STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Change of Condition (COC - a major decline in a resident ' s status), and notify the physician for one of five sampled residents (Resident 1) who had a significant COC that started on [DATE] at 4 a.m. On [DATE], at 4 a.m., Resident 1 ' s tracheal tube (trach tube, a two-inch-to three-inch-long curved metal or plastic tube placed in a surgically created opening [tracheostomy] in the windpipe to keep it open) was partially (not completely) displaced (removed from the usual or proper place). Respiratory Therapist 2 (RT 2) was unable to replace the tracheal tube with the same size (7.5 millimeter (mm, one thousandth of a meter) but was able to replace the tracheal tube with a smaller-sized tube (6 mm). RT 2 noted Resident 1 with bilateral (both lungs) diminished (decreased) breath sounds and minimal airflow from the airway (a passageway for air into or out of the lungs). RT 2 endorsed Registered Nurse 1 (RN 1) to notify Resident 1 ' s Medical Doctor (MD 1), but RN 1 did not notify MD 1 regarding Resident 1 ' s COC and RT 2 replaced Resident 1 ' s tracheal tube with a different tracheal tube. As a result, on [DATE] at 5:55 a.m., RN 1 and Licensed Vocational Nurse 2 (LVN 2) found Resident 1 with breathing difficulty, vital signs (clinical measurements, specifically pulse/heart rate, temperature, respiration rate [number of breaths a person takes per minute], and blood pressure [the force of the blood pushing against the walls of the arteries], that indicated the state of a patient ' s/resident ' s essential body functions) unappreciated (not located, felt, or heard), and Resident 1 starting to turn blue. The paramedics (health professionals certified to perform advanced life support procedures) arrived at the facility at 6:08 a.m. The paramedic found Resident 1 lying in bed with rigor (stiffening of the body muscles due to chemical changes after death) and lividity (the bluish-purple discoloration of skin after death) and pronounced Resident 1 dead on [DATE], at 6:13 a.m. On [DATE] at 2:02 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility ' s failure to notify the physician regarding Resident 1 ' s COC under 42 CFR S483.10(g)(14) Notification of Changes. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:12 p.m., the ADM and DON submitted an IJ Removal Plan (a detailed plan to address the IJ findings). While onsite at the facility, the SSA verified that the IJ situation was no longer present and confirmed the facility ' s implementation of the IJ Removal Plan through observations, interviews, and record reviews, the SSA accepted the IJ Removal Plan and removed the IJ situation in the presence of the ADM and DON on [DATE], at 3:30 p.m. The acceptable IJ Removal Plan included the following summarized actions: 1. On [DATE], the DON provided one on one (1:1) in-service education and COC competency to RN 1 regarding the proper procedures for assessing, identifying, and addressing a resident ' s COC, monitoring for any change of condition, and prompt notification of the physician to request for appropriate interventions for a COC. 2. On [DATE], the DON and Sub-Acute unit (unit with patients/residents who required lesser degree than acute care) RN 1 initiated in-service/education for all interdisciplinary (IDT- a group of healthcare professional from different discipline who participate in the care of the residents) staff (Nursing, Respiratory, Environmental, Dietary, Activities,, Medical Records, Social Services, and Rehab Services) regarding: the proper procedures for identifying a resident ' s COC, reporting a COC, monitoring for any COC, and prompt notification of the physician to request for appropriate interventions for a COC. All decannulations (removal of the tracheostomy tube) or trach changes that require a smaller tracheal tube will be reported to the physician promptly for interventions. 3. On [DATE], the DON and a RN reviewed 15 residents ' medical records with a change of condition in the last 72 hours. All documentation reflected that the physician was notified promptly regarding the change of condition as required. 4. On [DATE], the DON and the Quality Assurance (QA) Consultant created a new COC Validation Competency which included recognizing signs and symptoms of respiratory distress (a condition where the body needs more oxygen), identifying a COC, notifying the physician regarding a COC immediately and documenting in the resident's medical record. 5. On [DATE], all 43 residents with tracheostomy tubes were assessed by the respiratory therapists and no other residents were identified with abnormal findings. All residents had the proper trach size as ordered by the physician and no issues with tracheal tube placement. There were no residents with decannulation in the last 72 hours. 6. The DON/ Designee will randomly review at least 10 residents ' medical records with COC per month for 3 months and then quarterly thereafter. Cross Reference F695 and F726 Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs), dysphagia (swallowing difficulties), encephalopathy (a group of conditions that cause brain dysfunction), and respiratory (pertaining to the lungs) failure. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Care Plan titled, Tracheostomy tube care with risk for accidental decannulation and associated respiratory distress, developed on [DATE], indicated Resident 1 needed special treatments for tracheal tube care with risk for accidental decannulation and associated respiratory distress. The approached interventions included when decannulation occurs RT (any RT) or RN (any RN) to replace the tracheostomy tube with the same size or smaller size ASAP (right away), observe and monitor vital signs, notify physician and responsible party of change of condition, and keep extra trach tubes with the same size or smaller size at the resident ' s bedside with other tracheostomy supplies. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE] indicated Resident 1 had the ability to be understood and had the ability to understand. The MDS indicated Resident 1 was dependent on staff on oral care, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. A review of the Physician ' s Orders for Resident 1, dated [DATE] at 1:47 p.m., indicated to place Resident 1 on a T-bar (T-shaped tubing connected to an endotracheal tube [a small, usually plastic tube inserted into the trachea through the mouth or nose to maintain an unobstructed passageway especially to deliver oxygen to the lungs] used to deliver oxygen therapy in an intubated patient who does not require mechanical ventilation [a type of therapy that helps the patient/resident breathe or breathes when the patient/resident cannot breathe]) as tolerated ,d+[DATE] (24 hours a day, seven days a week) on oxygen, every shift. A review of Resident 1 ' s Respiratory Daily Notes entered by RT 2, dated [DATE] at 11:36 p.m., indicated Resident 1 was on a T-bar, at 5 liters of oxygen per minute (LPM-unit of measurement), with thick white sputum (a mixture of saliva and mucus coughed up from the respiratory tract), and bilateral rhonchi (large airway sounds, are continuous gurgling or bubbling sounds typically heard during both inhalation [breathe in] and exhalation [breathe out]). The notes indicated Resident 1 ' s tracheal tube was midline (refers to the imaginary line that divides the body into symmetrical left and right halves) and intact, airway was patent (open) and secured. During a review of Resident 1 ' s Tracheostomy Tube Change form, dated [DATE] at 3:32 a.m. and an interview with RT 2, RT 2 stated on [DATE], at 3:32 a.m. Resident 1 ' s original tracheal tube was the Bivona 75HA60 (type of tracheal tube) which was 7.5 mm in size, and it was decannulated outside of Resident 1 ' s stoma (an opening made during surgery). RT 2 stated It appeared that Resident 1 was on his (Resident 1 ' s) side and his position may have caused his Bivona to come out of his stoma. RT 2 stated the Portex 7 mm (a type of tracheal tube) uncuffed (not cuffed) was not successfully inserted. RT 2 stated a Portex 6 mm uncuffed was inserted and a catheter (a flexible tube) was able to pass through Resident 1 ' s tracheostomy with little resistance. RT 2 stated Resident 1 ' s breath sounds were diminished with minimal airflow noted from the airway. RT 2 stated RT 2 recommended/endorsed RN 1 to obtain an order from MD 1 for an x-ray (a type of medical imaging that creates pictures of the bones and soft tissues) to confirm Resident 1 ' s new tracheal tube (Portex 6 mm) placement. The Tracheostomy Tube Change form indicated for staff (in general) to notify the physician (MD 1) if a smaller size tracheal tube was used. