administration). The DP stated if the medication nurse was unable to sign the MAR of Resident 66, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated medications should be given at the scheduled time. The DLTC stated when medications are not given at the scheduled time, Resident 66 may not get the full effect and may have potential drug interactions. The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication of Resident 66 and document the communication with the provider. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. 2. During a review of Resident 19's FS, the FS indicated the facility admitted the resident on 8/7/2024. During a review of Resident 19's CRA, the CRA indicated Resident 19 had diagnoses including dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and constipation (a problem with passing stool). During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had minimal difficulty hearing, clear speech, had the ability to make self understood and understand others. The MDS indicated Resident 19 required staff assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and mobility. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Orders, the Orders indicated the following: - donepezil HCL (Aricept-used to treat dementia), give 5 mg, one tablet by mouth daily, indication for dementia, dated 8/7/2024. - gabapentin (Neurontin- nerve pain medication), give 100 mg, one capsule by mouth, twice a day, indication for depression m/b refusing and resistance to care, dated 12/24/2024. - metformin extended release (Glucophage Extended Release- medication that helps lower high blood sugar) 500 mg, give 1000 mg (two tablets) by mouth, twice a day, indication for diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dated 8/7/2024. - pantoprazole (Protonix- decreases amount of acid produced in the stomach) 40 mg, give 40 mg, one tablet by mouth, daily, indication for gastroesophageal reflux disease (GERD- a condition in which the stomach contents move up into the esophagus), dated 8/7/2024. - polyethylene glycol 3350 (Miralax- used to treat constipation) 15 grams (g-a unit of measurement)/dose, give 17 g (one powder) by mouth daily, mix with eight (8) ounces (oz- a unit of measurement) of liquid or juice, indication for constipation, dated 8/7/2024. - solifenacin succinate (Vesicare- used to treat overactive bladder [OAB- a problem with bladder (organ that stores urine before leaving the body) function that causes the sudden need to urinate]) 5 mg, give 5 mg (one tablet) by mouth, daily, indication for OAB, dated 2/21/2025. - During a review of Resident 19's MAR, for April 2025, the MAR indicated the scheduled time for Resident 19's medications to be given at 9 a.m. on 4/10/2025 included donepezil HCL, gabapentin, metformin extended release, pantoprazole, polyethylene glycol 3350, and solifenacin. During a concurrent observation and interview on 4/10/2025 at 7:37 a.m. with LVN 1, LVN 1 prepared Resident 19's including medications: pantoprazole 40 mg, one tab; metformin 500 mg, two tabs; gabapentin 100 mg, one capsule; solifenacin 5 mg, one tab; donepezil 5 mg, one tab; polyethylene glycol 17 g. LVN 1 stated she will administer a total of eight medications with seven tablets and one powder. LVN 1 stated she will separate buspirone and gabapentin into a separate medication cup because Resident 19 usually does not want to take all the medications. During a concurrent observation and interview on 4/10/2025 at 7:43 a.m. with LVN 1, at Resident 19's bedside, LVN 1 stated Resident 19 does not want to take all the medications. LVN 1 offered two tablets, buspirone and gabapentin, to Resident 19, Resident 19 agreed. Resident 19 took the two tablets. LVN 1 offered the rest of the medications and Resident 19 refused. During a concurrent interview and record review on 4/10/2025 at 7:44 a.m. with LVN 1, reviewed Resident 19's MAR for 4/10/2025. LVN 1 stated she cannot sign at 7:44 a.m. the medications administered because the electronic MAR will not save the date and time she gave the medications. LVN 1 stated she will have to wait until 8 a.m. to sign Resident 19's medications. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Resident 19's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurse) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. During an interview on 4/11/2025 at 11:26 a.m. with the [NAME], the [NAME] stated Resident 19's medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early. During an interview on 4/11/2025 at 1:18 p.m. with the DP, the DP stated their (facility) MARs have a built-in one hour before and one hour after time frames to record medication administration. The DP stated if the medication nurse was unable to sign Resident 19's MAR, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the DLTC, the DLTC stated Resident 19's medications should have been given at the scheduled time. The DLTC stated when medications are not given at the scheduled time the resident may not get the full effect and may have potential drug interactions.The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication and document the communication with the provider. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 86's FS, the FS indicated the facility admitted Resident 86 on 3/5/2025. During a review of Resident 86's CRA, the CRA indicated Resident 86 had diagnoses including epilepsy (a condition that affects the brain and causes frequent seizures, muscle spasm (a sudden, involuntary movement in one or more muscles), neuralgia (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve), and neuritis (inflammation of a nerve). During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 had unclear speech, adequate hearing, rarely/never made self understood, and rarely/never understands others. The MDS indicated Resident 86 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 86 required assistance from staff with ADLs and mobility. The MDS indicated the resident had a feeding tube (a flexible tube inserted into the stomach or intestines to deliver liquid nutrition) while a resident of the facility. During a review of Resident 86's Orders, the Orders indicated: - gabapentin 300 mg, give 300 mg (one tablet) via g-tube three times a day, administer through the percutaneous endoscopic gastrostomy (PEG- a procedure for placing a feeding tube directly into the stomach through the abdominal wall, bypassing the mouth and esophagus) tube, indication for neuralgia and neuritis, dated 3/5/2025. - quetiapine fumarate (Seroquel- drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) 100 mg, give 100 mg (one tablet) via g-tube three times a day via PEG tube, indications for encephalopathy (a disease that affects the function or structure of the brain) secondary to hypoxic brain injury (low levels of oxygen in the brain causing irreversible damage) m/b agitation, dated 3/6/2025. - baclofen 10 mg, give 15 mg (1.5 tablets) via g-tube, three times a day, indication for muscle spasticity of cerebral (brain) origin, dated 4/6/2025. During a review of Resident 86's MAR, for April 2025, the MAR indicated the scheduled time for Resident 86's medications to be given at 2 p.m. included gabapentin, quetiapine, and baclofen. During a concurrent observation and interview on 4/10/2025 at 1 p.m. with LVN 1, LVN 1 prepared Resident 86's medications: quetiapine 100 mg, one tab; gabapentin 300 mg, one capsule; baclofen 10 mg, 1.5 tablets. LVN 1 stated she will administer three medications, total 3.5 tablets to give. LVN 1 crushed each tablets separately in a plastic pouch and poured separately into each medication cup. Observed LVN 1 poured five to 10 ml of water into each medication cup and stirred the medications. During an observation on 4/10/2025 at 1:10 p.m. with LVN 1, at Resident 86's bedside, LVN 1 informed Resident 86 that she (LVN 1) prepared the resident's medications to administer. LVN 1 located Resident 86's g-tube and checked g-tube residual (the amount aspirated from the stomach following administration of enteral feed) which was zero (0) ml. LVN 1 flushed Resident 86's g-tube with 30 ml of water by gravity. LVN 1 administered all three medications with no flushing of water in between medications then flushed with 30 ml of water afterwards. LVN 1 stated she had completed medication pass for Resident 86. (continued on next page)

