STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was treated with respect and in a dignified manner. The facility failed to: 1. Ensure Resident 1 ' s was treated with dignity and respect when the Certified Nurse Assistant (CNA) 1 removed Resident 1 ' s glasses from his hands without his permission when turning Resident 1 to his side while he was lying in bed. 2. Ensure Resident 1 ' s rights were upheld when the facility did not provide Resident 1 with an admission packet, which provided the resident ' s bill of rights and policies and procedures pertaining to the facility. These deficient practices resulted in: 1. Resident 1 ' s feeling violated by CNA 1 and not wanting further interaction with CNA 1. 2. Resident 1 being unaware of his rights, policies and procedures of the facility. This deficient practice violated Resident 1 ' s right to dignity and the right to be informed. This deficient practice had the potential for care and services to be unprovided to Resident 1 due to Resident 1 ' s distrust of CNA 1 and unexplained expectations of the facility and resident relationship. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including amyotrophic lateral sclerosis ([ALS] progressive disease that affects nerve cells in the brain and spinal cord, leading to the weakness, paralysis and death, major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that interfere with daily life), type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s History and Physical (H&P), dated 4/29/2025, the H&P indicated, Resident 1 had the capacity to understand and make decisions. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Minimum Data Set [(MDS), a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 ' s cognition (ability to register and recall information) was intact. a. During a review of the facility investigation conducted by the Administrator and Social Services Director (SSD), dated 4/29/2025, the document indicated on 4/29/2025 Resident 1 reported that Certified Nurse Assistant (CNA) 1 and CNA 2 asked him to roll over onto this side and hold the grab bar, Resident 1 stated he had a pair of glasses that CNA 1 removed from his hand so he could try to hold the grab bar. During a review of Certified Nurse Assistant (CNA) 1 ' s written interview, dated 4/29/2025, the document indicated she along with Certified Nurse Assistant (CNA) 2 proceeded to provide Activities of Daily Living (ADL) care to Resident 1. The document indicated CNA 1 asked Resident 1 if he could help with his hands and his feet, Resident 1 responded by staying quiet and not answering her question. The document indicated Resident 1 kept his mouth closed, did not say one word and never answered CNA 1. During an interview on 5/8/2024 at 3:30 p.m., Resident 1 ' s stated he felt violated on 4/29/2025, when CNA 1 took his glasses out of his hands without his consent. Resident 1 stated CNA 1 and CNA 2 wanted me to grab the grab bar when so they could turn me. Resident 1 stated I did not agree to anyone taking my glasses and I felt too weak to move. Resident 1 stated during an earlier interaction with CNA 1, Resident 1 felt angry and responded by staying quiet and not answering questions. Resident 1 stated, I did not give CNA 1 permission to remove my glasses out of my hand, but she did it anyway without my consent and then she proceeded to move me forcefully onto my side, jabbing my shoulder with their hands. Resident 1 stated he felt distrustful of staff and felt his rights were violated. During an interview on 5/9/2024 at 10:35 a.m., the DON stated she was not aware that Resident 1 ' s glasses were removed from his hands without permission. The DON acknowledged that staff must ask a resident for consent prior to taking away a personal belonging from their possession. During an interview on 5/9/2024 at 4 p.m., the Administrator stated per his interview with Resident 1, Resident 1 informed him that CNA 1 removed Resident 1 ' s glasses from his hands. The administrator stated at the time of the interview, he (the Administrator) did not realize removing Resident 1 ' s glasses without consent was violation of residents ' rights. The administrator acknowledged that CNA 1 should not have removed Resident 1 ' s glasses from his possession without permission. The Administrator stated CNA 1 ' s actions could have contributed to Resident 1 ' s distrust toward the facility staff. b. During an interview on 5/8/2025 at 3:35 p.m., Resident 1 ' s stated that since he arrived at the facility, he feel like he was being punished. Resident 1 stated, I am constantly told what I cannot do. I did not receive an orientation to the facility. I don ' t know what the rules and the expectations are here in the facility, I don ' t know what ' s allowed and not allowed, such as when I can smoke. I feel like everyone here is out to get me. Resident 1 stated I know I have rights, but the facility staff haven ' t told me what those are. Resident 1 stated no one has presented him with an admission packet or a resident ' s [NAME] of Rights. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2025 at 8:50 a.m., the Admission Coordinator (AC) stated it is her role to provide newly admitted residents with an admission packet which includes the facility policies, resident rights, behold information and smoking policies. The AC stated it is important for residents to receive this information upon admission. The AC stated is the resident ' s right to be aware of their rights, to be given an orientation and explanation of the policies and procedures of the facility. The AC stated failure to provide this to the resident will lead to confusion and misunderstanding of the expectations of staff and residents. The AC stated she did not provide Resident 1 with an admission packet, nor did she provide Resident 1 with orientation or ensure he understood the facility ' s policies and procedures (P&P). The AC stated Resident 1 has resided in the facility for over 10 days and her failure to provide this information to the Resident 1 lead to confusion and Resident 1 ' s distrust toward the facility staff. The AC stated she should have informed the administrator, Director of Nursing (DON), or SSD that Resident 1 has not received an orientation nor received his [NAME] of Rights. During an interview on 5/9/2024 at 10:35 a.m., the DON stated she was not aware that Resident 1 was not provided an admission packet, made aware of rights or provided an orientation pertaining to the facility ' s policies and procedures. The DON stated it is the admission coordinator ' s role to provide this to newly admitted residents however, all staff members are responsible for ensuring Resident 1 understood his rights and received information regarding the facility ' s policies and procedures. The DON stated Resident 1 did not receive the necessary information which caused confusion between Resident 1 and the staff and led to distrust in Resident directed toward the facility demonstrated by Resident 1 ' s resistance in working with the staff. During a review of the facility ' s P&P, titled, Resident ' s Rights, revised 10/1/2023, the P&P indicated the purpose of the policy ensure all residents are treated with the level of dignity they are entitled to [NAME] residing at the facility. The P&P indicated that each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality. The P&P indicated, staff will not handle or move a resident ' s personal belongings without the resident ' s permission. During a review of the facility ' s P&P, titled, Admission and Orientation of Resident, revised 1/1/2024, the P&P indicated the purpose of the admission process of residents while ensuring that residents and resident representatives are properly oriented to the facility. The P&P indicated when a new resident arrives at the facility, the admissions coordinator or designee will provide the resident or representative with California Standard Admission Agreement, answering any question, provide the resident with Resident Bills of Rights and ask the resident/resident representative to review the document. The P&P indicated the admission coordinator will explain to the resident/resident representative the facility ' s additional documents requiring review to ensure the resident/resident representative is fully informed about facility policies and procedures.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44958 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was diagnosed with amyotrophic lateral sclerosis ([ALS]progressive disease that affects nerve cells in the brain and spinal cord, leading to the weakness, paralysis and death), was injured, when he was hit on his head by the mechanical lift (mechanical device used by caregivers to safely transfer patients) lift upon transfer from his bed to the wheelchair. As a result of this deficient practice, Resident 1 required transfer via 911 to a General Acute Care Hospital for evaluation and treatment and was found to have a head and chest contusion (bruise). Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including ALS. During a review of Resident 1's History and Physical (H&P), dated 4/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 1's cognition (ability to register and recall information) was intact and had the ability to understand and be understood by others. The MDS further indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for toileting hygiene, showering /bathing, dressing, putting on/taking off footwear. During a review of Resident 1's Clinical Record (Care Plan section), initiated on 4/29/2025, the Care Plan indicated Resident 1 at risk for falls and or injuries related to antihypertensive medications (drugs used to treat high blood pressure (hypertension), balance deficit, bladder/bowel dysfunction (difficulties controlling urination or bowel movements, including issues like incontinence, constipation, or an urgent need to use the bathroom), decreased strength/endurance, psychotherapeutic medications (drugs that that alter mental processes, behavior, mood and perception), unsteady gait, diagnosis ALS. The care plan goals indicated, Resident 1 will be free from falls and or injuries by the review date of 7/28/2025. During a review of Resident 1's Clinical Record (Care Plan section), initiated on 5/4/2025, the Care Plan indicated Resident 1 got hit in the forehead while four staff transferred him from bed to the wheelchair and complained of pain. The Care Plan goal indicated resident will have no or less pain by a review date of 7/28/2025. The Care Plan interventions included Resident 1's medical doctor (MD 1) was notified, and an order was received to send Resident 1 to the GACH for evaluation and treatment. During a review of Resident 1's Change of Condition (COC) Evaluation, dated 5/4/2025, the COC indicated Resident 1 complained of forehead pain after his head was hit by the mechanical lift during transfer. The COC further indicated MD 1 recommended Resident 1 to be transferred to the GACH for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nursing Notes, dated 5/4/2025, the Nursing Notes indicated Resident 1 was transferred to a GACH via 911 at approximately 5:30 p.m. During a review of Resident 1's GACH emergency room (ER) records, dated 5/4/2025, the records indicated Resident 1 arrived at the GACH at approximately 5:42 p.m. with a chief complaint of head injury. The records indicated Resident 1 was administered Toradol (medication to treat pain) 60 milligrams (mg - unit of measurement) intramuscular injection (IM - method of administering medication directly into a muscle tissue) and stated his head pain was better. The records indicated Resident 1 refused any radiological studies and was discharged back to the facility with a prescription of ibuprofen (medication to treat mild pain) 800 mg tablet every six hours as needed for pain. The records indicated Resident 1 had a discharge diagnosis of head and chest contusion. During a review of Resident 1's Nurses Notes, dated 5/4/2025, the Nurses Notes indicated Resident 1 returned to the facility at 8:28 p.m. During an interview on 5/8/2025 at 3:35 p.m., Resident 1 stated while he was being transferred from his bed to a wheelchair, the mechanical lift tipped to the side and hit him on the forehead. Resident 1 stated he felt discomfort from the injury and was taken to the GACH for evaluation. During an interview on 5/9/2025 at 11:40 a.m., Restorative Nurse Assistant (RNA) 1 stated on 5/4/2025, while he and three other staff members were assisting Resident 1 from the bed to the wheelchair, Resident 1 leaned back into the sling, and it caused the mechanical lift to tilt to the side. RNA 1 stated he and the three staff members were able to lower Resident 1 into the wheelchair, however the sling bar hit Resident 1 on the head as they were detaching the sling from the mechanical lift sling bar attachments. During an interview on 5/9/2025 at 4 p.m., the Director of Nursing (DON) stated that Resident 1 should have had a physician's order to use the mechanical lift. The DON stated, per review of Resident 1's clinical records, Resident 1 did not have a physician order to use the mechanical lift. The DON stated it is the facility responsibility for Resident 1 to remain free from injury. The DON stated the facility failed to ensure Resident 1's safety while using the mechanical lift resulting Resident 1 being transferred to the GACH. During a review of the facility's Policy and Procedure (P&P) titled, Total Mechanical Lift, dated 10/1/2023, the P&P indicated the mechanical lift is used appropriately to facilitate transfers of residents. The P&P further indicated the resident will have a physician's order for the use of the lift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to ensure a resident (Resident 1), who was alert, continent (ability to control) of bowel and bladder, and had a high risk for a pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) development, received care and services to maintain bowel and bladder function for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure the nursing staff assisted Resident 1 timely to use the urinal to maintain the resident's bladder continence (the ability to voluntarily control emptying the bladder). 