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Change of Condition notes entered by RN 1, dated [DATE] at 5:14 a.m., indicated Resident 1 expired (died). The notes indicated (on [DATE]), at 4 a.m., during rounds, charge nurse (LVN 2) noted that Resident 1 ' s tracheal tube was not fully secured (not attached firmly so that it cannot be moved). RT 2 and RN 1 were notified immediately. Vital signs checked after RT 2 replaced Resident 1 ' s displaced tracheal tube. The notes indicated (on [DATE]), at around 5:55 a.m. Resident 1 was noted with breathing difficulty, Resident 1 ' s vital signs were unappreciated (unrecognized), and MD 1 was notified. The notes indicated on ([DATE]) at 6:08 a.m., the paramedics arrived and took over the care and the paramedics pronounced Resident 1 expired at 6:13 a.m. A review of the Los Angeles Fire Department (LAFD) Care Report for Resident 1, dated [DATE], at 6:01 a.m. , indicated LAFD received dispatch notification (on [DATE]), at 6:01 a.m. with dispatch complaint as cardiac arrest (occurs when the heart suddenly and unexpectedly stops pumping). The report indicated the paramedics arrived on scene (at the facility) at 6:08 a.m. and at 6:12 a.m., exam indicated Resident 1 was unresponsive, pale, with bilateral eyes fixed (did not react to light) and dilated (became wider/larger). The report indicated Resident 1 was lying in hospital bed of nursing home obviously dead. The report indicated Resident 1 had rigor and lividity. Resident 1 was determined dead at 6:13 a.m. During an interview on [DATE] at 2:29 p.m., RN 1 stated that (on [DATE]) at around 4 a.m. LVN 2 and RT 2 told RN 1 that Resident 1 ' s tracheostomy tube was partially displaced, and RT 2 replaced Resident 1 ' s tracheostomy tube. RN 1 stated at 5:55 a.m. LVN 2 and RN 1 walked into Resident 1 ' s room and saw Resident 1 was gasping for air like he (Resident 1) could not breathe. RN 1 stated he (RN 1) yelled for help. RN 1 stated RT 3 who was close by arrived and asked RN 1 to call code blue, (generally used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention, most often as the result of a respiratory or cardiac arrest [occurs when the heart suddenly and unexpectedly stops pumping]) and RT 3 came into Resident 1 ' s room and started cardiopulmonary resuscitation (CPR- an emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped). During an interview on [DATE] at 3 p.m., LVN 2 stated (on [DATE]) at 4 a.m., she (LVN 2) found Resident 1 ' s tracheostomy tube was out (displaced) and called RT 2. LVN 2 stated RT 2 placed Resident 1 ' s tracheal tube, and Resident 1 ' s vital signs were taken and were within normal ranges (the results were normal, and no further investigation or treatment is needed). LVN 2 stated (on [DATE]), at 5:55 a.m. RN 1 called LVN 2 for help when RN 1 saw Resident 1 was having difficulty breathing/labored breathing (breathing that requires observed effort or an increased amount of energy). LVN 2 stated she (LVN 2) tried to obtain Resident 1 ' s vital signs but she was not able to get the vital signs reading. LVN 2 stated Resident 1 started to turn blue. LVN 2 stated RN 1 called the code blue and RT 3 then got inside Resident 1 ' s room. LVN 2 stated Resident 1 lost consciousness and RT 3 started CPR on Resident 1. LVN 2 stated the paramedics arrived at the facility (on [DATE]) at around 6:08 a.m., and the paramedics took over Resident 1 ' s care. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:30 p.m., RT 2 stated that (on ,d+[DATE]) at around 3:30 a.m. Resident 1 ' s tracheostomy tube came out (displaced) while Resident 1 was lying on Resident 1 ' s side (did not indicate which side). RT 2 stated when he (RT 2) asked Resident 1 how long the tracheostomy tube had been out Resident 1 stated he (Resident 1) did not know. RT 2 stated he (RT 2) then did an emergency tracheostomy tube change. RT 2 stated emergency tracheostomy tube change meaning he must insert a new tracheal tube. RT 2 stated Resident 1 ' s tracheal tube was a size 7.5 mm and he tried to insert a size 7 mm, but it (the new tracheal tube size 7 mm) did not go through. RT 2 stated he then inserted a smaller tracheostomy tube size 6 mm and Resident 1 ' s oxygen saturations (the amount of oxygen being carried by red blood cells and normal level is usually 95% or higher) went from 95% to 98%. RT 2 stated he informed RN 1 to get an x-ray to confirm the new tracheal tube placement. RT 2 stated Resident 1 ' s breath sounds were diminished with minimal airflow due to a smaller size of the new tracheal tube. During an interview on [DATE] at 4:30 p.m., RN 1 stated RT 2 did ask RN 1 to obtain an order for an x-ray on Resident 1 to confirm the new tracheal tube placement, but RT 2 said Resident 1 was okay. RN 1 stated RT 2 mentioned it casually and he (RN 1) did not call MD 1 to obtain a new order for the x-ray to confirm Resident 1 ' s new tracheal tube placement as requested by RT 2. RN 1 stated he (RN 1) informed MD 1 when Resident 1 was having distress on [DATE] at 5:55 a.m. RN 1 stated there were no prior notifications made to MD 1. During a concurrent interview with RT 5 and a review of Resident 1 ' s Tracheostomy Tube Change form, dated [DATE], on [DATE] at 10:33 a.m., RT 5 stated that when RT 2 was unable to insert the current size (same size) tracheal tube, RT 2 must notify the doctor and get a new order for the new size of the tracheal tube. RT 5 stated when RT 2 noticed Resident 1 had diminished breath sounds as indicated on RT 2 ' s notes, RT 2 needed to send Resident 1 to a General Acute Care Hospital (GACH) for further evaluation. RT 5 stated Resident 1 ' s minimal airflow was not a good thing. RT 5 stated it would be a concern when Resident 1 ' s diminished breath sounds was a new onset. RT 5 stated on [DATE] at around 5:58 a.m., RN 2 called her in Resident 1 ' s room. RT 5 stated RT 3 and RT 6 were already performing chest compressions on Resident 1. RT 5 stated Resident 1 was lying flat in bed, pulseless (without a heart rate), and Resident 1 ' s nail beds were pale. During an interview on [DATE] at 11:39 a. m., RN 2 stated on [DATE] at around 5:50 a.m., while getting a report from RN 1, RN 1 stated Resident 1 needed a follow up due to prior issue with tracheostomy. RN 2 stated he (RN 2) did an initial round and saw Resident 1 was pale in color. RN 2 stated he yelled, I need help here. RN 2 stated Resident 1 was still breathing but he (Resident 1) was struggling to breathe. RN 2 stated when RT 2 downsized Resident 1 ' s tracheal tube, and RT 2 endorsed to RN 1 to notify MD 1 then RN 1 must notify MD 1. RN 2 stated RT 2 can also communicate to the doctor (MD 1). During an interview on [DATE] at 1:07 p.m., RT 2 stated RNs (any RN) must notify the doctor when RTs (any RT) downsized the resident ' s tracheal tube. RT 2 stated RNs must update the doctor because it is a new airway and RNs must obtain new orders for the new tracheal tube size. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:17 p.m., RT 3 stated that on [DATE] at 5:55 a.m. he (RT 3) was close by when RN 1 called to help Resident 1. RT 3 stated he ran into Resident 1 ' s room and he (RT 3) was the first staff assessing Resident 1. RT 3 stated Resident 1 was not breathing, the resident had no pulse, and the resident ' s color was dark. RT 3 stated he (RT 3) checked and saw Resident 1 ' s tracheostomy tie was loose, and Resident 1 was not breathing. RT 3 stated the canula (a small tube that is inserted into a body cavity for medical purposes) was still in and he tightened the tracheostomy tie. RT 3 stated when there is a need to downsize the tracheal tube due to decannulation, one must notify the doctor and ask for a new order for the new tracheal tube size. During an interview on [DATE] at 4:30 p.m., MD 1 stated he (MD 1) was notified of Resident 1 ' s change in condition only when Resident 1 required emergency services on [DATE], at 5:55 a.m. During an interview on [DATE] at 9:32 a.m., RN 1 stated if RT 2 had told RN 1 that Resident 1 had diminished equal breath sounds and minimal airflow, he (RN 1) would monitor Resident 1. RN 1 stated he would do a COC but would have not reported to MD 1 at 4 a.m. because MD 1 would have not responded to his (RN 1 ' s) call at that time (4 a.m.). RN 1 stated he would have waited until the morning (unspecified time) to inform MD 1. During a concurrent review of Resident 1 ' s Trach tube change document, dated [DATE] and interview with the DON on [DATE] at 10:11 a.m., the DON stated, tracheal tube decannulation is not expected but it can happen. The DON reviewed Resident 1 ' s Trach tube change document, and stated staff (in general) needed to notify the physician when a smaller tracheal tube is used. The DON stated MD 1 was not notified when RT 2 downsized Resident 1 ' s tracheal tube. The DON stated the start of the COC for Resident 1 was when Resident 1 ' s tracheal tube decannulation occurred. The DON stated when there was a COC, the resident ' s family member and doctor must be notified. The DON stated RN 1 should have called MD 1 when Resident 1 was not stable. The DON stated that based on Resident 1 ' s Trach tube change notes written by RT 2, Resident 1 was not stable when Resident 1 had diminished bilateral breath sounds with minimal airflow. During a concurrent review of Resident 1 ' s Tracheostomy Notes and interview with the DON on [DATE] at 10:55 a.m., the DON stated Resident 1 ' s Tracheostomy notes, dated [DATE] indicated that Resident 1 had been rhonchi throughout his (Resident 1 ' s) stay then after the tracheostomy tube changed on [DATE] due to the tracheal tube decannulation, Resident 1 had diminished bilateral breath sounds with minimal airflow. The DON stated, it was a new change of condition. A review of the current facility-provided P&P titled, Change of Condition, last revised on [DATE], indicated ensure proper assessment and follow-through for any resident with a change of condition. c. Upon a change in condition for any reason, nursing staff member are to take the following actions. Physician shall be called promptly. If for some reason physician cannot be reached, alternative physician shall be contacted. If alternate cannot be reached, Medical Director is to be contacted. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All contacts or attempt to contact shall be documented and include the correct time of the activity. If no physician is available, arrangements are to be made for physician services that may include transfer to ER (emergency room) for appropriate care.

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) received tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs) care when on [DATE] at 4 a.m., Resident 1 ' s tracheal tube (trach tube, a catheter that is inserted into the trachea for the primary purpose of establishing and maintaining an open airway) was partially (not completely) displaced (removed from the usual or proper place). Respiratory Therapist 2 (RT 2) was unable to replace the tracheal tube with the same size (7.5 millimeter [mm, a metric unit of length equal to one thousandth of a meter]) but was able to replace it (the trach tube) with a smaller-sized tube (6 mm) and RT 2 noted Resident 1 had bilateral (both lungs) diminished (decreased) breath sound and minimal airflow from airway. As a result, on [DATE] at 5:55 a.m., Registered Nurse 1 (RN 1) and Licensed Vocational Nurse 2 (LVN 2) found Resident 1 with breathing difficulty, vital signs (clinical measurements, specifically pulse rate/heart rate, temperature, respiration rate [number of breaths a person takes per minute], and blood pressure [the force of the blood pushing against the walls of the arteries], that indicate the state of a patient ' s essential body functions) unappreciated (not located, felt, or heard), and Resident 1 starting to turn blue. The paramedics (health professionals certified to perform advanced life support procedures) arrived at the facility at 6:08 a.m. The paramedic found Resident 1 lying in bed with rigor (stiffening of the body muscles due to chemical changes after death) and lividity (the bluish-purple discoloration of skin after death) and pronounced Resident 1 dead on [DATE], at 6:13 a.m. On [DATE] at 2:02 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility ' s failure to provide Resident 1 with tracheostomy care under 42 CFR S483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. On [DATE] at 12:12 p.m., the ADM and DON submitted an IJ Removal Plan (a detailed plan to address the IJ findings). While onsite at the facility, the SSA verified the IJ situation was no longer present and confirmed the facility ' s implementation of the IJ Removal Plan through observations, interviews, and record reviews, the SSA accepted the IJ Removal Plan and removed the IJ situation in the presence of the ADM and DON on [DATE], at 3:30 p.m. The acceptable IJ Removal Plan included the following summarized actions: 1. On [DATE], the DON provided one on one (1:1, one staff to one staff) in-service education and COC competency to RN 1 regarding the proper procedures for assessing, identifying, and addressing a resident ' s COC, monitoring for any change of condition, and prompt notification of the physician to request for appropriate interventions for a COC. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On [DATE], the DON and the Sub-Acute Unit (unit with patients/residents who required lesser degree than acute care) RN 1 initiated in-service/education for all interdisciplinary (IDT- a group of healthcare professional from different discipline who participate in the care of the residents) staff (Nursing, Respiratory, Environmental, Dietary, Activities, Medical Records, Social Services, and Rehab Services) regarding the proper procedures for identifying a resident ' s COC, reporting a COC, monitoring for any COC, and prompt notification of the physician to request for appropriate interventions for a COC. All decannulations (removal of the tracheostomy tube) or trach changes that require a smaller tracheal tube will be reported to the physician promptly for interventions. 3. On [DATE], the DON and RN (unidentified) reviewed 15 residents ' medical records with a change of condition in the last 72 hours. All documentation reflected that the physician was notified promptly regarding the change of condition as required. 4. On [DATE], the DON and the Quality Assurance (QA) Consultant created a new COC Validation Competency which included recognizing signs and symptoms of respiratory distress (a condition where the body needs more oxygen), identifying a COC, notifying the physician regarding a COC immediately and documenting in the resident's medical record. 5. On [DATE], all 43 residents with tracheostomy tubes were assessed by the respiratory therapist and no other residents were identified with abnormal findings. All residents had the proper trach size as ordered by the physician and no issues with tracheal tube placement. There were no residents with decannulation in the last 72 hours. 6. The DON/ Designee will randomly review at least 10 residents ' medical records with COC charts per month for 3 months and then quarterly thereafter. 7. On [DATE], The Director of Staff Development (DSD) reviewed all RNs competencies to ensure completion. No other RNs were affected. 8. RN 1 will receive and pass competency training monthly for 3 months and then annually thereafter. The DON/DSD/ Designee will repeat in-service training monthly for 3 months and then quarterly and as needed regarding the proper procedures for identifying a resident's change of condition, reporting a change of condition, monitoring for any change of condition, and prompt notification of the physician to request for appropriate interventions for a change of condition, calling the paramedics in a timely manner during an emergency, and contacting the medical director if a physician does not answer. 9. The DON/Designee will complete 10 competencies per month for IDT staff using the COC Competency and Validation form. 10. Any negative findings of the residents ' medical records audit will be reported by the Medical Records Director/ Designee to the Quality Assurance Committee monthly for 3 months and then quarterly thereafter for review and further action as needed. Cross Reference: F580 and F726 Findings: (continued on next page)