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	04/11/2025

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 1:24 p.m. with LVN 1, LVN 1 stated she prepared Resident 86's medications then she went inside Resident 86's room. LVN 1 stated she checked Resident 86's g-tube residual and there was none. LVN 1 stated she flushed the g-tube with 30 ml and gave the medications then flushed the g-tube another 30 ml afterwards. LVN 1 stated she did not check for patency during the medication pass because in the morning before the night shift nurse left, she (LVN 1) checked Resident 86's g-tube and it was patent. LVN 1 stated she uses a stethoscope to check for patency. LVN 1 stated her supervisor has told her that she did not need to check for patency every medication pass (medication administration). LVN 1 stated she checks for g-tube patency once per day at the beginning of her shift. LVN 1 stated she did not flush the g-tube in between medications because she follows the physician's order which was to flush the g-tube before and after medication administration. LVN 1 stated there was no order to flush the g-tube in between medications. During a concurrent interview and record review on 4/10/2025 at 2:15 p.m. with the DLTC, reviewed the facility's policy and procedure (P&P) titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024. The DLTC stated the P&P for g-tube medication administration is to check placement, patency, and residual before every scheduled medication administration time. The DLTC stated the P&P indicated #10 administer prepared medication separately (Do not mix medication) and flush with 15 ml to 30 ml (unless otherwise ordered) of water between each med (prevent air from entering the tube and follow feeding procedure). The DLTC stated medication nurses are expected to flush 15 to 30 ml between every medication unless there is an order to administer specific amount of water to flush. The DLTC stated if there is no physician's order; the standard of practice applicable to residents including Resident 86 is to flush 15 ml to 30 ml of water between medications. During a concurrent interview and record review on 4/10/2025 at 2:47 p.m. with LVN 1, reviewed Resident 86's MAR. LVN 1 stated there was a physician's order to flush Resident 86's g-tube with 30 ml of water before and after medication administration which she did. LVN 1 stated she did not give water flush in between medications because there was no order to flush in between medications. During a concurrent interview and record review on 4/10/2025 at 2:55 p.m. with LVN 1, reviewed the facility's P&P titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024. LVN 1 stated she did not follow their P&P to flush in between medications and did not check Resident 86's g-tube placement and patency at every scheduled medication administration. LVN 1 stated the [NAME] provided the instructions that there is no need to check for g-tube placement and patency at every scheduled medication administration, and that checking for g-tube placement and patency once at the beginning of the shift or the first scheduled medication during her shift was good. During an interview on 4/11/2025 at 11:26 a.m. with the [NAME], the [NAME] stated the standard of practice for g-tube administration is to check for placement, patency, residual, flush with water before medication administration, in between medications, and after medication administration. The [NAME] stated she did not provide instruction to LVN 1 to only checking placement and patency at the beginning of the shift during the first scheduled medication. The [NAME] stated their policy is to check for placement, patency, and residual done before administering every scheduled medication to be administered. The [NAME] stated flushing in between medications is done as to not mix the medications. The [NAME] stated when flushing in between medications is not done, then it is the same as mixing the medications in the same cup. The [NAME] stated LVN 1 should have followed their policy when LVN 1 administered medications to Resident 86. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/2025 at 1:18 p.m. with the DP, the DP stated their (facility) MARs have a built-in one hour before and one hour after time frames to record medication administration. The DP stated if the medication nurse was unable to sign Resident 19's MAR, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 1:25 p.m. with the DP, the DP stated medications given through the g-tube should not be mixed and should be flushed in between medications to maintain g-tube patency and to ensure Resident 86 received the whole dose. The DP stated there is a potential for medication interactions and clogging of the g-tube. During an interview on 4/11/2025 at 5:17 p.m. with the DLTC, the DLTC stated it is important for the medication nurse to flush in between medications because they would not know what the drug interaction for Resident 86 and this is to ensure the patency of the g-tube and that the resident receives the medications as ordered. The DLTC stated the purpose of checking for patency and placement is to ensure the g-tube is in the right place. The DLTC stated when this is not done the resident could potentially not receive the medications or the medication could go to a different area of the body and would not be properly absorbed. During a review of the facility's P&P titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024, the P&P indicated the purpose of the policy is to provide medication administration when unable to take orally and to monitor for signs and symptoms of infection, irritation at the stoma (a surgically created opening on the abdomen) site. The P&P indicated procedure for medication administration: 1. Check doctor's order. 2. Wash hands and prepare equipment. 3. Identify patient and explain procedure. 4. Position patient; semi-Fowler's position. 5. [NAME] (put on) gloves and check feeding tube for placement, patency, and residual. 6. For GT/JT placement check: air auscultation (a method used to listen to the sounds of the body by using a stethoscope [medical device), stomach secretions, aspiration . 7. Check gastric residual before giving medication (unless otherwise ordered). 8. If residual is greater than 100 ml, hold medication for one hour and repeat check . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Flush tube with 30 ml of water prior to administering medication unless physician orders different amount for flush. 10. Administer prepared medication separately (Do not mix medication) and flush with 15 ml to 30 ml (unless otherwise ordered) of water between each med (Prevent air from entering the tube and follow feeding procedure). 11. After medication is administered, instill 30 mls of water to clear the tube or as GNP/ General Nurse Practitioner (GNP)/Physician order indicates. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients slash resident, by authorized personnel. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medications errors for one (1) of 1 sampled resident (Resident 10) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use and for three of five sampled residents (Resident 66, 19, and 86) reviewed under Medication Administration facility task, by: 1. Failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites for Resident 10. This deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). 2. Failing to ensure Residents 66 and 19's scheduled medications were administered as ordered at the scheduled time. 3. Failing to flush water in between medications for Resident 86 when Licensed Vocational Nurse (LVN) 1 administered the resident's gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems). These deficient practices had the potential to result in Resident 86 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 66 and 19's health and well-being to be negatively impacted. Cross reference: F658, F755, F759) Findings: 1. During a review of Resident 66's Face Sheet (FS- front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted the resident on 8/18/2023. During a review of Resident 66's Clinical Record Abstract (CRA), the CRA indicated Resident 66 had diagnoses including dementia (a progressive state of decline in mental abilities), paraplegia (loss of movement and/or sensation, to some degree, of the legs), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 66's Minimum Data Set (MDS-a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 66 had adequate hearing, clear speech, had the ability to make self understood, and usually understand others. The MDS indicated Resident 66 required substantial assistance with eating and was dependent on staff on functional abilities in mobility. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66's Orders (physician's orders), the Orders indicated: - carboxymethylcellulose sodium (Refresh Tears-eye drops) 0.5 percent (%-a unit of measurement), take two drops twice a day, indication for irritation or dry eye, dated 9/29/2023. - cetirizine hydrochloride (HCL) (Zyrtec-antihistamine helps relieve allergies), give 10 milligrams (mg-a unit of measurement), give 10 mg (1 tablet) by mouth daily, indication for pruritus (itching), dated 4/9/2024. - Eyelid cleanser (Ocusoft lid scrub), instill one pad into both eyes, twice a day, indication for blepharitis (inflammation of the eyelid), dated 12/6/2024. - lacosamide (Vimpat-antiseizure medication) give 150 mg, one tablet by mouth, twice a day, indication for seizure disorder, dated 8/31/2023. - levetiracetam (Keppra- antiseizure) 500 mg, give 750 mg (1.5 tablets) by mouth, twice a day, indication for seizure disorder, dated 2/8/2024. During a review of Resident 66's Medication Administration Record (MAR-a record of medications administered to residents), for April 2025, the MAR indicated the scheduled time for Resident 66's medications to be given at 9 a.m. included carboxymethylcellulose sodium, cetirizine hydrochloride, eyelid cleanser, lacosamide, and levetiracetam. During a concurrent observation and interview on 4/10/2025 at 7:27 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following medications for Resident 66: lacosamide, one tablet (tab); levetiracetam 500 mg, 1.5 tabs; cetirizine 10 mg, one tab; carboxymethylcellulose eye drops; and eyelid cleanser. LVN 1 stated she has a total of 3.5 tablets and one eye drops to give. During an observation and interview on 4/10/2025 at 7:31 a.m. with LVN 1, at Resident 66's bedside, LVN 1 administered 3.5 tablets, and one eye drop medications to Resident 66. LVN 1 stated she completed medication administration for Resident 66. During a concurrent interview and record review on 4/10/2025 at 7:34 a.m. with LVN 1, reviewed Resident 66's MAR for 4/10/2025. LVN 1 stated she cannot sign Resident 66's MAR with the actual time she gave the medications because the system will not allow her until 8 a.m. LVN 1 stated the medications she gave were scheduled at 9 a.m. LVN 1 stated she will continue to pass (administer) medications. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Residents 66's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurses) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. LVN 1 stated she gave the medications earlier because when Resident 66 was up in the chair, it was difficult to administer the eye drops compared to when the resident is was still on bed. LVN 1 stated she also asked Resident 66 if he would like to receive his medications before the scheduled time and Resident 66 stated he would like to take his medications if they were ready. LVN 1 stated she gives the medications to Resident 66 outside the scheduled time about three times a week but not all the time. During an interview on 4/11/2025 at 11:26 a.m. with the Employee Health Manager ([NAME]), the [NAME] stated medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early for Resident 66. During an interview on 4/11/2025 at 1:18 p.m. with the Director of Pharmacy (DP), the DP stated their MARs have a built-in one hour before and one hour after (time frames to record medication administration). The DP stated if the medication nurse was unable to sign the MAR of Resident 66, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated medications should be given at the scheduled time. The DLTC stated when medications are not given at the scheduled time, Resident 66 may not get the full effect and may have potential drug interactions. The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication of Resident 66 and document the communication with the provider. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. 2. During a review of Resident 19's FS, the FS indicated the facility admitted the resident on 8/7/2024. During a review of Resident 19's CRA, the CRA indicated Resident 19 had diagnoses including dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and constipation (a problem with passing stool). During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had minimal difficulty hearing, clear speech, had the ability to make self understood and understand others. The MDS indicated Resident 19 required staff assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 19's Orders, the Orders indicated the following: - donepezil HCL (Aricept-used to treat dementia), give 5 mg, one tablet by mouth daily, indication for dementia, dated 8/7/2024. - gabapentin (Neurontin- nerve pain medication), give 100 mg, one capsule by mouth, twice a day, indication for depression m/b refusing and resistance to care, dated 12/24/2024. - metformin extended release (Glucophage Extended Release- medication that helps lower high blood sugar) 500 mg, give 1000 mg (two tablets) by mouth, twice a day, indication for diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dated 8/7/2024. - pantoprazole (Protonix- decreases amount of acid produced in the stomach) 40 mg, give 40 mg, one tablet by mouth, daily, indication for gastroesophageal reflux disease (GERD- a condition in which the stomach contents move up into the esophagus), dated 8/7/2024. - polyethylene glycol 3350 (Miralax- used to treat constipation) 15 grams (g-a unit of measurement)/dose, give 17 g (one powder) by mouth daily, mix with eight (8) ounces (oz- a unit of measurement) of liquid or juice, indication for constipation, dated 8/7/2024. - solifenacin succinate (Vesicare- used to treat overactive bladder [OAB- a problem with bladder (organ that stores urine before leaving the body) function that causes the sudden need to urinate]) 5 mg, give 5 mg (one tablet) by mouth, daily, indication for OAB, dated 2/21/2025. During a review of Resident 19's MAR, for April 2025, the MAR indicated the scheduled time for Resident 19's medications to be given at 9 a.m. on 4/10/2025 included donepezil HCL, gabapentin, metformin extended release, pantoprazole, polyethylene glycol 3350, and solifenacin. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/10/2025 at 7:37 a.m. with LVN 1, LVN 1 prepared Resident 19's including medications: pantoprazole 40 mg, one tab; metformin 500 mg, two tabs; gabapentin 100 mg, one capsule; solifenacin 5 mg, one tab; donepezil 5 mg, one tab; polyethylene glycol 17 g. LVN 1 stated she will administer a total of eight medications with seven tablets and one powder. LVN 1 stated she will separate buspirone and gabapentin into a separate medication cup because Resident 19 usually does not want to take all the medications. During a concurrent observation and interview on 4/10/2025 at 7:43 a.m. with LVN 1, at Resident 19's bedside, LVN 1 stated Resident 19 does not want to take all the medications. LVN 1 offered buspirone and gabapentin to Resident 19 which the resident took. LVN 1 offered the rest of the medications but Resident 19 refused. During a concurrent interview and record review on 4/10/2025 at 7:44 a.m. with LVN 1, reviewed Resident 19's MAR for 4/10/2025. LVN 1 stated she cannot sign at 7:44 a.m. the medications administered because the electronic MAR will not save the date and time she gave the medications. LVN 1 stated she will have to wait until 8 a.m. to sign Resident 19's medications. During an interview on 4/10/2025 at 7:45 a.m. with LVN 1, LVN 1 stated she has notified Resident 19's nurse practitioner weeks before (does not recall exact date) with regard to the resident's preference to administer the medications earlier than the scheduled time. LVN 1 stated they (licensed nurse) have one hour before and one after from the scheduled time to give the medications. LVN 1 stated she was informed by the nurse practitioner and/or physician (does not recall exactly who) that if the resident continues to request to receive the medications earlier than the scheduled time then the timing will be changed. During an interview on 4/11/2025 at 11:26 a.m. with the [NAME], the [NAME] stated Resident 19's medications should be administered at the scheduled time and can be administered one hour before or one hour after the scheduled time. The [NAME] stated LVN 1 should have documented the reason for giving medication early. During an interview on 4/11/2025 at 1:18 p.m. with the DP, the DP stated their (facility) MARs have a built-in one hour before and one hour after time frames to record medication administration. The DP stated if the medication nurse was unable to sign Resident 19's MAR, they (licensed nurses) would need to check with the provider (resident's physician) if it is okay to give outside the scheduled time. The DP stated the MAR has specified window of when medications can be given because they do not want to give medications too early or too late. The DP stated she expects the medication nurse (licensed nurse) to notify the provider directly or to let the pharmacy know so they (licensed nurses) can place the order. The DP stated the medication nurse should not give the medication outside of the prescribed time because it is deviating from the current order. The DP stated all medications administered should be documented on the MAR and reflect the actual time it was given. During an interview on 4/11/2025 at 5:17 p.m. with the DLTC, the DLTC stated Resident 19's medications should have been given at the scheduled time. The DLTC stated when medications are not given at the scheduled time the resident may not get the full effect and may have potential drug interactions.The DLTC stated the medication nurse is expected to clarify with the provider regarding the timing of the medication and document the communication with the provider. (continued on next page)