2. Implement Resident 1's plan of care and the Interdisciplinary Team ([IDT] a team of healthcare professionals, working with the resident, from different professional disciplines who work together to manage the physical, psychological, and spiritual needs of the resident) assessment for the staff to assist the resident with toileting to ensure the resident's needs are met. 3. Ensure Resident 1's dignity was maintained by not placing an incontinence brief (absorbent undergarments designed to provide full incontinence protection) on the residents for staff convenience due to staff being busy with other residents. These failures resulted in: 1. Resident 1 being encouraged to use an incontinence brief instead of a urinal or commode to maintain his continence. 2. Resident 1 having feelings of lack of dignity and being embarrassed about having to use an incontinence brief and left to sit in his own urine. 3. The potential for Resident 1 to sustain skin breakdown due to the use of an incontinence brief. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including amyotrophic lateral sclerosis ([ALS] a progressive disease that affects nerve cells in the brain and spinal cord, leading to the weakness, paralysis and death), major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that interfere with daily life), and type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical (H&P), dated 4/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 1 was able to understand and be understood by others and his cognition (ability to register and recall information) was intact. The MDS indicated Resident 1 was dependent on staff for toileting hygiene (ability to maintain perineal hygiene, adjust clothing before and after voiding or having a bowel movement). The MDS further indicated that Resident 1 was at risk for developing pressure injuries. During a review of Resident 1's Clinical Record (Care Plan section), initiated on 4/29/2025, the Care Plan indicated Resident 1 was at risk for bladder/bowel dysfunction (difficulties controlling urination or bowel movements, including issues like incontinence, constipation, or an urgent need to use the bathroom). Under this Care Plan interventions included to respect Resident 1 's wishes, independence, and dignity. During a review of Resident 1's Nurses Notes, dated 4/30/2025, the notes indicated on 4/30/2025, Resident 1 complained he was soiled with urine, needed to be changed, and was told by his Certified Nurse Assistant (CNA) that he would have to wait to be cleaned up because the CNA was assisting another resident. The Nurses Notes indicated Resident 1 was not happy with the answer and continued to remark about being wet. During an interview on 5/8/2023 at 3:35 p.m., Resident 1 stated the staff did not ask him about his toileting ability and had not been part of a care plan to discuss his toileting needs and habits. Resident 1 stated he was not asked by the nursing staff if he is continent or incontinent upon admission to the facility. Resident 1 stated he was admitted to the facility wearing an incontinence brief and assumed the nursing staff thought he was incontinent because he needed help holding the urinal and assistance cleaning himself after. Resident 1 stated he does not need to wear an incontinence brief. Resident 1 stated the nursing staff had not given him the time to toilet regularly and arrived too late after calling for help, which results in Resident 1 urinating on himself. Resident 1 stated, he felt embarrassed and humiliated wearing an incontinence brief. Resident 1 stated sitting in a diaper irritates his skin and he is worried he is developing a rash or a sore. During an interview on 5/9/2025 at 10:45 a.m., Registered Nurse (RN) 1 stated upon admission Resident 1 should have been assessed for the possibility of being placed on the facility's toileting program. RN 1 stated Resident 1 would be a strong candidate because he is alert and oriented. RN 1 stated the purpose of the toileting program is to maintain a resident's highest level of functioning to promote dignity and independence. During an interview on 5/9/2025 at 11:04 a.m., CNA 3 stated Resident 1 can use the restroom using a urinal or a bedpan. CNA 3 stated Resident 1 has difficulty using his hands due to his diagnosis but could urinate in a urinal if staff are there to help him. CNA 3 stated Resident 1 is not on a toileting schedule or program so staff are not aware he needs help unless he asks for it. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025 at 2 p.m., the Director of Nursing (DON) stated the facility must accommodate the toileting needs of all residents. The DON stated during admission, Resident 1's toileting habits and needs should have been accurately assessed. The DON stated the assessment is used to develop and implement a care plan to address Resident's 1 toileting needs. The DON stated during her review of Resident 1's clinical records, Resident 1 had not been placed on a toileting diary (used to track a residents toileting patterns) to assess bowel and bladder readiness. The DON stated Resident 1 does not have a care plan addressing his bowel/ bladder status which resulted in Resident 1's need wearing a diaper causing him to feel undignified and increasing his risk for skin breakdown. During a review of the facility's policy & procedure (P&P)titled, Bowel and Bladder Evaluation, revised 10/1/2023, the P&P indicated a resident who is incontinent is to receive appropriate treatment and services to prevent urinary tract infections (infection where bacteria enter the urinary system and multiply in the bladder or kidneys) and to restore as much normal bladder and bowel function as possible. The P&P indicated a continence assessment will be completed on all residents upon admission, re-admission or when resident experiences a change in urinary continence status, transient causes of incontinence should be identified and the underlying cause treated as the resident's condition allows, if a history does not suggest a transient cause for incontinence, proceed to a three day trial toileting diary, if history suggest a transient cause, notify attending physician for possible treatment options. The P&P indicated the IDT will develop a care plan that addresses strategies to effectively manage incontinence and restorative activities. During a review of the facility's P&P titled, Resident's Rights, Quality of life, revised 10/1/2023, the P&P indicated the facility will ensure all residents are treated with the level of dignity they are entitled to while residing at the facility. The P&P indicated the facility staff will provide care and services that ensure residents' abilities in activities of daily living do not diminish while in the care of the facility, except when unavoidable as evidenced by clinical condition. The P&P further indicated demeaning practices and standard of care that compromise dignity is prohibited, facility staff will promote dignity and assist residents as needed by promptly responding to the resident's request for toileting assistance.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44958 Based on interview and record review, the facility failed to accurately document the medications administered to one of three sampled residents (Resident 1), when Resident 1 refused to receive medications from Licensed Vocational Nurse (LVN) 1 on 5/2/2025 at 9 p.m. This deficient practice resulted in inaccurate documentation on Resident 1 ' s Medication Administration Record (MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) when the Licensed Vocational Nurses (LVNs 1 and 2) administered Resident 1 ' s 9 p.m. medications on 5/2/2025. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including amyotrophic lateral sclerosis ([ALS] progressive disease that affects nerve cells in the brain and spinal cord, leading to the weakness, paralysis and death, major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that interfere with daily life), type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s History and Physical (H&P), dated 4/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 1 ' s cognition (ability to register and recall information) was intact and was able to understand and be understood by others. During a review of Resident 1 ' s Nurses Notes, dated 5/3/2025, timed at 6:36 a.m., the Nurses Notes indicated Resident 1 filed a complaint regarding the 3 p.m. to 11 p.m. shift related to a charge nurse asking another nurse to give him (Resident 1) his medications. The Nurses Notes indicated Resident 1 was reassured that management would be made aware of his complaint. During an interview on 5/8/2023 at 3:35 p.m., Resident 1 stated on 4/29/2025, when he arrived at the facility, he felt that LVN 1 did not treat him with dignity and respect, and did not want LVN 1 to care for him. Resident 1 stated on during the evening shift on 5/2/2025, around 9 p.m., he saw LVN 1 handing over his medications to LVN 2 at the doorway of his room. Resident 1 stated he informed LVN 2 that he would not take any medications prepared by LVN 1. LVN 1 then discarded the medications and LVN 2 prepared the medications again, and Resident 1 agreed to take the medications from LVN 2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025 at 2:30 p.m., LVN 1 stated she did prepare to give Resident 1 his night medications when he informed her (LVN 1) that he was refusing to take any medications