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	555686	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs), dysphagia (swallowing difficulties), encephalopathy (a group of conditions that cause brain dysfunction), and respiratory (pertaining to the lungs) failure. A review of Resident 1 ' s Care Plan titled, Tracheostomy tube care with risk for accidental decannulation and associated respiratory distress, developed on [DATE], indicated Resident 1 needed special treatments for tracheal tube care with risk for accidental decannulation and associated respiratory distress. The approached interventions included when decannulation occurs RT (any RT) or RN (any RN) to replace the tracheostomy tube with the same size or smaller size ASAP (right away), observe and monitor vital signs, notify physician and responsible party of change of condition, and keep extra trach tubes with the same size or smaller size at the resident ' s bedside with other tracheostomy supplies. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE] indicated Resident 1 had the ability to be understood and had the ability to understand. The MDS indicated Resident 1 was dependent on staff on oral care, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. A review of the Physician ' s Orders for Resident 1, dated [DATE] at 1:47 p.m., indicated to place Resident 1 on a T-bar (T-shaped tubing connected to an endotracheal tube [a small, usually plastic tube inserted into the trachea through the mouth or nose to maintain an unobstructed passageway especially to deliver oxygen to the lungs] used to deliver oxygen therapy in an intubated patient who does not require mechanical ventilation [a type of therapy that helps the patient/resident breathe or breathes when the patient/resident cannot breathe]) as tolerated ,d+[DATE] (24 hours a day, seven days a week) on oxygen, every shift. A review of Resident 1 ' s Respiratory Daily Notes entered by RT 2, dated [DATE] at 11:36 p.m., indicated Resident 1 was on a T-bar, at 5 liters of oxygen per minute (LPM-unit of measurement), with thick white sputum (a mixture of saliva and mucus coughed up from the respiratory tract), and bilateral rhonchi (large airway sounds, are continuous gurgling or bubbling sounds typically heard during both inhalation [breathe in] and exhalation [breathe out]). The notes indicated Resident 1 ' s tracheal tube was midline (refers to the imaginary line that divides the body into symmetrical left and right halves) and intact, airway was patent (open) and secured. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Tracheostomy Tube Change form, dated [DATE] at 3:32 a.m. and an interview with RT 2, RT 2 stated on [DATE], at 3:32 a.m. Resident 1 ' s original tracheal tube was the Bivona 75HA60 (type of tracheal tube) which was 7.5 mm in size, and it was decannulated outside of Resident 1 ' s stoma (an opening made during surgery). RT 2 stated It appeared that Resident 1 was on his (Resident 1 ' s) side and his position may have caused his Bivona to come out of his stoma. RT 2 stated the Portex 7 mm (a type of tracheal tube) uncuffed (not cuffed) was not successfully inserted. RT 2 stated a Portex 6 mm uncuffed was inserted and a catheter (a flexible tube) was able to pass through Resident 1 ' s tracheostomy with little resistance. RT 2 stated Resident 1 ' s breath sounds were diminished with minimal airflow noted from the airway. RT 2 stated RT 2 recommended/endorsed RN 1 to obtain an order from MD 1 for an x-ray (a type of medical imaging that creates pictures of the bones and soft tissues) to confirm Resident 1 ' s new tracheal tube (Portex 6 mm) placement. The Tracheostomy Tube Change form indicated for staff (in general) to notify the physician (MD 1) if a smaller size tracheal tube was used. A review of Resident 1 ' s Change of Condition notes entered by RN 1, dated [DATE] at 5:14 a.m., indicated Resident 1 expired (died). The notes indicated (on [DATE]), at 4 a.m., during rounds, charge nurse (LVN 2) noted that Resident 1 ' s tracheal tube was not fully secured (not attached firmly so that it cannot be moved). RT 2 and RN 1 were notified immediately. Vital signs checked after RT 2 replaced Resident 1 ' s displaced tracheal tube. The notes indicated (on [DATE]), at around 5:55 a.m. Resident 1 was noted with breathing difficulty, Resident 1 ' s vital signs were unappreciated (unrecognized), and MD 1 was notified. The notes indicated on ([DATE]) at 6:08 a.m., the paramedics arrived and took over the care and the paramedics pronounced Resident 1 expired at 6:13 a.m. A review of the Los Angeles Fire Department (LAFD) Care Report for Resident 1, dated [DATE], at 6:01 a.m. , indicated LAFD received dispatch notification (on [DATE]), at 6:01 a.m. with dispatch complaint as cardiac arrest (occurs when the heart suddenly and unexpectedly stops pumping). The report indicated the paramedics arrived on scene (at the facility) at 6:08 a.m. and at 6:12 a.m., exam indicated Resident 1 was unresponsive, pale, with bilateral eyes fixed (did not react to light) and dilated (became wider/larger). The report indicated Resident 1 was lying in hospital bed of nursing home obviously dead. The report indicated Resident 1 had rigor and lividity. Resident 1 was determined dead at 6:13 a.m. During an interview on [DATE] at 2:29 p.m., RN 1 stated that (on [DATE]) at around 4 a.m. LVN 2 and RT 2 told RN 1 that Resident 1 ' s tracheostomy tube was partially displaced, and RT 2 replaced Resident 1 ' s tracheostomy tube. RN 1 stated at 5:55 a.m. LVN 2 and RN 1 walked into Resident 1 ' s room and saw Resident 1 was gasping for air like he (Resident 1) could not breathe. RN 1 stated he (RN 1) yelled for help. RN 1 stated RT 3 who was close by arrived and asked RN 1 to call code blue, (generally used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention, most often as the result of a respiratory or cardiac arrest [occurs when the heart suddenly and unexpectedly stops pumping]) and RT 3 came into Resident 1 ' s room and started cardiopulmonary resuscitation, (CPR- an emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped). RN 1 stated the crash cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations) was nearby and it (the crash cart) was pulled into Resident 1 ' s room. RN 1 stated there was a phone on top of the crash cart and he (RN 1) called 911. RN 1 stated RT 3 checked Resident 1 ' s tracheostomy tube and changed the oxygen via artificial manual breathing unit (ambu bag - a type of device known as a bag valve mask, which is used to provide respiratory support to patients) to a full-face mask. RN 1 stated he did not assist with the CPR as it was all done by RT 3. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3 p.m., LVN 2 stated (on [DATE]) at 4 a.m., she (LVN 2) found Resident 1 ' s tracheostomy tube was out (displaced) and called RT 2. LVN 2 stated RT 2 placed Resident 1 ' s tracheal tube, and Resident 1 ' s vital signs were taken and were within normal ranges (the results were normal, and no further investigation or treatment is needed). LVN 2 stated (on [DATE]), at 5:55 a.m. RN 1 called LVN 2 for help when RN 1 saw Resident 1 was having difficulty breathing/labored breathing (breathing that requires observed effort or an increased amount of energy). LVN 2 stated she (LVN 2) tried to obtain Resident 1 ' s vital signs but she was not able to get the vital signs reading. LVN 2 stated Resident 1 started to turn blue. LVN 2 stated RN 1 called the code blue and RT 3 then got inside Resident 1 ' s room. LVN 2 stated Resident 1 lost consciousness and RT 3 started CPR on Resident 1. LVN 2 stated the paramedics arrived at the facility (on [DATE]) at around 6:08 a.m., and the paramedics took over Resident 1 ' s care. During an interview on [DATE] at 3:30 p.m., RT 2 stated that (on ,d+[DATE]) at around 3:30 a.m. Resident 1 ' s tracheostomy tube came out (displaced) while Resident 1 was lying on Resident 1 ' s side (did not indicate which side). RT 2 stated when he (RT 2) asked Resident 1 how long the tracheostomy tube had been out Resident 1 stated he (Resident 1) did not know. RT 2 stated he (RT 2) then did an emergency tracheostomy tube change. RT 2 stated emergency tracheostomy tube change meaning he must insert a new tracheal tube. RT 2 stated Resident 1 ' s tracheal tube was a size 7.5 mm and he tried to insert a size 7 mm, but it (the new tracheal tube size 7 mm) did not go through. RT 2 stated he then inserted a smaller tracheostomy tube size 6 mm and Resident 1 ' s oxygen saturations (the amount of oxygen being carried by red blood cells and normal level is usually 95% or higher) went from 95% to 98%. RT 2 stated he informed RN 1 to get an x-ray to confirm the new tracheal tube placement. RT 2 stated Resident 1 ' s breath sounds were diminished with minimal airflow due to a smaller size of the new tracheal tube. During an interview on [DATE] at 4:30 p.m., RN 1 stated RT 2 did ask RN 1 to obtain an order for an x-ray on Resident 1 to confirm the new tracheal tube placement, but RT 2 said Resident 1 was okay. RN 1 stated RT 2 mentioned it casually and he (RN 1) did not call MD 1 to obtain a new order for the x-ray to confirm Resident 1 ' s new tracheal tube placement as requested by RT 2. RN 1 stated he (RN 1) informed MD 1 when Resident 1 was having distress on [DATE] at 5:55 a.m. RN 1 stated there were no prior notifications made to MD 1. During a concurrent interview with RT 5 and a review of Resident 1 ' s Tracheostomy Tube Change form, dated [DATE], on [DATE] at 10:33 a.m., RT 5 stated that when RT 2 was unable to insert the current size (same size) tracheal tube, RT 2 must notify the doctor and get a new order for the new size of the tracheal tube. RT 5 stated when RT 2 noticed Resident 1 had diminished breath sounds as indicated on RT 2 ' s notes, RT 2 needed to send Resident 1 to a General Acute Care Hospital (GACH) for further evaluation. RT 5 stated Resident 1 ' s minimal airflow was not a good thing. RT 5 stated it would be a concern when Resident 1 ' s diminished breath sounds was a new onset. RT 5 stated on [DATE] at around 5:58 a.m., RN 2 called her in Resident 1 ' s room. RT 5 stated RT 3 and RT 6 were already performing chest compressions on Resident 1. RT 5 stated Resident 1 was lying flat in bed, pulseless (without a heart rate), and Resident 1 ' s nail beds were pale. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:39 a. m., RN 2 stated on [DATE] at around 5:50 a.m., while getting a report from RN 1, RN 1 stated Resident 1 needed a follow up due to prior issue with tracheostomy. RN 2 stated he (RN 2) did an initial round and saw Resident 1 was pale in color. RN 2 stated he yelled, I need help here. RN 2 stated Resident 1 was still breathing but he (Resident 1) was struggling to breathe. RN 2 stated when RT 2 downsized Resident 1 ' s tracheal tube, and RT 2 endorsed to RN 1 to notify MD 1 then RN 1 must notify MD 1. RN 2 stated RT 2 can also communicate to the doctor (MD 1). During an interview on [DATE] at 1:07 p.m., RT 2 stated RNs (any RN) must notify the doctor when RTs (any RT) downsized the resident ' s tracheal tube. RT 2 stated RNs must update the doctor because it is a new airway and RNs must obtain new orders for the new tracheal tube size. During an interview on [DATE] at 1:17 p.m., RT 3 stated that on [DATE] at 5:55 a.m. he (RT 3) was close by when RN 1 called to help Resident 1. RT 3 stated he ran into Resident 1 ' s room and he (RT 3) was the first staff assessing Resident 1. RT 3 stated Resident 1 was not breathing, the resident had no pulse, and the resident ' s color was dark. RT 3 stated he (RT 3) checked and saw Resident 1 ' s tracheostomy tie was loose, and Resident 1 was not breathing. RT 3 stated the canula (a small tube that is inserted into a body cavity for medical purposes) was still in and he tightened the tracheostomy tie. RT 3 stated when there is a need to downsize the tracheal tube due to decannulation, one must notify the doctor and ask for a new order for the new tracheal tube size. During an interview on [DATE] at 4:30 p.m., MD 1 stated he (MD 1) was notified of Resident 1 ' s change in condition only when Resident 1 required emergency services on [DATE], at 5:55 a.m. During an interview on [DATE] at 9:32 a.m., RN 1 stated if RT 2 had told RN 1 that Resident 1 had diminished equal breath sounds and minimal airflow, he (RN 1) would monitor Resident 1. RN 1 stated he would do a COC but would have not reported to MD 1 at 4 a.m. because MD 1 would have not responded to his (RN 1 ' s) call at that time (4 a.m.). RN 1 stated he would have waited until the morning (unspecified time) to inform MD 1. During a concurrent review of Resident 1 ' s Trach tube change document, dated [DATE] and interview with the DON on [DATE] at 10:11 a.m., the DON stated, tracheal tube decannulation is not expected but it can happen. The DON reviewed Resident 1 ' s Trach tube change document, and stated staff (in general) needed to notify the physician when a smaller tracheal tube is used. The DON stated MD 1 was not notified when RT 2 downsized Resident 1 ' s tracheal tube. The DON stated the start of the COC for Resident 1 was when Resident 1 ' s tracheal tube decannulation occurred. The DON stated when there was a COC, the resident ' s family member and doctor must be notified. The DON stated RN 1 should have called MD 1 when Resident 1 was not stable. The DON stated that based on Resident 1 ' s Trach tube change notes written by RT 2, Resident 1 was not stable when Resident 1 had diminished bilateral breath sounds with minimal airflow. During a concurrent review of Resident 1 ' s Tracheostomy Notes and interview with the DON on [DATE] at 10:55 a.m., the DON stated Resident 1 ' s Tracheostomy notes, dated [DATE] indicated that Resident 1 had been rhonchi throughout his (Resident 1 ' s) stay then after the tracheostomy tube changed on [DATE] due to the tracheal tube decannulation, Resident 1 had diminished bilateral breath sounds with minimal airflow. The DON stated, it was a new change of condition. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the current facility-provided policy and procedure (P&P) titled, Change of Condition, last revised on [DATE], indicated, to ensure proper assessment and follow-through for any resident with a change of condition. c. Upon a change in condition for any reason, nursing staff member are to take the following actions. Physician shall be called promptly. If for some reason physician cannot be reached, alternative physician shall be contacted. If alternate cannot be reached, Medical Director is to be contacted. All contacts or attempt to contact shall be documented and include the correct time of the activity. If no physician is available, arrangements are to be made for physician services that may include transfer to ER (emergency room) for appropriate care. A review of the current facility-provided P&P titled, Reinsertion (putting something back into or inside of something else) of Accidental Extubation (removal) of Trach Tube, undated, indicated sub-acute licensed staff, including RCPs (Respiratory Care Practitioners), RNs, and LVNs, must reinsert trach tubes that have been accidentally extubated. 