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	04/11/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. The P&P indicated that All medications administered to patients must be first ordered by a physician on the MPTF medical staff or an individual who has been granted clinical privileges. Each dose of medication shall be accurately recorded in the patient's medical record. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. The procedure P&P indicated the licensed nurses to Sign the eMAR after administration or non-administration of all medications. The P&P indicated the six (6) Rights of Safe Medication Administration are Right Medication, Right Dose, Right Patient/Resident, Right Route, Right Time, and Right Documentation. The P&P indicated the physician's order must include the date and time of the order, name of medication, dose, frequency, route, indication, duration, if appliable, and diagnosis. 3. During a review of Resident 86's FS, the FS indicated the facility admitted Resident 86 on 3/5/2025. During a review of Resident 86's CRA, the CRA indicated Resident 86 had diagnoses including epilepsy (a condition that affects the brain and causes frequent seizures, muscle spasm (a sudden, involuntary movement in one or more muscles), neuralgia (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve), and neuritis (inflammation of a nerve). During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 had unclear speech, adequate hearing, rarely/never made self understood, and rarely/never understands others. The MDS indicated Resident 86 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 86 required assistance from staff with ADLs and mobility. The MDS indicated the resident had a feeding tube (a flexible tube inserted into the stomach or intestines to deliver liquid nutrition) while a resident of the facility. During a review of Resident 86's Orders, the Orders indicated: - gabapentin 300 mg, give 300 mg (one tablet) via g-tube three times a day, administer through the percutaneous endoscopic gastrostomy (PEG- a procedure for placing a feeding tube directly into the stomach through the abdominal wall, bypassing the mouth and esophagus) tube, indication for neuralgia and neuritis, dated 3/5/2025. - quetiapine fumarate (Seroquel- drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) 100 mg, give 100 mg (one tablet) via g-tube three times a day via PEG tube, indications for encephalopathy (a disease that affects the function or structure of the brain) secondary to hypoxic brain injury (low levels of oxygen in the brain causing irreversible damage) m/b agitation, dated 3/6/2025. (continued on next page)

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	04/11/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- baclofen 10 mg, give 15 mg (1.5 tablets) via g-tube, three times a day, indication for muscle spasticity of cerebral (brain) origin, dated 4/6/2025. During a review of Resident 86's MAR, for April 2025, the MAR indicated the scheduled time for Resident 86's medications to be given at 2 p.m. included gabapentin, quetiapine, and baclofen. During a concurrent observation and interview on 4/10/2025 at 1 p.m. with LVN 1, LVN 1 prepared Resident 86's medications: quetiapine 100 mg, one tab; gabapentin 300 mg, one capsule; baclofen 10 mg, 1.5 tablets. LVN 1 stated she will administer three medications, total 3.5 tablets to give. LVN 1 crushed each tablets separately in a plastic pouch and poured separately into each medication cup. Observed LVN 1 poured five to 10 ml of water into each medication cup and stirred the medications. During an observation on 4/10/2025 at 1:10 p.m. with LVN 1, at Resident 86's bedside, LVN 1 informed Resident 86 that she (LVN 1) prepared the resident's medications to administer. LVN 1 located Resident 86's g-tube and checked g-tube residual (the amount aspirated from the stomach following administration of enteral feed) which was zero (0) ml. LVN 1 flushed Resident 86's g-tube with 30 ml of water by gravity. LVN 1 administered all three medications with no flushing of water in between medications then flushed with 30 ml of water afterwards. LVN 1 stated she had completed medication pass for Resident 86. During an interview on 4/10/2025 at 1:24 p.m. with LVN 1, LVN 1 stated she prepared Resident 86's medications then she went inside Resident 86's room. LVN 1 stated she checked Resident 86's g-tube residual and there was none. LVN 1 stated she flushed the g-tube with 30 ml and gave the medications then flushed the g-tube another 30 ml afterwards. LVN 1 stated she did not flush the g-tube in between medications because she follows the physician's order which was to flush the g-tube before and after medication administration. LVN 1 stated there was no order to flush the g-tube in between medications. During a concurrent interview and record review on 4/10/2025 at 2:15 p.m. with the DLTC, reviewed the facility's policy and procedure (P&P) titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024. The DLTC stated the P&P for g-tube medication administration is to check placement, patency, and residual before every scheduled medication administration time. The DLTC stated the P&P indicated #10 administer prepared medication separately (Do not mix medication) and flush with 15 ml to 30 ml (unless otherwise ordered) of water between each med (prevent air from entering the tube and follow feeding procedure). The DLTC stated medication nurses are expected to flush 15 to 30 ml between every medication unless there is an order to administer specific amount of water to flush. The DLTC stated if there is no physician's order; the standard of practice applicable to residents including Resident 86 is to flush 15 ml to 30 ml of water between medications. During a concurrent interview and record review on 4/10/2025 at 2:47 p.m. with LVN 1, reviewed Resident 86's MAR. LVN 1 stated there was a physician's order to flush Resident 86's g-tube with 30 ml of water before and after medication administration which she did. LVN 1 stated she did not give water flush in between medications because there was no order to flush in between medications. During a concurrent interview and record review on 4/10/2025 at 2:55 p.m. with LVN 1, reviewed the facility's P&P titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024. LVN 1 stated she did not follow their P&P to flush in between medications and did not check Resident 86's g-tube placement and patency at every scheduled medication administration. (continued on next page)