from her (LVN 1). LVN 1 stated she gave did not administer the medications to Resident 1 and instead gave the medications she prepared to LVN 2 to give to Resident 1. LVN 1 stated she remembers pre-charting the medications in Resident 1 ' s MAR. LVN 1 stated she thought Resident 1 would take his medications from LVN 2, but Resident 1 did not want the medications LVN 1 prepared and wasted Resident 1 ' s medications. LVN 1 stated she should have documented the medication that was refused by Resident 1 in the MAR. During an interview on 5/9/2025 at 3:45 p.m., LVN 2 stated she was asked by LVN 1 to give Resident 1 his medications on 5/2/2025 at 9 p.m. LVN 2 stated, LVN 1 handed her the medications she prepared to give to Resident 1. Resident 1 stated he would not take the medications if LVN 1 was the nurse that prepared them. LVN 2 stated she proceeded to waste the drugs given to her by LVN 1 and proceeded to prepare Resident 1 ' s ordered medications within Resident 1 ' s view. LVN 2 stated, Resident 1 agreed to take the medication from her (LVN 2). During a concurrent interview and record review on 5/9/2025 at 3:50 p.m., with LVN 2, Resident 1 ' s Medication Administration Record (MAR), dated May 2025, was reviewed. The MAR indicated LVN 1 ' s initials on 5/2/2025 for the 5 p.m. administration time, indicating the following medications were administered to Resident 1: 1. Famotidine (medication that reduces the amount of acid the stomach) 20 milligrams ([mg] unit of measurement). 2. Melatonin (hormone that regulates sleep)10 milligrams ([mg] unit of measurement). 3. Thiamine (B vitamins) HCL 100 mg. 4. Trazadone (medication used to treat major depressive disorder) HCL 50 mg. 5. Riluzole (medication used to treat ALS) 50 mg. 6. Baclofen (medication used to treat muscle stiffness and tightness) 5 mg. LVN 2 stated LVN 1 had already pre-charted the medications prior to administering them to Resident 1. Due to this fact, LVN 2 did not edit the record to reflect her (LVN 2 ' s) initials, since Resident 1 agreed to take the medications from her (LVN 2). LVN 2 stated she should have edited the record to accurately reflect that she (LVN 2) was the nurse who administered the following medications to Resident 1. LVN 2 stated failing to accurately document medications is a violation of facility policy and nurse practice standards of care and stated a nurse must give meds by checking the five rights of medication administration and then document their nurses ' initials verifying the nurse completed the steps and meds were given safely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 4:10 p.m., the Director of Nursing (DON) stated licensed nurses should document the care provided to the residents accurately to ensure the resident is receiving quality of care per facility standards and state regulations. The DON stated failure accurately documenting medication administration prevents accurate communication between other health care professionals. The DON stated accurate documentation provides important information that the facility can use to monitor how the facility delivers care to residents and the nurse charting the meds is accountable to the administration of that medication and if there is a concern that nurse will be able to attest to it. During a review of the facility ' s policy and procedure (P&P) titled, Medication-Administration revised 10/1/2023, the P&P indicated the purpose of the policy is to practice standards of safe administration of medications for residents in the facility, medications must be given to the resident by the licensed nurse preparing the medication. The P&P indicated the licensed nurse will remain with the resident until the medication is actually swallowed, if the resident is refusing to the take the medication, the licensed nurse who is passing the medication will initial and draw a circle around his/her initials in the designed area on the MAR, the documentation will entered on the back of the MAR stating the reason for refusal. The P&P indicated the time and dose of the drug or treatment administered to the resident will be recorded in the resident ' s individual medication record by the person who administers the drug or treatment. During a review of the facility ' s Job Description Licensed Vocational Nurse, revised 5/2017, the Job Description indicated under the direct supervision of a registered nurse, the licensed nurse responsibilities include maintenance of the record of care provided. The Job Description further indicated the licensed nurses must timely, accurately and thoroughly prepare documentation in a manner that conforms to the prescribed style and format and respond to common inquiries from customers (residents) and regulatory agencies