3. Unsuccessful attempts to reinsert trach tube will be brought to the attention of the RCP or Nurse Manager. 4. Orders to replace extubated trach tube will be included in the physicians ' orders.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to ensure Registered Nurse 1 (RN 1) had the skills and knowledge to provide nursing services to one of five sampled resident (Resident 1) by failing to ensure: 1. RN 1 followed the facility ' s policy and procedure (P&P) titled, Change of Condition, (COC - a major decline in a resident ' s status) and called Resident 1 ' s Medical Doctor (MD) 1 to secure orders or request for interventions from MD 1 to address Resident 1 ' s COC when Respiratory Therapist 2 (RT 2) endorsed RN 1 to notify MD 1, after RT 2 replaced Resident 1 ' s tracheal tube (size 7.5 millimeter (mm, one thousandth of a meter) with a smaller-sized tube (6 mm) and RT 2 noted Resident 1 had bilateral (both lungs) diminished (decreased) breath sounds and minimal airflow from the airway (a passageway for air into or out of the lungs). 2. RN 1 followed the facility ' s policy titled, Cardiopulmonary Resuscitation, (CPR- an emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped) and immediately called the paramedics (health professionals certified to perform advanced life support procedures) on [DATE] at 5:55 am upon finding Resident 1 with vital signs (clinical measurements, specifically pulse rate/heart rate, temperature, respiration rate [number of breaths a person takes per minute], and blood pressure [the force of the blood pushing against the walls of the arteries], that indicated the state of a patient ' s/resident ' s essential body functions) unappreciated (not located, felt, or heard). RN 1 called the paramedics at 6:01 a.m. (6 mins after). As a result, on [DATE] at 5:55 a.m., Registered Nurse 1 (RN 1) and Licensed Vocational Nurse 2 (LVN 2) found Resident 1 with breathing difficulty, and Resident 1 starting to turn blue. The paramedics arrived at 6:08 a.m. The paramedic found Resident 1 lying in bed with rigor (stiffening of the body muscles due to chemical changes after death) and lividity (the bluish-purple discoloration of skin after death) and pronounced Resident 1 dead on [DATE], at 6:13 a.m. On [DATE] at 2:02 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility ' s failure to ensure RN 1 had the skills and knowledge to identify Resident 1 ' s COC and immediately call 911 (phone number for emergency services) when Resident 1 did not have a vital signs under 42 CFR S483.35 Nursing Services. On [DATE] at 12:12 p.m., the ADM and DON submitted an IJ Removal Plan (a detailed plan to address the IJ findings). While onsite at the facility, the SSA verified the IJ situation was no longer present and confirmed the facility ' s implementation of the IJ Removal Plan through observations, interviews, and record reviews, the SSA accepted the IJ Removal Plan and removed the IJ situation in the presence of the ADM and DON on [DATE], at 3:30 p.m. The acceptable IJ Removal Plan included the following summarized actions: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On [DATE], the DON provided one on one (1:1, one staff to one staff) in-service education and COC competency to RN 1 regarding the proper procedures for assessing, identifying, and addressing a resident ' s COC, monitoring for any change of condition, and prompt notification of the physician to request for appropriate interventions for a COC. 2. On [DATE], the DON and the Sub-Acute unit (unit with patients/residents who required lesser degree than acute care) RN 1 initiated in-service/education for all interdisciplinary (IDT- a group of healthcare professional from different discipline who participate in the care of the residents) staff (Nursing, Respiratory, Environmental, Dietary, Activities, Medical Records, Social Services, and Rehab Services) regarding the proper procedures for identifying a resident ' s COC, reporting a COC, monitoring for any COC, and prompt notification of the physician to request for appropriate interventions for a COC. All decannulations (removal of the tracheostomy tube) or trach changes that require a smaller tracheal tube will be reported to the physician promptly for interventions. 3. On [DATE], the DON and RN (unidentified) reviewed 15 residents ' medical records with a change of condition in the last 72 hours. All documentation reflected that the physician was notified promptly regarding the change of condition as required. 4. On [DATE], the DON and the Quality Assurance (QA) Consultant created a new COC Validation Competency which included recognizing signs and symptoms of respiratory distress (a condition where the body needs more oxygen), identifying a COC, notifying the physician regarding a COC immediately and documenting in the resident's medical record. 5. On [DATE], all 43 residents with tracheostomy tubes were assessed by the respiratory therapist and no other residents were identified with abnormal findings. All residents had the proper trach size as ordered by the physician and no issues with tracheal tube placement. There were no residents with decannulation in the last 72 hours. 6. The DON/ Designee will randomly review at least 10 residents ' medical records with COC charts per month for 3 months and then quarterly thereafter. 7. On [DATE], The Director of Staff Development (DSD) reviewed all RNs competencies to ensure completion. No other RNs were affected. 8. RN 1 will receive and pass competency training monthly for 3 months and then annually thereafter. The DON/DSD/ Designee will repeat in-service training monthly for 3 months and then quarterly and as needed regarding the proper procedures for identifying a resident's change of condition, reporting a change of condition, monitoring for any change of condition, and prompt notification of the physician to request for appropriate interventions for a change of condition, calling the paramedics in a timely manner during an emergency, and contacting the medical director if a physician does not answer. 9. The DON/Designee will complete 10 competencies per month for IDT staff using the COC Competency and Validation form. 10. Any negative findings of the residents ' medical records audit will be reported by the Medical Records Director/ Designee to the Quality Assurance Committee monthly for 3 months and then quarterly thereafter for review and further action as needed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross Reference: F580 and F695 Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs), dysphagia (swallowing difficulties), encephalopathy (a group of conditions that cause brain dysfunction) and respiratory (pertaining to the lungs) failure. A review of Resident 1 ' s Care Plan titled, Tracheostomy tube care with risk for accidental decannulation and associated respiratory distress, developed on [DATE], indicated Resident 1 needed special treatments for tracheal tube care with risk for accidental decannulation and associated respiratory distress. The approached interventions included when decannulation occurs RT (any RT) or RN (any RN) to replace the tracheostomy tube with the same size or smaller size ASAP (right away), observe and monitor vital signs, notify physician and responsible party of change of condition, and keep extra trach tubes with the same size or smaller size at the resident ' s bedside with other tracheostomy supplies. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE] indicated Resident 1 had the ability to be understood and had the ability to understand. The MDS indicated Resident 1 was dependent on staff on oral care, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. A review of the Physician ' s Orders for Resident 1, dated [DATE] at 1:47 p.m., indicated to place Resident 1 on a T-bar (T-shaped tubing connected to an endotracheal tube [a small, usually plastic tube inserted into the trachea through the mouth or nose to maintain an unobstructed passageway especially to deliver oxygen to the lungs] used to deliver oxygen therapy in an intubated patient who does not require mechanical ventilation [a type of therapy that helps the patient/resident breathe or breathes when the patient/resident cannot breathe]) as tolerated ,d+[DATE] (24 hours a day, seven days a week) on oxygen, every shift. A review of Resident 1 ' s Respiratory Daily Notes entered by RT 2, dated [DATE] at 11:36 p.m., indicated Resident 1 was on a T-bar, at 5 liters of oxygen per minute (LPM-unit of measurement), with thick white sputum (a mixture of saliva and mucus coughed up from the respiratory tract), and bilateral rhonchi (large airway sounds, are continuous gurgling or bubbling sounds typically heard during both inhalation [breathe in] and exhalation [breathe out]). The notes indicated Resident 1 ' s tracheal tube was midline (refers to the imaginary line that divides the body into symmetrical left and right halves) and intact, airway was patent (open) and secured. (continued on next page)