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	04/11/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/2025 at 11:26 a.m. with the [NAME], the [NAME] stated the standard of practice for g-tube administration is to check for placement, patency, residual, flush with water before medication administration, in between medications, and after medication administration. The [NAME] stated flushing in between medications is done as to not mix the medications. The [NAME] stated when flushing in between medications is not done, then it is the same as mixing the medications in the same cup. The [NAME] stated LVN 1 should have followed their policy when LVN 1 administered medications to Resident 86. During an interview on 4/11/2025 at 1:25 p.m. with the DP, the DP stated medications given through the g-tube should not be mixed and should be flushed in between medications to maintain g-tube patency and to ensure Resident 86 received the whole dose. The DP stated there is a potential for medication interactions and clogging of the g-tube. During an interview on 4/11/2025 at 5:17 p.m. with the DLTC, the DLTC stated it is important for the medication nurse to flush in between medications because they would not know what the drug interaction for Resident 86 and this is to ensure the patency of the g-tube and that the resident receives the medications as ordered. The DLTC stated the purpose of checking for patency and placement is to ensure the g-tube is in the right place. The DLTC stated when this is not done the resident could potentially not receive the medications or the medication could go to a different area of the body and would not be properly absorbed. During a review of the facility's P&P titled, Tube Feeding Maintenance and Medication Administration, last reviewed 12/5/2024, the P&P indicated the purpose of the policy is to provide medication administration when unable to take orally and to monitor for signs and symptoms of infection, irritation at the stoma (a surgically created opening on the abdomen) site. The P&P indicated procedure for medication administration: 1. Check doctor's order. 2. Wash hands and prepare equipment. 3. Identify patient and explain procedure. 4. Position patient; semi-Fowler's position. 5. [NAME] (put on) gloves and check feeding tube for placement, patency, and residual. 6. For GT/JT placement check: air auscultation (a method used to listen to the sounds of the body by using a stethoscope [medical device), stomach secretions, aspiration . 7. Check gastric residual before giving medication (unless otherwise ordered). 8. If residual is greater than 100 ml, hold medication for one hour and repeat check . 9. Flush tube with 30 ml of water prior to administering medication unless physician orders different amount for flush. (continued on next page)

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	04/11/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Administer prepared medication separately (Do not mix medication) and flush with 15 ml to 30 ml (unless otherwise ordered) of water between each med (Prevent air from entering the tube and follow feeding procedure). 11. After medication is administered, instill 30 mls of water to clear the tube or as GNP/ General Nurse Practitioner (GNP)/Physician order indicates. During a review of the facility's P&P titled, General Administrative, last reviewed 3/2024, the P&P indicated the purpose its policy to provide a safe and efficient medication distribution system which shall include the evaluation, selection, purchase, storage, control, dispensing and administration of all drugs, chemicals and pharmaceuticals used throughout the Motion Picture and Television Fund Hospital (MPTF) organization. During a review of the facility's P&P titled, Medication Administration, last reviewed 12/5/2024, the P&P indicated Medication shall be accurately and safely administered to MPTF patients/resident by authorized personnel. 43988 4. During a review of Resident 10's Face Sheet, the Face Sheet indicated the facility admitted the resident on 6/30/2021. During a review of Resident 10's Clinical Record Abstract printed on 4/11/2025, the Clinical Record Abstract indicated Resident 10's diagnoses including type 2 diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life), and chronic pain syndrome. During a review of Resident 10's History and Physical (H&P) dated 9/27/2024, the H&P indicated Resident 10 was alert and oriented to full name, exact date, and location. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 3/4/2025, the indicated Resident 10 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 10 received insulin. During a review of Resident 10's physician's order, the physician's order dated 10/2/2024 liraglutide (Victoza - a long-acting insulin) 0.6 milligrams (mg - a unit of measurement) per 0.1 milliliter (ml - a unit of measurement), inject 1.8 mg (0.3 ml) subcutaneously daily at eight (8) a.m. for DM 2. During a review of Resident 10's care plan (CP) titled Medical Condition: related to DM2, initiated on 6/30/2021, the CP indicated to administer liraglutide (Victoza) as one of the interventions to prevent complications or problems with medical conditions. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/11/2025 at 8:57 am., reviewed Resident 10's physician's order, subcutaneous administration sites for Victoza from 1/8/2025 to 4/11/2025, and the MDS with Registered Nurse (RN) 1. RN 1 stated Resident 10 received insulin, had a physician's order for Victoza, and were administered as follows: - 3/19/2025 9:26 a.m. left middle mid-thigh - 3/20/2025 9:10 a.m. left middle mid-thigh - 1/27/2025 9:21 a.m. right lower back of arm - 1/28/2025 8:43 a.m. right lower back of arm - 1/5/2025 8:59 a.m. right lower quadrant - 1/6/2025 8:22 a.m. right lower quadrant RN 2 stated administration sites for insulin should be rotated per standards of practice and manufacturer's guideline to prevent hardening or lumps in the skin. RN 2 stated the location of administration sites for Resident 10's insulin was not rotated. RN 2 stated Resident 10's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin which can affect the absorption of the insulin. RN 2 stated not rotating the insulin administration sites can be considered a medication due to no following the standards of practice and manufacturer's guideline. During an interview on 4/11/2025 a 4 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated the nurses are supposed to rotate insulin administration sites according to standards of practice, and as indicated in the manufacturer's guideline. The DLTC stated the location of administration sites for Resident 10's insulin was not rotated. The DLTC stated Resident 10's administration sites for the Victoza should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. The DLTC stated not rotating the insulin administration sites can be considered a medication due to no following the standards of practice and manufacturer's guideline. During a review of the facility-provided manufacturer's guideline for Victoza liraglutide injection1.2 mg/1.8 mg dated 11/2024, the manufacturer's guideline indicated: - Inject Victoza SQ in the abdomen, thigh, or upper arm. - Rotate injection sites within the same region in order to reduce the risk of cutaneous amyloidosis. - Adverse reaction includes injection site reactions such as injection site rash and erythema (redness of the skin).

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	055034	A. Building B. Wing	04/11/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44244 Based on observation, interview and record review, the facility failed to ensure medication and biologicals were stored with currently accepted professional standards for one of three sampled residents (Resident 39) reviewed during the Pressure Ulcer / Injury (PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) care area by failing to ensure mupirocin (a topical medication that treats skin infections caused by bacteria) was removed from the One [NAME] Treatment Cart when the medication was discontinued on 2/12/2025. This deficient practice resulted in Licensed Vocational Nurse (LVN) 1 administering the discontinued mupirocin to Resident 39 potentially resulting in a delay or decline in the resident's PI healing process. Cross reference F755 Findings: During a review of Resident 39's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/18/2018. During a record review of Resident 39's Patient Diagnosis Information, the Patient Diagnosis Information indicated the resident had diagnoses that included neurocognitive disorder with Lewy bodies (a progressive disorder characterized by the gradual decline of thinking and reasoning abilities, often accompanied by movement and sleep disturbances, and visual hallucinations) and PI of the sacral region (lower back at the base of the spine) stage two (partial-thickness loss of skin, presenting as a shallow open sore or wound). During a review of Resident 39's Minimum Data Set (MDS - resident assessment tool) dated 3/14/2025, the MDS indicated the facility most recently admitted the resident on 8/21/2018. The MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make himself understood. The MDS further indicated the resident was dependent on assistance from staff for eating, toileting, bathing, dressing, personal and oral hygiene, and mobility. During a review of Resident 39's Care Plan (CP) titled, Pressure Injury Stage 2 on sacrum related to previous pressure injury on area, incontinence, impaired mobility, initiated 11/25/2024, the CP indicated a goal that the area would heal without complications in the next 120 days. During a review of Resident 39's physician orders, the physician orders indicated the following treatment orders: - Dated 3/26/2025, cleanse PI of the sacrum with wound cleansing spray, gently pat dry, apply maxorb plus silver (an antimicrobial wound dressing), cut to fit wound, cover with opti foam (a type of dressing), change dressing daily. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 1/30/2025 and discontinued (DC'd) on 2/12/2025, mupirocin 2 %, apply ointment 1 dose topically twice a day. cleanse PI of the sacrum with warm cleansing wipes, gently pat dry, apply mupirocin ointment prior to application of moisture barrier cream. Indication: stage 2 pressure injury. During a concurrent observation and interview on 4/10/2025 at 11:30 a.m. with LVN 1, observed Resident 39's wound care treatment in the resident's room. LVN 1 stated the LVNs provide daily wound care for facility residents. LVN 1 gathered the following wound care supplies from the One [NAME] Treatment Cart: mupirocin ointment placed in a clear medication cup, an opti foam dressing, cleansing spray, and the maxorb dressing. LVN 1 entered Resident 39's room with the supplies, cleansed Resident 39's wound, applied the mupirocin ointment to cover the wound, placed the maxorb dressing on top of the mupirocin ointment, then applied the opti foam dressing. Upon completion of the treatment, LVN 1 exited the resident's room. During a follow up observation, interview, and record review on 4/10/2025 at 11:55 a.m. with LVN 1, LVN 1 reviewed Resident 39's physician orders. LVN 1 stated LVN 1 applied mupirocin ointment to Resident 39. LVN 1 stated LVN 1 always applies the mupirocin when providing Resident 39's wound care treatment. LVN 1 then reviewed Resident 39's treatment orders and noted Resident 39 did not have an active order to apply mupirocin. During a concurrent interview and record review on 4/10/2025 at 1:13 p.m. with RN 2, RN 2 reviewed Resident 39's physician orders. RN 2 stated when a medication is discontinued, the pharmacy and the nurse receive a notification to remove the medication from the cart. RN 2 stated Resident 39's mupirocin order was discontinued on 2/12/2025 and the medication should have been removed immediately on 2/12/2025 from the One [NAME] Treatment Cart to ensure the medication was not administered by mistake. During an interview on 4/10/2025 at 2:02 p.m. with LVN 1, LVN 1 stated it is important to remove discontinued medication from the cart to make sure the medication is not administered by mistake and without an order. LVN 1 stated Resident 39's discontinued mupirocin ointment remained in the One [NAME] Treatment Cart and LVN 1 administered the discontinued medication to Resident 39 every day that she worked this week including 4/10/2025, 4/9/2025, 4/8/2025, and 4/7/2025. LVN 1 stated LVN 1 just saw the mupirocin ointment in the cart, grabbed it, and applied it to Resident 39. During a follow up interview on 4/10/2025 at 2:12 p.m. with RN 3, RN 3 stated when the discontinued mupirocin was administered to Resident 39 there was the potential that the PI healing process would be affected causing a delay in healing or a decline in the resident's condition. During a concurrent interview and record review on 4/11/2025 at 11:15 a.m. with the Director of Long Term Care (DLTC), the DLTC reviewed the facility policy and procedure regarding medication administration and medication storage. The DLTC stated medications are discontinued for a reason. The DLTC stated discontinued medication may not be an effective treatment, or a different treatment may be more appropriate. The DLTC stated the nurse who receives the notification that a medication is discontinued is responsible for removing the medication from the cart and discarding the medication, but Resident 39's discontinued mupirocin was not removed. The DLTC stated when a discontinued medication was left in the treatment cart and administered to Resident 39, there was a potential that the mupirocin would have a negative effect on the resident's healing process. The DLTC stated the facility policy was not followed when Resident 39's discontinued mupirocin was not discarded and left in the treatment cart. (continued on next page)

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	04/11/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedure (P&P) titled, Discontinued Medications, last reviewed 3/2024, the P&P indicated discontinued medications are removed from the nursing stations to prevent the inadvertent administration of discontinued medications. All discontinued medications are returned immediately to the pharmacy for proper disposal. In the event that the pharmacy is closed medications may be given to the Nursing Supervisor for storage in the night locker. All opened, used liquid ointments, lotions, creams, aerosols & powders returned from patient care areas shall be destroyed/disposed of.

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	055034	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43988 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. One disposable cup of coffee belonging to a kitchen staff was placed on top of a metal cart outside the dry food storage area. 2. One and a half boxes of open box of dried noodles and not labeled with an open date was stored in the dry storage area 3. One open bottle of instant coffee and not labeled with an open date was stored in the dry storage area. 4. One open box of wonton chips inside an unsealed plastic bag as not labeled with an open date. 5. One container had a label peas, black eyed dried but observed brown colored short grain inside the container. 6. Observed red potatoes inside a bin that was wet. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 88 of 89 residents who receive food from the kitchen. Findings: During a concurrent observation during initial kitchen tour and interview on 4/7/2025 at 8:05 a.m. with the Director of Hospitality Services (DHS), observed the following: 1. One cup of disposable cup of coffee belonging to a kitchen staff was placed on top of a metal cart outside the dry food storage area. The DHS stated there should be no personal or staff food items in the kitchen area to prevent cross contamination. 2. One and a half boxes of open box of dried noodles and not labeled with an open date in the dry storage area. The DHS stated the facility has a labeling machine that dispenses the exact date and time and that all opened items should have a label with an open date. The DHS stated both boxes of the noodles should have been labeled with an open date so the staff would know when the item or product was opened. 3. One open bottle of instant coffee and not labeled with an open date in the dry storage area. The DHS stated all opened items should have a label with an open date. The DHS stated the bottle of instant coffee should have been labeled with an open date so the staff would know when the item or product was opened. (continued on next page)

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	04/11/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. One open box of wonton chips inside an unsealed plastic bag and was not labeled with an open date. The DHS stated all opened items should be labeled with an open date and sealed inside the plastic bag. The DHS stated the plastic bag containing the wonton chips should have been sealed when opened and labeled with an open date to prevent contamination of the food item inside the box. 5. One container had a label peas, black eyed dried but observed brown colored short grain inside the container. The DHS stated the brown colored short grain inside the container did not look like dried black-eyed peas. The DHS stated the brown colored short grain in the container looks like brown rice. The DHS food items should be labeled correctly to prevent confusion. The DHS stated the container should have been labeled properly to prevent confusion with the staff. 6. Observed red potatoes inside a bin that was wet. The DHS stated produce items should be stored in a dry container. The DHS stated the red potatoes should have been stored in a dry container as it had the potential to develop mildew and cause contamination of the food item in the container. During an interview on 4/11/2025 at 3:30 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated there should be no personal food items by the kitchen staff in the kitchen food preparation area as it had the potential for cross contamination in the kitchen. The DLTC stated all opened items should be labeled with an open date so the staff would know when to discard the items. The DLTC stated all produce should be stored in a dry container as it had the potential to develop mold. The DLTC stated the containers should be labeled properly to prevent confusion with the staff during food preparation. The DLTC all these failures placed the residents at risk for food borne illnesses. During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, last reviewed on 1/2025, the P&P indicated all food and non-food items and supplies used in food preparation shall be stored in a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P further indicated: - Cover, label, and date unused portions and open packages. - Store potatoes in a dry, dark area. - Store foods in their original packages. Foods that must be opened must be stores in NSF approved containers that have tight fitting lids. Label both the bin and the lid. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety.

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	055034	A. Building B. Wing	04/11/2025

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to maintain timely and accurate resident medical records for two of 21 sampled residents (Residents 4 and 86) when: a. For Resident 4, the Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) Discharge Summary (DC) and Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary was not completed after PT treatment and OT treatments were completed in 1/2025. b. For Resident 86, the PT Discharge Summary was not completed after PT treatment was completed on 3/26/2025. These deficient practices had the potential for inaccurate medical documentation and cause a delay in provision of appropriate interventions for Residents 4 and 86. Findings: a. During a review of Resident 4's Face Sheet (FS), the FS indicated Resident 4 admitted to the facility on [DATE] with diagnoses including, but not limited to congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and polyarthritis (swelling and tenderness of multiple joints causing pain and stiffness). During a review of Resident 4's Minimum Data Set (MDS, resident assessment tool) dated 2/21/2025, the MDS indicated Resident 4 had moderate cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 4 had no functional limitations in range of motion (ROM, full movement potential of a joint) in both upper extremities (UE, shoulder, elbow, wrist/hand) and had impairments in ROM on both sides of the lower extremities (LE, hip, knee, ankle/foot). The MDS indicated Resident 4 required supervision for eating, substantial assistance with toileting, bathing, sit to stand, and bed to chair transfers. During a review of Resident 4's Physical Therapy Evaluation dated 8/29/2024, the PT evaluation indicated a recommendation for PT treatment two times a week for four weeks and recommended Resident 4 for ROM and strengthening at discharge. During a review of Resident 4's PT medical records, the PT medical records indicated the last PT treatment note was completed on 1/3/2025. There was no PT DC noted in the resident's medical record. During a review of Resident 4's OT Evaluation dated 8/29/2024, the OT Evaluation indicated a recommendation for OT treatment two times a week for four weeks. During a review of Resident 4's OT medical records, the OT medical records indicated the last OT treatment note was completed on 1/4/2025. There was no OT DC noted in the resident's medical record. (continued on next page)