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	555686	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Tracheostomy Tube Change form, dated [DATE] at 3:32 a.m. and an interview with RT 2, RT 2 stated on [DATE], at 3:32 a.m. Resident 1 ' s original tracheal tube was the Bivona 75HA60 (type of tracheal tube) which was 7.5 mm in size, and it was decannulated outside of Resident 1 ' s stoma (an opening made during surgery). RT 2 stated It appeared that Resident 1 was on his (Resident 1 ' s) side and his position may have caused his Bivona to come out of his stoma. RT 2 stated the Portex 7 mm (a type of tracheal tube) uncuffed (not cuffed) was not successfully inserted. RT 2 stated a Portex 6 mm uncuffed was inserted and a catheter (a flexible tube) was able to pass through Resident 1 ' s tracheostomy with little resistance. RT 2 stated Resident 1 ' s breath sounds were diminished with minimal airflow noted from the airway. RT 2 stated RT 2 recommended/endorsed RN 1 to obtain an order from MD 1 for an x-ray (a type of medical imaging that creates pictures of the bones and soft tissues) to confirm Resident 1 ' s new tracheal tube (Portex 6 mm) placement. The Tracheostomy Tube Change form indicated for staff (in general) to notify the physician (MD 1) if a smaller size tracheal tube was used. A review of Resident 1 ' s Change of Condition notes entered by RN 1, dated [DATE] at 5:14 a.m., indicated Resident 1 expired (died). The notes indicated (on [DATE]), at 4 a.m., during rounds, charge nurse (LVN 2) noted that Resident 1 ' s tracheal tube was not fully secured (not attached firmly so that it cannot be moved). RT 2 and RN 1 were notified immediately. Vital signs checked after RT 2 replaced Resident 1 ' s displaced tracheal tube. The notes indicated (on [DATE]), at around 5:55 a.m. Resident 1 was noted with breathing difficulty, Resident 1 ' s vital signs were unappreciated (unrecognized), and MD 1 was notified. The notes indicated on ([DATE]) at 6:08 a.m., the paramedics arrived and took over the care and the paramedics pronounced Resident 1 expired at 6:13 a.m. A review of the Los Angeles Fire Department (LAFD) Care Report for Resident 1, dated [DATE], at 6:01 a.m. , indicated LAFD received dispatch notification (on [DATE]), at 6:01 a.m. with dispatch complaint as cardiac arrest (occurs when the heart suddenly and unexpectedly stops pumping). The report indicated the paramedics arrived on scene (at the facility) at 6:08 a.m. and at 6:12 a.m., exam indicated Resident 1 was unresponsive, pale, with bilateral eyes fixed (did not react to light) and dilated (became wider/larger). The report indicated Resident 1 was lying in hospital bed of nursing home obviously dead. The report indicated Resident 1 had rigor and lividity. Resident 1 was determined dead at 6:13 a.m. During an interview on [DATE] at 2:29 p.m., RN 1 stated that (on [DATE]) at around 4 a.m. LVN 2 and RT 2 told RN 1 that Resident 1 ' s tracheostomy tube was partially displaced, and RT 2 replaced Resident 1 ' s tracheostomy tube. RN 1 stated at 5:55 a.m. LVN 2 and RN 1 walked into Resident 1 ' s room and saw Resident 1 was gasping for air like he (Resident 1) could not breathe. RN 1 stated he (RN 1) yelled for help. RN 1 stated RT 3 who was close by arrived and asked RN 1 to call code blue, (generally used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention, most often as the result of a respiratory or cardiac arrest [occurs when the heart suddenly and unexpectedly stops pumping]) and RT 3 came into Resident 1 ' s room and started CPR. RN 1 stated the crash cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations) was nearby and it (the crash cart) was pulled into Resident 1 ' s room. RN 1 stated there was a phone on top of the crash cart and he (RN 1) called 911. RN 1 stated RT 3 checked Resident 1 ' s tracheostomy tube and changed the oxygen via artificial manual breathing unit (ambu bag - a type of device known as a bag valve mask, which is used to provide respiratory support to patients) to a full-face mask. RN 1 stated he did not assist with the CPR as it was all done by RT 3. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3 p.m., LVN 2 stated (on [DATE]) at 4 a.m., she (LVN 2) found Resident 1 ' s tracheostomy tube was out (displaced) and called RT 2. LVN 2 stated RT 2 placed Resident 1 ' s tracheal tube, and Resident 1 ' s vital signs were taken and were within normal ranges (the results were normal, and no further investigation or treatment is needed). LVN 2 stated (on [DATE]), at 5:55 a.m. RN 1 called LVN 2 for help when RN 1 saw Resident 1 was having difficulty breathing/labored breathing (breathing that requires observed effort or an increased amount of energy). LVN 2 stated she (LVN 2) tried to obtain Resident 1 ' s vital signs but she was not able to get the vital signs reading. LVN 2 stated Resident 1 started to turn blue. LVN 2 stated RN 1 called the code blue and RT 3 then got inside Resident 1 ' s room. LVN 2 stated Resident 1 lost consciousness and RT 3 started CPR on Resident 1. LVN 2 stated the paramedics arrived at the facility (on [DATE]) at around 6:08 a.m., and the paramedics took over Resident 1 ' s care. During an interview on [DATE] at 3:30 p.m., RT 2 stated that (on [DATE]) at around 3:30 a.m. Resident 1 ' s tracheostomy tube came out (displaced) while Resident 1 was lying on Resident 1 ' s side (did not indicate which side). RT 2 stated when he (RT 2) asked Resident 1 how long the tracheostomy tube had been out Resident 1 stated he (Resident 1) did not know. RT 2 stated he (RT 2) then did an emergency tracheostomy tube change. RT 2 stated emergency tracheostomy tube change meaning he must insert a new tracheal tube. RT 2 stated Resident 1 ' s tracheal tube was a size 7.5 mm and he tried to insert a size 7 mm, but it (the new tracheal tube size 7 mm) did not go through. RT 2 stated he then inserted a smaller tracheostomy tube size 6 mm and Resident 1 ' s oxygen saturations (the amount of oxygen being carried by red blood cells and normal level is usually 95% or higher) went from 95% to 98%. RT 2 stated he informed RN 1 to get an x-ray to confirm the new tracheal tube placement. RT 2 stated Resident 1 ' s breath sounds were diminished with minimal airflow due to a smaller size of the new tracheal tube. During an interview on [DATE] at 4:30 p.m., RN 1 stated RT 2 did ask RN 1 to obtain an order for an x-ray on Resident 1 to confirm the new tracheal tube placement, but RT 2 said Resident 1 was okay. RN 1 stated RT 2 mentioned it casually and he (RN 1) did not call MD 1 to obtain a new order for the X-ray to confirm Resident 1 ' s new tracheal tube placement as requested by RT 2. RN 1 stated he (RN 1) informed MD 1 when Resident 1 was having distress on [DATE] at 5:55 a.m. RN 1 stated there were no prior notifications made to MD 1. During a concurrent interview with RT 5 and a review of Resident 1 ' s Tracheostomy Tube Change form, dated [DATE], on [DATE] at 10:33 a.m., RT 5 stated that when RT 2 was unable to insert the current size (same size) tracheal tube, RT 2 must notify the doctor and get a new order for the new size of the tracheal tube. RT 5 stated when RT 2 noticed Resident 1 had diminished breath sounds as indicated on RT 2 ' s notes, RT 2 needed to send Resident 1 to a General Acute Care Hospital (GACH) for further evaluation. RT 5 stated Resident 1 ' s minimal airflow was not a good thing. RT 5 stated it would be a concern when Resident 1 ' s diminished breath sounds was a new onset. RT 5 stated on [DATE] at around 5:58 a.m., RN 2 called her in Resident 1 ' s room. RT 5 stated RT 3 and RT 6 were already performing chest compressions on Resident 1. RT 5 stated Resident 1 was lying flat in bed, pulseless (without a heart rate), and Resident 1 ' s nail beds were pale. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:39 a. m., RN 2 stated on [DATE] at around 5:50 a.m., while getting a report from RN 1, RN 1 stated Resident 1 needed a follow up due to prior issue with tracheostomy. RN 2 stated he (RN 2) did an initial round and saw Resident 1 was pale in color. RN 2 stated he yelled, I need help here. RN 2 stated Resident 1 was still breathing but he (Resident 1) was struggling to breathe. RN 2 stated when RT 2 downsized Resident 1 ' s tracheal tube, and RT 2 endorsed to RN 1 to notify MD 1 then RN 1 must notify MD 1. RN 2 stated RT 2 can also communicate to the doctor (MD 1). During an interview on [DATE] at 1:07 p.m., RT 2 stated RNs (any RN) must notify the doctor when RTs (any RT) downsized the resident ' s tracheal tube. RT 2 stated RNs must update the doctor because it is a new airway and RNs must obtain new orders for the new tracheal tube size. During an interview on [DATE] at 1:17 p.m., RT 3 stated that on [DATE] at 5:55 a.m. he (RT 3) was close by when RN 1 called to help Resident 1. RT 3 stated he ran into Resident 1 ' s room and he (RT 3) was the first staff assessing Resident 1. RT 3 stated Resident 1 was not breathing, the resident had no pulse, and the resident ' s color was dark. RT 3 stated he (RT 3) checked and saw Resident 1 ' s tracheostomy tie was loose, and Resident 1 was not breathing. RT 3 stated the canula (a small tube that is inserted into a body cavity for medical purposes) was still in and he tightened the tracheostomy tie. RT 3 stated when there is a need to downsize the tracheal tube due to decannulation, one must notify the doctor and ask for a new order for the new tracheal tube size. During an interview on [DATE] at 4:30 p.m., MD 1 stated he (MD 1) was notified of Resident 1 ' s change in condition only when Resident 1 required emergency services on [DATE], at 5:55 a.m. During an interview on [DATE] at 9:32 a.m., RN 1 stated if RT 2 had told RN 1 that Resident 1 had diminished equal breath sounds and minimal airflow, he (RN 1) would monitor Resident 1. RN 1 stated he would do a COC but would have not reported to MD 1 at 4 a.m. because MD 1 would have not responded to his (RN 1 ' s) call at that time (4 a.m.) RN 1 stated he would have waited until the morning (unspecified time) to inform MD 1. During a concurrent review of Resident 1 ' s Trach tube change document, dated [DATE] and interview with the DON on [DATE] at 10:11 a.m., the DON stated, tracheal tube decannulation is not expected but it can happen. The DON reviewed Resident 1 ' s Trach Tube Change Document, and stated staff (in general) needed to notify the physician when a smaller tracheal tube is used. The DON stated MD 1 was not notified when RT 2 downsized Resident 1 ' s tracheal tube. The DON stated the start of the COC for Resident 1 was when Resident 1 ' s tracheal tube decannulation occurred. The DON stated when there was a COC, the resident ' s family member and doctor must be notified. The DON stated RN 1 should have called MD 1 when Resident 1 was not stable. The DON stated that based on Resident 1 ' s Trach tube change notes written by RT 2, Resident 1 was not stable when Resident 1 had diminished bilateral breath sounds with minimal airflow. During a concurrent review of Resident 1 ' s Tracheostomy Notes and interview with the DON on [DATE] at 10:55 a.m., the DON stated Resident 1 ' s Tracheostomy notes, dated [DATE] indicated that Resident 1 had been rhonchi throughout his (Resident 1 ' s) stay then after the tracheostomy tube change on [DATE] due to the tracheal tube decannulation, Resident 1 had diminished bilateral breath sounds with minimal airflow. The DON stated, it was a new change of condition. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the current facility-provided P&P titled, Change of Condition, last revised on [DATE], indicated, to ensure proper assessment and follow-through for any resident with a change of condition. c. Upon a change in condition for any reason, nursing staff member are to take the following actions. Physician shall be called promptly. If for some reason physician cannot be reached, alternative physician shall be contacted. If alternate cannot be reached, Medical Director is to be contacted. All contacts or attempt to contact shall be documented and include the correct time of the activity. If no physician is available, arrangements are to be made for physician services that may include transfer to ER (emergency room) for appropriate care. A review of the current facility-provided P&P titled, Reinsertion (putting something back into or inside of something else) of Accidental Extubation (removal) of Trach Tube, undated, indicated sub-acute licensed staff, including RCPs (Respiratory Care Practitioners), RNs, and LVNs, must reinsert trach tubes that have been accidentally extubated. 3. Unsuccessful attempts to reinsert trach tube will be brought to the attention of the RCP or Nurse Manager. 4. Orders to replace extubated trach tube will be included in the physicians ' orders. A review of the current facility-provided P&P titled, Cardiopulmonary Resuscitation, undated, indicated to provide life support to an individual. Steps: 1. Determine consciousness of individual shake and shout, Are you alright? 2. Call for help: 911 or EMS (Emergency Medical Services). 3. Position the individual flat on back. 4. Tilt head back and open airway. 5. Check for breathing. 6. Give two full breaths. 7. Check for pulse.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43878 Based on observation, interview and record review, the facility failed to post the daily staffing information accurately in the sub-acute unit on 5/14/2024. The posted daily staffing information posted was for 5/15/2024. This deficient practice had the potential to result in residents, visitors, and facility staff not knowing how many staff were available to provide care to the residents. Findings: During a concurrent observation and interview on 5/14/2024 at 4:45p.m., with the Infection Preventionist (IP), the IP stated the posted nursing staffing information posted in the subacute unit nursing station is dated for 5/15/2024. The IP stated the posted nursing staffing information for 5/14/2024, is behind the 5/15/2024 nursing staffing information. During a concurrent observation and interview on 5/14/2024 at 5:06 p.m. with the Director of Nursing (DON), the DON stated the posted nursing staffing information is dated 5/15/2024. The DON stated that the Director of Staff Development (DSD) is the one responsible for posting the nursing staffing information. The DON stated the DSD posted the nursing staffing information for the next day before she left facility at 3 p.m. The DON stated the posted nursing staffing information should should be the current nursing staffing information to show the accurate hours worked by the nursing staff. A review of the facility ' s policies and procedures, titled, Posting Direct Care Daily Staffing Numbers, last revised on 8/2022 indicated facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two hours of the beginning of each shift, the number of licensed nurses (RNs, LPN, LVNs, and the number of unlicensed nursing personnel (CNA and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The information recorded on the form shall include the following: b. The current date (the date for which the information is posted).