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	055034	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/2025 at 2:51 p.m., the Registered Nurse Supervisor (RN 1) stated once a resident was discharged from PT and OT services, the therapists would write a discharge summary and recommendation and inform the nursing staff so that nursing could input the recommendations. During an interview and record review on 4/10/2025 at 11:04 a.m., the Therapy Manager/Occupational Therapist (TM/OT) reviewed Resident 4's therapy medical records and stated the last OT treatment was completed on 1/4/2025 and Resident 4 was discharged from OT on 1/7/2025. TM/OT stated the OT DC should have been completed on 1/7/2025 and it was not completed. The TM/OT stated the last PT treatment was on 1/3/2025 and Resident 4 was discharged from PT on 1/7/2025. TM/OT stated the PT DC should have been completed on 1/7/2025 and it was not completed. TM/OT stated all residents that have been discharged from therapy services should have a completed DC summary. TM/OT stated the DC summary shows the resident's progress, current level of function, and recommendations at DC such as an RNA program. TM/OT stated Resident 4's RNA recommendation at therapy DC should have been for ROM and transfers and Resident 4's RNA orders should have been updated. During a review of the facility's policies and procedures (P&P) proved 6/13/2024, titled, Inter-disciplinary Resident/Patient Assessment and Reassessment, the P&P indicated all documentation must be completed within 48 hours of service provided or service attempted. b. During a review of Resident 86's Face Sheet (FS), the FS indicated Resident 86 admitted to the facility on [DATE] with diagnoses including but not limited to anoxic brain damage (damage to brain due to lack of oxygen supply to the brain), hemiplegia (weakness to one side of the body) affecting right dominant side, monoplegia (paralysis of one side of the body) of upper limb affecting left nondominant side, and aphagia (a disorder that makes it difficult to speak). During a review of Resident 86's MDS dated [DATE], the MDS indicated was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 86 had functional limitation impairments in ROM on both sides of the upper extremities and on one side of the lower extremities. The MDS indicated Resident 86 was dependent on staff for oral hygiene, toileting, bathing, dressing, and bed to chair transfers. During a review of Resident 86's PT Evaluation dated 3/6/2025, the PT Evaluation indicated a recommendation for PT treatment three times a week for four weeks. During a review of Resident 86's PT medical records, the PT medical records indicated the last PT treatment note was completed on 3/26/2025. There was no PT DC noted in the resident's medical record. During an interview and record review on 4/9/2025 at 3:43 p.m., the Physical Therapist (PT 1) stated Resident 86's last PT treatment was completed on 3/26/2025 and was discharged from PT on 4/1/2025. PT 1 stated the PT DC was not completed. PT 1 stated it was important for therapy staff to complete DC summaries for all residents, because it informed everyone that Resident 86 was no longer on PT services. PT 1 stated it provided a summary of how the resident performed during PT, and provided recommendations after discharge for the resident. During a review of the facility's policies and procedures (P&P) proved 6/13/2024, titled, Inter-disciplinary Resident/Patient Assessment and Reassessment, the P&P indicated all documentation must be completed within 48 hours of service provided or service attempted.

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	04/11/2025

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Motion Picture and T.V. Hosp D/P Snf	23388 Mulholland Dr. Woodland Hills, CA 91364

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for three of 21 sampled residents (Residents 47, 86, 39) investigated during the Infection Control task by failing to ensure: 1) Activities Assistant (AA) 1 donned (put on) Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) upon entering Resident 47's room who was on droplet precautions (measure aimed to prevent the spread of diseases transmitted through respiratory droplets). 2) Certified Nursing Assistant (CNA 1) and Staff 1 donned an isolation gown when performing high contact activities with Resident 86 who was on Enhanced Barrier Precautions (EBP, infection control practice to reduce transmission of infectious organisms). 3) Certified Nursing Assistant (CNA 5) donned proper PPE prior to performing activities of daily living (ADL - basic tasks that must be accomplished every day for an individual to thrive) care to Resident 39 who was on EBP. 4) Linen Carts A, B, C were not covered with a loosely woven/permeable (having pores or openings that permit liquids or gases to pass through) material to protect the clean linens inside the cart. These deficient practices had the potential to spread infections and illnesses to residents, visitors, and staff. Findings: 1. During a review of Resident 47's Face Sheet, the Face Sheet indicated the facility admitted the resident on 9/8/2021. During a review of Resident 47's Patient Diagnosis Information, the Patient Diagnosis Information indicated the resident had diagnoses including bilateral (both, left and right) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knees and hypertensive heart disease with heart failure (refers to heart problems that occur because of high blood pressure that is present over a long time, and results in heart failure in which the heart does not pump blood to the body effectively). During a review of Resident 47's Minimum Data Set (MDS - resident assessment tool), dated 2/7/2025, the MDS indicated the facility most recently admitted the resident on 4/25/2022. The MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required substantial/maximal assistance from staff for upper body dressing and was dependent on staff for toileting, bathing, lower body dressing, and chair to chair/bed transfers. (continued on next page)

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	04/11/2025

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Motion Picture and T.V. Hosp D/P Snf	23388 Mulholland Dr. Woodland Hills, CA 91364

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 47's Care Plan (CP) titled, Alteration in Respiratory Function as evidenced by low grade fever, cough, nasal congestion, watery eyes, initiated 4/8/2025, the CP indicated interventions including the infection control nurse was notified, to test the resident for viruses, and to place the resident on droplet precautions for respiratory symptoms. During a review of Resident 47's physician orders, dated 4/9/2025, the physician orders indicated an order for droplet precautions until 4/14/2025. During a concurrent observation and interview, on 4/9/2025, at 9 a.m., with AA 1, outside of Resident 47's room, Resident 47 had a droplet precaution sign posted at the room entrance. Resident 47's room entrance had a closed door. AA 1 opened Resident 47's door from inside the room. AA 1 spoke with Resident 47 without a mask and exited the room. AA 1 stated he was discussing activities with Resident 47 and did not need to wear a mask or any PPE because he was not providing care to Resident 47. AA 1 looked at the droplet precaution sign and stated the sign was a different color than it was yesterday. AA 1 stated he did not read the sign prior to entering Resident 47's room. AA 1 reviewed the droplet precaution sign and stated the sign indicated droplet precautions, stop and see the nurse before entering the room, and wear a disposable surgical-grade mask when entering the resident room. AA 1 stated he was not sure why there was a droplet precaution sign on Resident 47's door but would ask the assigned nurse. During a concurrent observation and interview, on 4/9/2025, at 9:05 a.m., with Licensed Vocational Nurse (LVN) 3 and AA 1, AA 1 spoke with LVN 3 and stated he did not wear any PPE while speaking to Resident 47 at the bedside. LVN 3 stated the droplet precaution sign was placed on the resident's door because the resident is symptomatic of a respiratory virus. LVN 3 stated AA 1 should pay attention and read the sign prior to entering the resident's room to ensure AA 1 donned a mask. AA 1 stated he did not see the sign. LVN 3 stated the importance of wearing a mask in the resident's room is to prevent the spread of contagious illnesses like the flu (a highly contagious respiratory illness, which spreads easily through the air or when people touch contaminated surfaces) or COVID-19 (a highly contagious viral infection that can trigger respiratory tract infection) to other staff, visitors, or residents. During an interview, on 4/11/2025, at 11:15 a.m., with the Director of Long-Term Care (DLTC), the DLTC stated droplet precautions are used to prevent the transmission of infections by coughing. The DLTC stated isolation signs are posted at the entrance to a resident's room as the main method of communication with staff and visitors regarding any precautions. The DLTC stated she was made aware that AA 1 entered Resident 47's room without a mask. The DLTC stated AA 1 did not check the droplet precaution sign prior to entering Resident 47's room, but AA 1 should have. The DLTC stated the facility policy and procedure (P&P) was not followed by AA 1 and there is the potential that AA 1 may spread infections from Resident 47 to other staff and residents resulting in resident illness. (continued on next page)

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	04/11/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Listing of Category - Specific Isolation Precaution Techniques, last reviewed 10/2024, the P&P indicated there are two (2) levels of isolation precautions. The first, and most important, level are those precautions designed for the care of all residents, regardless of their diagnosis or presumed infection status. These are called Standard Precautions. The second level are precautions designed only for the care of specified residents. These additional Transmission-Based Precautions are for residents known or suspected to be infected by significant pathogens spread by airborne or droplet transmission or by contact with dry skin or contaminated surfaces. In addition to Standard Precautions, use Droplet Precautions, or the equivalent, for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets that can be generated by the patient during coughing or sneezing). In addition to standard precautions, wear a mask when working within six feet (a unit of measure) of the patient/resident. 41379 2. During a review of Resident 86's Face Sheet (FS), the FS indicated Resident 86 admitted to the facility on [DATE] with diagnoses including but not limited to anoxic brain damage (damage to brain due to lack of oxygen supply to the brain), hemiplegia (weakness to one side of the body) affecting right dominant side, monoplegia (paralysis of one side of the body) of upper limb affecting left nondominant side, and aphagia (a disorder that makes it difficult to speak). During a review of Resident 86's Minimum Data Set (MDS, a resident assessment tool) dated 3/11/2025, the MDS indicated was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 86 was dependent on staff for oral hygiene, toileting, bathing, dressing, and bed to chair transfers. During a review of Resident 86's Care Plan (CP) dated 3/5/2025, the CP indicated Resident 86 was on EBP related to gastronomy tube (g-tube, a tube placed directly into the stomach for long-term feeding), wear appropriate PPE during activities of daily living, cleaning and disinfecting the environment, mobility assistance and preparing to leave the room, and transferring. During an observation and interview on 4/8/2025 at 9:33 a.m., there was a sign outside Resident 86's room indicating EBP for Resident 86 and an isolation cart with gowns and gloves. Resident 86 was laying on the bed dressed and had a hoyer lift (a mechanical lift that allows a person to be transferred from one surface to another) sling underneath Resident 86. CNA 1 stated she was going to get assistance from another staff to transfer Resident 86 to the geriatric chair (a large, padded chair designed to help persons with limited mobility). CNA 1 exited the room and CNA 1 re-entered the room and put on gloves. Staff 1 put on gloves and entered Resident 86's room. CNA 1 and Staff 1 proceeded to transfer Resident 86 from the bed to the geriatric chair with a hoyer lift. While Resident 86 was in the geriatric chair, CNA 1 assisted Resident 86 with oral hygiene using swabs. CNA 1 and Staff 1 were not observed wearing isolation gowns while providing care inside Resident 86's room. During an interview on 4/8/2025 at 9:46 a.m., Licensed Vocational Nurse (LVN 1) stated Resident 86 was on EBP, because Resident 86 had a g-tube. LVN 1 stated staff providing care such as transferring and hygiene for Resident 86 would need to wear an isolation gown and gloves. (continued on next page)

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	04/11/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/2025 at 9:51 a.m., CNA 1 stated Resident 86 had a g-tube so staff needed to wear isolation gown and gloves when working with Resident 86. CNA 1 stated she did not wear an isolation gown when she assisted Resident 86 with transfers and when providing oral hygiene. CNA 1 stated staff should wear PPE when there was possible contact with bodily fluids because it protected staff and the residents they worked with. CNA 1 read the EBP sign outside Resident 86's door and stated the sign indicated to wear gown and gloves during activities such as transferring and hygiene. During an interview on 4/9/2025 at 11:03 a.m., the Infection Preventionist (IP) stated for any resident with wounds or devices like a g-tube, staff need to follow EBP when performing close contact activities with residents. IP stated staff needed to wear isolation gowns and gloves with resident-care activities such as dressing, toileting, transferring, and oral care,. During a review of the facility's policy and procedures (P&P) revised 3/1/2025, titled, Enhanced Barrier Precautions, the P&P indicated the need for EBP by healthcare providers while caring for residents at high-risk for MDRO transmission, presence of indwelling devices: feeding tube, wounds covered by a dressing. High-contact resident care activities for which EBP would apply: dressing, transferring, changing linens, changing briefs or assisting with toileting. Procedure: perform hand hygiene, don PPE gown, gloves upon entry and before beginning activity. Remove and discard PPE and perform hand hygiene in the room when activity is complete. 43988 3. During a review of Resident 39's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/18/2018. During a review of Resident 39's Clinical Record Abstract, the Clinical Record Abstract indicated Resident 39's diagnoses including neurocognitive (a decline in thinking, reasoning, and memory abilities due to a medical condition, injury, or illness affecting the brain) disorder with Lewy bodies dementia (a type of progressive dementia [a progressive state of decline in mental abilities] that leads to a decline in thinking, reasoning and independent function due to protein deposits in the brain), stage 2 pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) sacral region (a bone located at the bottom of the spine), and retention of urine. During a review of Resident 39's History and Physical (H&P) dated 2/17/2025, the H&P indicated the resident was non-verbal but occasionally makes eye contact and able to track voices. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool) dated 3/14/2025, the MDS indicated Resident 39 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 39's care plan (CP) on stage 2 pressure injury on sacrum initiated on 11/25/2024, the CP indicated the resident is on EBP related to wound, wear appropriate PPE during ADL as one of the interventions to assist heal the wound without complications. (continued on next page)

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	04/11/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/7/2025 at 10:18 a.m., inside Resident 39's room, observed Certified Nursing Assistant (CNA) 5 providing care to the resident and not wearing a gown. Observed a sign outside the door for an EBP which indicated everyone must clean their hands before entering and when leaving the room, and providers and staff must wear gloves and a gown during high-contact resident care activities such as dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device, and wound care. During an interview on 4/7/2025 at 10:24 a.m. with CNA 5 outside Resident 39's room, CNA 5 stated he did not clean his hands prior to putting on gloves and did not put on a gown while providing care to Resident 39. CNA 5 stated he forgot that the resident was on EBP. CNA 5 stated the staff are supposed to clean their hands using the hand sanitizer and put on gloves and gown prior to providing care to residents on EBP. CNA 5 stated he should have cleaned his hands with the hand sanitizer prior to putting on gloves and wear a gown while providing care to Resident 39 to protect the spread of infection between residents. During an interview on 4/7/2025 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 39 was on EBP due to presence of wound on the sacral region and the staff should wear a gown while providing care to the resident and during wound care. LVN 1 stated CNA 5 should have put on a gown while providing care to Resident 39 to prevent the spread of infection between residents. During an interview on 4/11/2025 at 3:43 p.m. with the Director of Long-Term Care (DLTC), the DLTC stated the staff are supposed to wear a gown during high contact activities such as dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device, and wound care as indicated in the signage outside the doors. The DLTC stated CNA 5 should have performed hand hygiene prior to putting on gloves and then put on a gown while providing care to Resident 30 to protect the staff as well as spread of infection to other residents who are vulnerable. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, last reviewed on 3/1/2025, the P&P indicated a purpose to implement EBP as a resident-centered approach and activity approach for preventing Multidrug Resistant Organisms (MDRO - a germ, usually bacteria, that has become resistant to many different antibiotics) transmission in a healthcare setting. The P&P further indicated: - The use of PPE by healthcare personnel during specific care activities is based on periodic assessments of a resident's risk for MDRO colonization and transmitting MDROs. - To assess characteristics of residents at high risk for MDRO colonization and transmission: Wounds covered by a dressing, especially chronic wounds. - High-contact resident care activities for which EBP would apply: Dressing Bathing/Showering Transferring (continued on next page)

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	04/11/2025

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Motion Picture and T.V. Hosp D/P Snf	23388 Mulholland Dr. Woodland Hills, CA 91364

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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 - Some	Changing linens Changing briefs or assisting with toileting Device care or use Wound care; any skin opening requiring a dressing - Perform hand hygiene. - If needed, based on the procedure about to be performed to a resident, don (put on) PPE such as gown and gloves upon entry and before beginning activity. 44376 4. During a concurrent observation and interview on 4/11/2025, at 10:21 a.m., with Certified Nursing Assistant (CNA) 3, on the unit hallway, observed Linen Carts A and B covered with loosely woven/permeable cover to protect the clean linens inside the cart. CNA 3 stated the cover had tiny holes that bacteria and viruses could go through, and liquid can permeate the cover and will not totally protect the linens from environmental contaminants. During a concurrent observation and interview on 4/11/2025, at 10:24 a.m., with CNA 4, on the unit hallway, observed linen Linen Cart C covered with loosely woven/permeable cover to protect the clean linens inside the cart. CNA 4 stated the cover had tiny holes that bacteria and viruses could go through, and liquid can permeate the cover and will not totally protect the linens from environmental contaminants. During a concurrent observation an interview on 4/11/2025, at 10:27 a.m., with Licensed Vocational Nurse (LVN) 3, on the unit hallway, observed Linen Carts A and B covered with loosely woven/permeable cover to protect the clean linens inside the cart. LVN 3 stated the cover was not totally protecting the linens inside the carts as air and water can penetrate the cover. LVN 3 stated viruses and bacteria were minute and can penetrate the cover and settle on the linen causing infection to residents. During an interview on 4/11/2025, at 10:51 a.m., with the Director of Environmental Services (DEVS), the DEVS stated the covers for the linens were not totally protecting them (linens) from environmental contaminants because air and water can seep through the covers. During an interview on 4/11/2025, at 3:23 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated they should use non-permeable cover to protect the clean linens in the facility to prevent the spread of infection among residents. During a review of the facility's recent policy and procedure (P&P) titled Linen, last reviewed on 10/2024, the P&P indicated to ensure that neither dirty laundry does not serve as a means of transmission for infection or colonization. To prevent contamination of clean linen. Clean linen should be transported in covered carts/containers.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 44376 Based on interview and record review, the facility failed to reduce the risk of adverse events (an undesirable experience or harm that happens to a patient as a result of medical care), including the development of antibiotic-resistant organisms (occurs when bacteria develop defenses against the antibiotics designed to kill them), from unnecessary or inappropriate antibiotic use for one of three sampled residents (Resident 21) reviewed for antibiotic use by failing to clarify with the ordering physician the appropriate indication of Azithromycin (also known as Zithromax, a type of antibiotic) used as a prophylaxis (an attempt to prevent disease) for pneumonia (an infection/inflammation in the lungs). This deficient practice had the potential to cause adverse side effects and risk for resistance associated with the use of inappropriate antibiotic therapy. Findings: During a review of Resident 21's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/30/2023. During a review of Resident 21's History and Physical (H&P), dated 11/24/2024, the H&P indicated the resident was awake, alert, pleasant, and cooperative. The H&P indicated the resident had dyslipidemia (an imbalance of lipids [fats] in the blood), chronic recurrent pneumonia (two or more episodes of pneumonia [lung infection] in twelve [12] months or three episodes altogether), and atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time). The H&P indicated, per the primary medical doctor, the resident will continue twice weekly azithromycin life-long, and daily prednisone (medication to help relieve swelling, redness, itching, and allergic reactions). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 2/14/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a decline in thinking and memory skills that are more noticeable than what's expected for someone of a given age, but not severe enough to interfere significantly with daily life). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 21's Active Orders, dated 11/25/2024, the Active Orders indicated an order for azithromycin 250 milligrams (mg - a unit of measurement for mass). Give 250 mg (one tablet) by mouth Monday and Friday per prescriber. Indication: pneumonia prophylaxis. During a review of Resident 21's Plan of Care (POC) with multiple medical conditions, dated 11/30/2023, the CP indicated an intervention of azithromycin (Zithromax) 250 mg. Give 250 mg (1 tablet) by mouth Monday and Friday per prescriber. Indication: pneumonia prophylaxis. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 4/10/2025, at 9:07 a.m., with Registered Nurse (RN) 2, Resident 21's Active Orders, Medication Administration Record (MAR), Progress Notes, and POC were reviewed. RN 2 confirmed and stated there was an order for azithromycin 250 mg 1 tablet by mouth every Monday and Friday for pneumonia prophylaxis. RN 2 stated there was no end date for the antibiotic and the indication is for pneumonia prophylaxis. RN 2 stated she received education from the facility regarding antibiotic use that it should have a stop date and an appropriate indication, if used for a longer period of time, it should have an explanation for its prolonged use. RN 2 stated their antibiotic stewardship program (a coordinated effort to ensure antibiotics are used appropriately and effectively, preventing overuse and misuse) was headed by the pharmacist and the infection prevention nurse (IP) and were responsible for making sure the antibiotics were appropriately used to prevent antibiotic resistance on residents. During a concurrent interview and record review, on 4/10/2024, at 1:20 p.m., with Nurse Practitioner (NP) 1, Resident 21's Active Orders and Progress Notes were reviewed. NP 1 stated azithromycin for pneumonia prophylaxis is very atypical (not normal). NP 1 stated antibiotics should have an end date, and the medication was prescribed by the pulmonologist (a doctor specializing in the diagnosis and treatment of diseases and conditions of the respiratory system, which includes the lungs and airways). NP 1 stated the pharmacist, and the infection preventionist are responsible for making sure the antibiotic is appropriate and had an appropriate indication. NP 1 stated the pulmonologist's notes indicated the resident was having chronic recurrent pneumonia and per the pulmonologist azithromycin will be continued twice weekly for azithromycin life-long. The NP stated she was not aware of which clinical practice guideline they were following regarding the use of azithromycin as a prophylaxis to pneumonia. The NP stated she will contact the provider and get back at the surveyor for which guideline they are following. During an interview, on 4/10/2025, at 2:40 p.m., with the Director of Pharmacy (DP), the DP stated she was aware of Resident 21 having azithromycin as prophylaxis for pneumonia and there should be no end date on the drug order. The DP stated that she had not had any discussion with the prescriber nor the IP nurse regarding its use for prophylaxis. The DP stated that if the IP brought to her attention that the indication was inappropriate, she could have asked the IP to clarify the order with the prescribing physician and asked what clinical practice guideline was used by the ordering physician. The DP stated it was important to ensure antibiotics were reviewed for its appropriate use to prevent antibiotic resistance. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/11/2024, at 9:09 a.m., with the IP, the IP stated the antibiotic stewardship program starts with the pharmacist receiving the order for antibiotics. The IP stated the pharmacist notifies her when there is a new order for antibiotics. The IP stated when she gets notified of new antibiotics prescribed for residents, she goes to the electronic medical record (EMR) to check the assessment done by NP 1 or physician, she makes sure there is an indication, she checks the laboratory results and uses the Loeb's criteria (a set of minimum signs and symptoms, that indicate a high likelihood of infection in a resident of a long-term care facility, potentially justifying antibiotic treatment even before confirming the infection with diagnostic tests) to check for its appropriateness of antibiotic use. The IP stated the pharmacist does not notify her if the antibiotic is being used for prophylaxis. The IP stated if she was notified of the azithromycin used as prophylaxis for pneumonia, she could have contacted the prescriber and clarified the order because she had a recollection of discussion with a physician that azithromycin is used as a prophylaxis for bronchitis (an inflammation of the bronchial tubes, the airways that carry air to and from the lung) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause ongoing inflammation and damage to the airways and air sacs in the lungs) only, aside from that, the order did not have a stop date, and the indication could have been clarified. The IP stated these are the type of issues she brings to Pharmacy and Therapeutics (P&T, a multidisciplinary group responsible for evaluating and recommending policies related to the safe and effective use of medications within the facility) for discussion to seek peer reviews. The IP stated the failure of the pharmacist to communicate the use of the azithromycin as a prophylaxis for pneumonia led to possible antibacterial resistance to resident. During a concurrent interview and record review, on 4/11/2025, at 1 p.m., with NP 1, NP 1 provided an article from American Journal of Translational Research, published on 6/15/2021, which according to NP 1 was provided to her by the prescriber, indicated it can be concluded from this study that azithromycin was effective in the treatment of COPD in patients with acute exacerbation of chronic bronchitis (CB). NP 1 stated there were no mention of the study using azithromycin used as prophylaxis for pneumonia. During an interview, on 4/11/2025, at 1:35 p.m., with the DP, the DP stated she is the first person to get the order, however she did not question the indication of azithromycin for pneumonia prophylaxis given the history of the resident. The DP denied discussing the issue with anybody, and the DP stated the issue should have been brought to P&T for discussion. During an interview, on 4/11/2025, at 3:23 p.m., with the Director of Long-Term Care (DLTC), the DLTC stated the pharmacist should have communicated Resident 21's use of azithromycin as prophylaxis for pneumonia to the IP to clarify why the antibiotic had no stop date and to ensure the indication is appropriate for its use. During a review of the facility's recent policy and procedure (P&P) titled, Antibiotic Stewardship, last reviewed on 6/12/2024, the P&P indicated to provide oversight of all antibiotic prescribing within the Long Term Care unit and the Center for Behavioral Health (CBH). The goals of the program are to reduce the risk of antibiotic resistance, to minimize inappropriate prescribing of antibiotics through the development and application of appropriate provider algorithms and to educate providers, nursing staff and pharmacists on the importance of antibiotic stewardship. When the order is received in the Pharmacy, the processing pharmacist will communicate the following information, via email, to the Infection Control Nurse. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Patient/Resident Name b. Patient/Resident Location c. Diagnosis d. Drug, dose, route and duration. During a review of the facility-provided Summary of Product Characteristics of Azithromycin dihydrate 200 mg/5 ml Powder for Oral Suspension, dated 5/2024, the Summary of Product Characteristics indicated for treatment of upper and lower respiratory tract infections, skin and soft tissues infections and odontostomatological (refers to the branch of medicine and science that deals with the study of teeth, the mouth, and related structures, including the jaw and face) infections 500 mg per day taken once daily, for 3 consecutive days. The same dosage regimen can be applied to elderly patients. Since elderly patients are more susceptible to developing cardiac arrythmia, particular caution is recommended due to the risk of developing cardiac arrhythmia (a problem with the heart's rhythm) and torsade de pointes (a type of very fast heart rhythm (tachycardia) that originates in the lower chambers of the heart [ventricles]).